

HOT FLASHES • EARLY MENOPAUSE • EXERCISE • MENOPAUSE IN JAPAN

Winter, 1990

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Healthsharing

A C A N A D I A N W O M E N ' S H E A L T H Q U A R T E R L Y

The Colours of Menopause

Experiences of women
from different cultures

HOT! HOT! HOT!

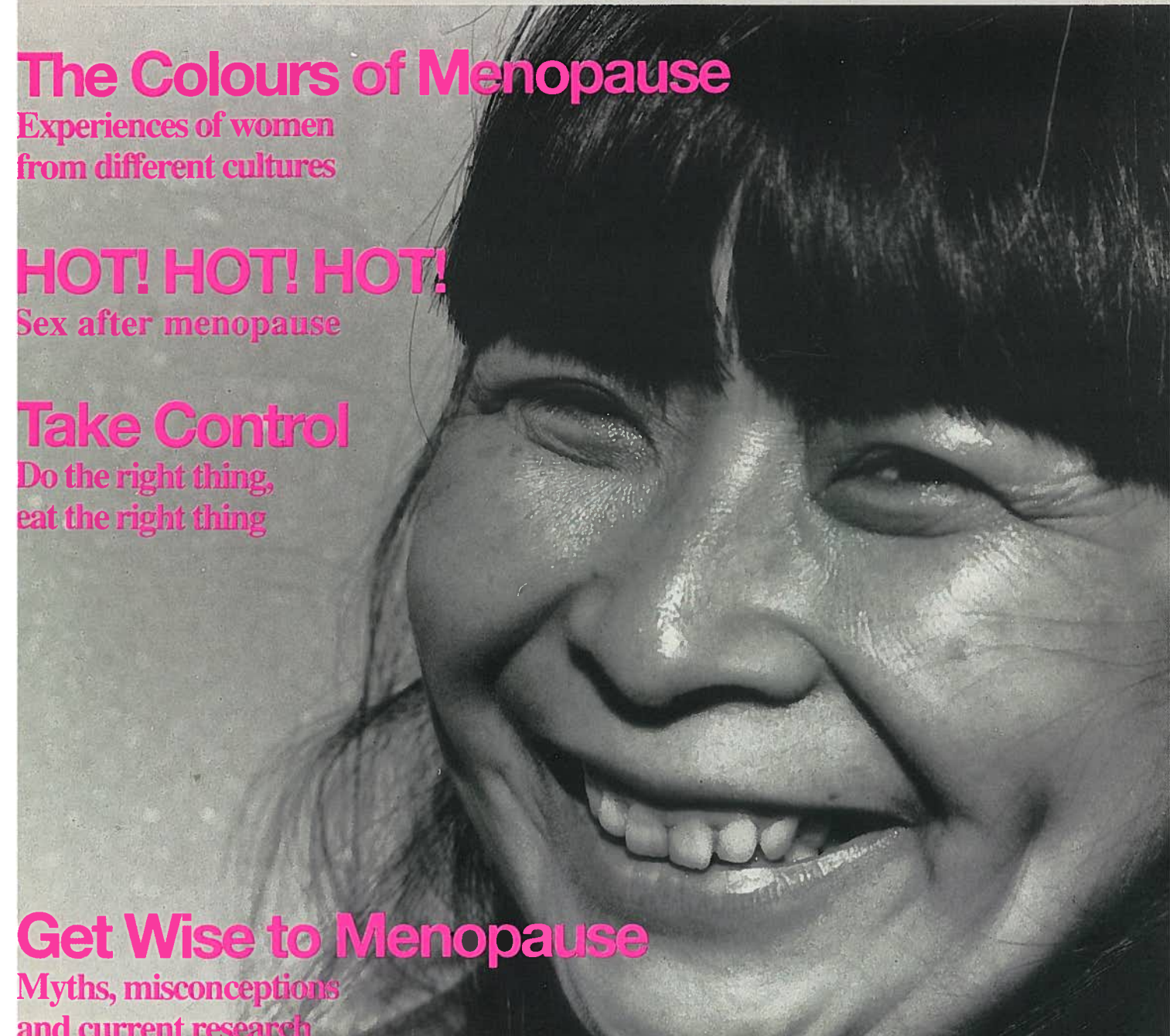
Sex after menopause

Take Control

Do the right thing,
eat the right thing

Get Wise to Menopause

Myths, misconceptions
and current research



INSIDE

Healthsharing

Vol 11:4 December, 1990

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Women Healthsharing would like to thank the following organizations for their financial contribution toward this special issue of *Healthsharing*: Regional Women's Health Centre and The Women's Health Centre at St. Joseph's Health Centre.



Barbara Pasternak

COLLECTIVE NOTES

Menopause is a Time of Life

We are extremely pleased that you are holding this issue of *Healthsharing* in your hands. It's been a long time coming and we feel very proud of it. We believe that this special issue represents some new thoughts on menopause and a perspective which speaks to all women. It was wonderful to work with the members of the guest editorial committee and we want to thank them for their insight, energy and commitment (as well as the many hours of meetings). We hope you find it useful personally and in your work with other women.

On a more sombre note, we are still alive eight months after the Tory budget cuts. We're struggling to build a solid financial base for the organization. We are also in the process of setting up a community board which we hope will bring new energy and ideas to our editorial direction and fundraising efforts.

In the last issue we asked you for donations and we want to thank everyone who sent money and letters of support. We're asking you to continue your support by renewing your own subscription, giving a gift subscription and convincing other women to subscribe. If every subscriber got one more person to subscribe, we would double our subscriber base and increase our income and influence. We also want to encourage all of our readers to ask their local bookstore or health food store to carry *Healthsharing*. (Our distributor is the Canadian Magazine Publishers Association.)

As you may have noticed, we didn't publish a Fall issue. Thank you for your patience. We have extended everyone's subscription by one issue to make up for this.

We're trying our best to hang in

there. We hope to have more positive news in the next issue. Until then, thank you for all your support.

Susan Elliott, Amy Gottlieb, Lisa McCaskell, Monica Ruitort

In the winter of 1986, *Healthsharing* published a special issue on menopause. To date it has been the most popular issue and *Healthsharing* continues to receive requests for copies. For this reason the Women Healthsharing collective believed that a second special issue on menopause was wanted and needed.

In this issue we address menopausal experiences of women from other cultures, lesbian women and women who face early menopause. We also examine issues around sexuality and look at the role of exercise and nutrition in dealing with menopausal changes. The task of addressing all of these issues in limited space is immense. We will begin to examine these concerns as well as update the continuing hormone debate and provide information about those ever persisting hot flashes. This issue acknowledges the need for further information and awareness by all women as they seek to fully understand menopause.

Menopause is a normal part of growing older. A weight gain of 10 pounds around the time of menopause is the body's response to staying healthy. Heavier women are less at risk for osteoporosis than thinner women. Yet our role models for aging are women like Jane Fonda and Joan Collins, two women committed to maintaining bodies of 20-year-olds. The societal norm is to deny our biology.

Advertising still plays too large

a role in the shaping of women's behaviour and self-images. Oil of Olay is determined to fight aging. "We are going to fight like hell," their ads say.

Pharmaceutical companies, along with the medical profession, continue to treat menopause as a deficiency disease and in spite of ongoing controversy, actively promote hormones. We have learned that a goal of the pharmaceutical industry is that menopausal women who visit their doctors leave with a prescription for hormone replacement therapy (HRT).

This past year, Ayerst, the producer of Premarin (the brand name for estrogen), started an aggressive national advertising campaign. Leading Canadian newspapers ran an advertisement which purported to be "A message in the interest of women, to help make life more livable." Following was a checklist of common discomforts and normal changes women frequently have at the time of menopause. The ad advised women to complete this checklist and discuss it with their physicians. Many of the check list items were common complaints expressed by men as well as women in mid-life.

At the same time Ayerst undertook an advertising campaign in medical journals informing physicians that "a public awareness program has been initiated urging women in their menopausal years to get the real story on the menopause, its cause and effect. And to get the facts from a professional source. You. The physician." This ad promoted Premarin for relief of menopausal symptoms.

We ask ourselves why Ayerst is conducting such an aggressive campaign now? Is it possible that Ayerst is responding to the growing independence of women? Indeed, women are organizing, questioning and becoming more aware of the choices available.

Menopause is about choice. For some women, it is a celebration, a rite of passage. Yet, others fear menopause as the beginning of the end. Our knowledge of menopause is from a white middle class perspective. We know little about menopausal women working in fac-

tories, domestic workers, immigrant women and poor women. Many of these women have no choice but to live through menopause as they struggle to maintain and support their families and communities. They can not take time off to attend to their needs; nor can they afford the costs of alternative therapies or prescription drugs.

Pharmaceutical companies, physicians, health care workers and women themselves focus on the individual's symptoms and behaviour. However, in so doing we

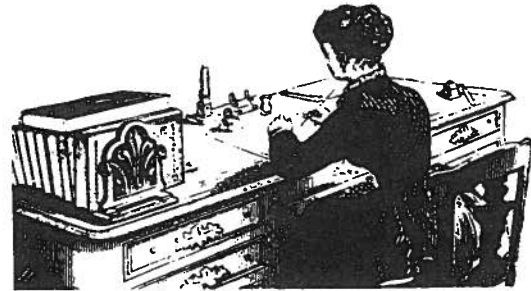
are not dealing with the real symptom of menopause - society's attitude toward aging, specifically women and aging. Aging women are not valued and their contributions are not recognized, in part because of the loss of reproductive abilities. The new and rapidly growing field of reproductive technology has put women's bodies and reproductive capabilities even more under the microscope, fragmenting women into bits and pieces. This process is now continuing into menopause where experiments with in vitro fertilization

include menopausal women.

The time has come where we must begin to shift from a fragmented approach to a more holistic approach. Menopausal women are not the problem. The problem is how menopausal women are viewed and subsequently treated. Aging is not a disease and menopause is a time of life.

Zelda Abramson, Jane Boudebab, Noreen Crawford, Margaret de Souza, Amy Gottlieb, Melida Jimenez, Janine O'Leary Cobb, Elsie Petch, Gail Weber

LETTERS



We encourage readers to write. Your comments and criticism are just as important as the original articles and columns published in the magazine. Please take the time to share your opinions with other readers.

Healthsharing reserves the right to edit letters for length, and print them, unless they are marked "not for publication."

Informed and Educated

My life has been made very busy over the last few months with the birth of my second child...and I must confess that I was also considering not renewing this and other magazine subscriptions as a way of making our budget more manageable as we as a family try to survive on one small income for a while. This morning, in spite of the fact that my infant daughter is sleeping in and I could be too, I got up early to read the issue of Healthsharing

that arrived in yesterday's mail. I thought about how *Healthsharing* has informed and educated me over the past few years about how I can enter a doctor's office with much more confidence than I was once able to do, and I've decided that there are many other things I would sooner do without for awhile.

*K. Franz
Gretna, Manitoba*

Motivated and Sane

Thanks for the sharing. It keeps me motivated and sane while I try to make changes from within the established medical system.

*K. Moyer
St. Catherines, Ontario*

Appalled

I was appalled to hear of the government's withdrawal of financial support to your excellent publication. Best wishes for your ability to continue operating despite

such adversity.

*K. Lafreniere
Weston, Ont.*

Cover to Cover

As always, your last issue of *Healthsharing* was excellent - it's one of the few magazines I read from cover to cover. I trust you will be around for many years to come.

*A. Grant
Minnedosa, Manitoba*

Can Not Turn Back the Clock

Thank you for the article on hysterectomy by Zelda Abramson. ["Don't Ask Your Gynecologist If You Need A Hysterectomy...," *Healthsharing*, Summer, 1990] I have had a hysterectomy...what I really need now is a subsequent article explaining some natural ways to keep me in good health. I can not turn back the clock so please write something positive that I can build on.

*J. Eden
Burlington, Ontario*

Wonderful Inspiration

Your magazine is a wonderful inspiration - I am continuously pleased with your articles. Colorado does not have a very connected sense of feminism - we find it here and there.

*L. Juliet
Boulder, Colorado*

Contact

It's good to have contact with a part of Canada through you.

*S. Costa
Pietrasanta, Italy*

Important Resource

Hearing from women satisfied with their breastfeeding experience is wonderful, and I'm pleased to hear of the supportive environment in which Ms. Park [Letters, *Healthsharing*, Summer, 1990] was able to give birth and breastfeed. All of us

working in the lactation field, whether volunteer or professional, look forward to the day when breastfeeding is indeed a community norm and this kind of reception is common. We also look forward to the day when most women breastfeed their babies and there is such extensive community knowledge about breastfeeding that a profession or organization for this purpose is unnecessary.

The frustration over the huge numbers of women experiencing so much difficulty with breastfeeding that they could not continue, however, is the reason La Leche League come into existence nearly thirty-five years ago, and why the lactation consultant field was established more recently. There is still much work to be done in Canada before all women who wish to breastfeed can successfully do so for as long as they wish with full support from society in general, and the health professions in specific.

Often women who breastfeed without difficulty find it difficult to understand why other women are not able to. The attitudes of our society and health care system toward breastfeeding play a big part in determining whether an individual woman will successfully breastfeed. Other factors, for example, babies with sucking problems, also play

a part and this is where expert help is often needed. Most women will never need to consult a lactation consultant, but for those who wish this type of contact, or those who require it due to breastfeeding difficulties, the profession is an important resource.

Breastfeeding happily is indeed one of the "pure joys of motherhood" as Ms. Parks mentions. The reason I became a volunteer breastfeeding counsellor, and then a professional lactation consultant, is because I experienced this joy and wanted to ensure that "more women could experience it as I have."

*Leslie Ayre-Jaschke
Peace River, Alberta*

Enjoyed and Benefitted

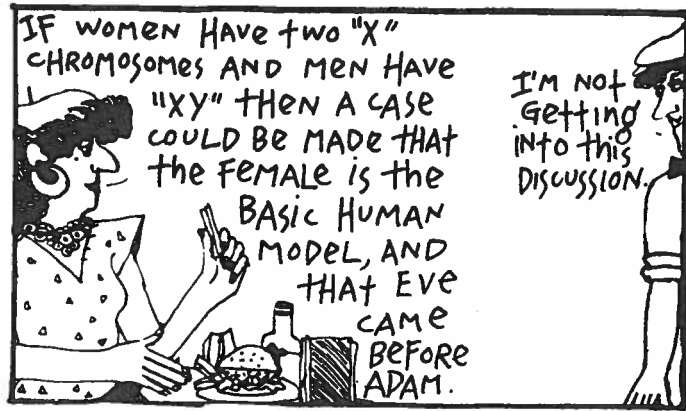
I have enjoyed and benefited from your excellent publication for several years, and was angered to hear about the federal government cut backs to *Healthsharing*.

*P. Disano
Kitchener, Ontario*

Slightly Different

I read your magazine for the first time last month...it's nice to read articles that reflect opinions that are "slightly" different from the ones we get in medical school! Keep up the good work.

*L. Duggan
Ottawa, Ontario*



Nicole Hollander/ Never Take Your Cat to a Salad Bar

HIV and Nonoxynol-9

I was pleased to see the issue of AIDS and sexual assault addressed by Megan Williams ["AIDS and Sexual Assault," *Healthsharing*, Summer, 1990]. There was however, a major problem with the article.

Although nonoxynol-9 foam has been found to kill the Human Immuno deficiency Virus (HIV) in the laboratory, there has been no absolute evidence that the foam prevents transmission of HIV in people. It is therefore, misleading to assure women that "the application of nonoxynol-9...will eliminate any possibility of HIV transmission."

I agree that any chance of spermicide foam working to prevent HIV infection and alleviate the fear of AIDS is reason to consider its use. Unfortunately, there is now also some concern that nonoxynol-9 foam may, by inducing vaginal irritation

and inflammation, actually enhance the spread of the AIDS virus. This possibility is outlined in an article in the *Medical Post*, Vol.26, no.27 (July 24, 1990).

I believe that women should be made aware of all available current information - pro and con - so that they can reach appropriate individual decisions with respect to the use of nonoxynol-9 foam.

*S. Friedman
Toronto, Ontario*

The Real Issue

The movement for patient's rights is growing in scope and voice. People are educated and informed and they want more autonomy. The article that Maggie Burston contributed, ("Patient's Rights: An Agenda for the Nineties," *Healthsharing*, Summer, 1990) is timely and helpful.

It is time for patients to assert their rights to infor-

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mation they can understand, to have access to their own lab results and files, to have their decisions respected and their intuition validated. For women, the patient's rights movement has evolved as we become increasingly fed up with the high tech medical monopoly. Feminist health networks object to the institutionalized and standardized medical procedures that remove choice and control from the female patient and impose it upon the overburdened health system.

This offence is most obvious and most outrageous in the area of reproductive health and choice. The handling of the contentious abortion issue and the controversies created by new reproductive technologies illustrate how political, legal and medical patriarchy fail to

respect the requirements of women. With the federally appointed Royal Commission on New Reproductive Technologies we are again seeing attention taken by issues of legislation, funding and standardization rather than being focused on the only issue that really concerns individual women and their advocates.

The real issue is control. Until women are in control of their own reproductive health and destiny we will find little comfort in royal commissions and new laws that seek to further institutionalize human procreation.

*Lisa Leger
Toronto, Ontario*



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UPDATE

Menopause and Birth Control

As menopause approaches and ovulation becomes more irregular, we become less fertile - that is, less likely to become pregnant. Irregular periods make it difficult to predict when we are fertile and we cannot use a missed period as an indicator of pregnancy the way we did before.

Pregnancy scares cause great anxiety when we know we are taking contraceptive risks. [Heterosexual women] should use some method of birth control for 12 to 24 months after our last period. If you are taking hormone

replacement therapy you still need to use birth control. The doses of estrogen and progesterone in HRT are not high enough to prevent ovulation.

Excerpted from A Book About Menopause, The Montreal Health Press, Montreal, 1988. Bulk orders of this 50 page booklet are available in French or English to women's groups and women's health centres from The Montreal Health Press, P.O. Box 1000, Station Place du Parc, Montreal, Quebec, H2W 2N1, (514) 272-5441.

Lupron - new wonder drug

LhRh analogs (commonly known as Lupron) are synthetic hormones often prescribed to women suffering from severe fibroids and endometriosis. The analogs are effective in reducing or eliminating pain, heavy bleeding, endometrial implants (in cases of endometriosis) and in shrinking fibroids. The analogs drastically reduce the ovaries' production of estrogen and progesterone, with an effect similar to menopause. But, once treatment is stopped, all benefits are lost. The side effects are many and vary from woman to woman. Like menopause, the most typical complaints are hot flashes, night sweats, vaginal dryness and osteoporotic changes (loss of bone mass). Other side effects include reduced libido, weight gain, headaches, diarrhea, anxiety, depression, forgetfulness, and low enthusiasm

and motivation.

Women generally are unaware that this last of side effects are related to the analogs and are confused and frustrated by the dramatic personality changes and lack of control they are experiencing.

Analogues are relatively new drugs and must be used with absolute caution. They are very potent and should not be taken for a long period of time. The long term effects are not known. Yet, it appears to be the new "wonder" gynecological drug. Even women suffering from pre-menstrual syndrome (PMS) are being prescribed analogs. PMS in extreme cases can disrupt and debilitate a woman's life for two weeks out of every calendar month. The analogs' effect is experienced every day of the calendar month.

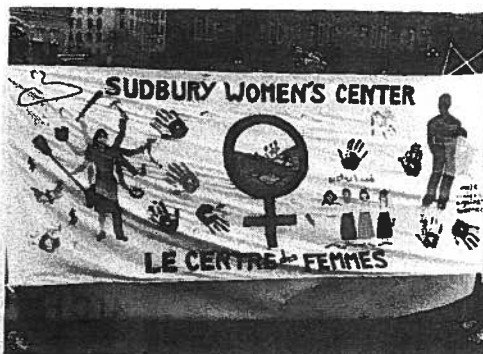
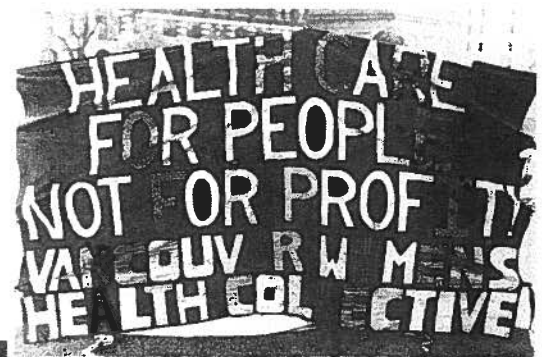
ZELDA ABRAMSON

Speaking the truth about our lives

Over 200 women's organizations across the country sent banners to Ottawa for the Banner Project protest in early October, coinciding with the Commonwealth minister's conference on women's affairs. Braving the rain, women unfurled the

beautiful banners on Parliament Hill, illustrating the reality of women's lives across Canada and challenged the federal government's abysmal record on women's equality.

WHS



Janine O'Leary Cobb

The Wisdom of Menopause

A great deal of medical research about menopause starts from the misconception that reproductive woman is the norm, and that non-reproductive woman is therefore abnormal, inadequate and potentially diseased.

This misconception permeates articles in medical journals, where naturally low estrogen levels during post-menopause are labelled "deficient," hormone production "insufficient," organs "atrophic" and almost every evidence of post-menopausal physiology a "lack" rather than a change.

And because the topic of menopause is not yet free of the taboos which have surrounded it for centuries, menopausal research is only in its infancy. An understanding of the mechanism of menstrual cycles became possible only in the 1920's with the discovery of hormones, and a fundamental aspect of menopause, the hot flash, was first scientifically investigated as recently as 1975.

Our knowledge about menopause is impoverished on a number of levels. In her recent

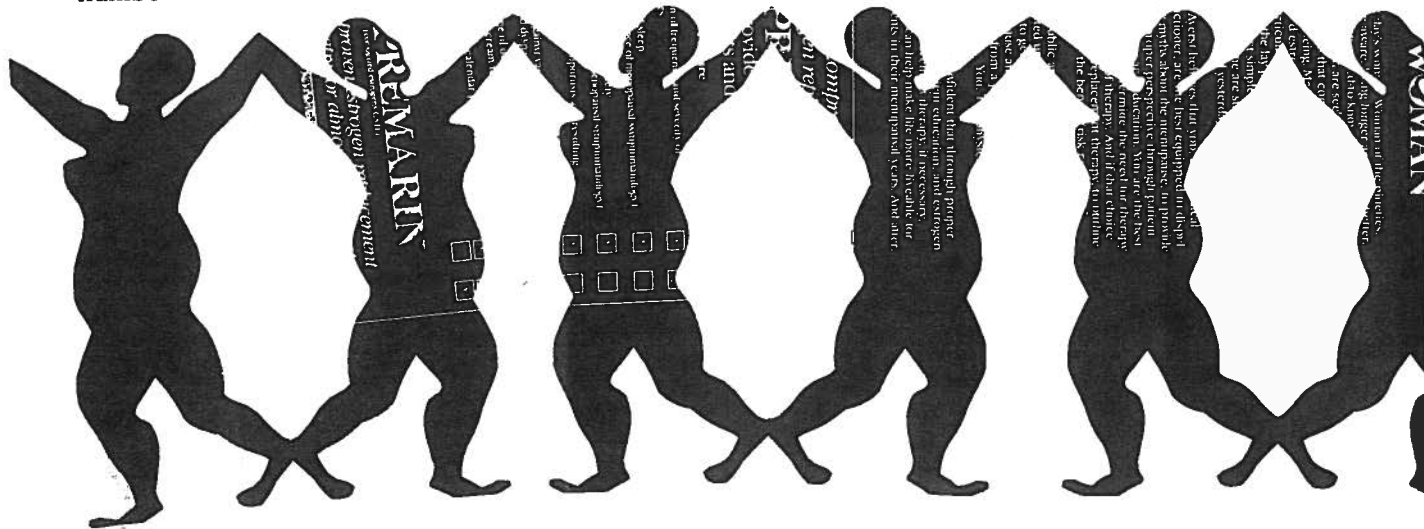
book, *The Meanings of Menopause*, Ruth Formanek tell us: "The absence of discussion about menopause kept it shrouded in obscurity, while hearsay, speculation, and reasoning by analogy kept misconceptions based on ancient ideas alive."

Members of an ageist society, scientists inevitably share in a general fear of aging, an attitude underlying medical studies which look at ways in which menopausal women might "look younger" — medications to erase wrinkles or stimulate hair growth and various cosmetic procedures to maintain the illusion of youth. While North American media continually urge women not to "look their age," medical researchers (and practitioners) uncritically accept this impossible standard and spend time and money coaxing women to

use insufficiently-tested medications or surgical procedures by appealing to their vanity.

Unfortunately, we have no studies of women who have never smoked, who have remained physically active, who have maintained a healthy low-fat diet and who move into menopause with bodies toned and fit. There must be such women in North America but there has been very little interest in studying well women and, until we can separate effects of menopause from the wear-and-tear of women's lives, menopause will continue to be blamed for a whole range of complaints arising at mid-life.

Rather than looking at the whole complex of factors which affect a menopausal woman — health habits, levels of stress, family and work situation, etc. — medicine is more apt to zero in on the pres-



ence or absence of functioning uterus and the activity or inactivity of the ovaries.

Nor can we look to historical information about menopause as women have experienced it, because this knowledge is virtually absent. When we try to compare how menopause was for our great-grandmothers with how it is for us today, we have very little to go on. Because the records of our past have been overwhelmingly compiled by men, there has been little to no interest in this aspect of a woman's life. The few sources on hand are in literature or the private diaries and letters of our foremothers.

We tend to hear that menopause was virtually unknown before this century. We are told that, today, for the first time, a woman can expect to live long enough to reach menopause which distracts us from research into past experiences of menopause. It's true that the life expectancy of a woman in the 19th century or earlier was 50 years or less. However, this ignores the fact that life expectancy was based on the average of all females ever born. So this statistic includes substantial numbers of girl babies who died of contagious diseases, no to mention women who died in childbirth. More women live past menopause into old age now, but there have always been many, many women who lived through menopause.

Cross-cultural data is only beginning to be analyzed. In the introduction to her book, *In Her Prime*, Judith Brown tells us that, in 1969, information about middle-aged women was

available from only 30 of the 700 societies filed in the Human Relations Area Files, one of the best sources for information on societies other than our own. This lack results from the dominance of a male perspective in research, a dominance that is in the process of changing, and which is resulting in new and fascinating material about menopause and mid-life in other cultures.

The topic of menopause is not yet free of taboos.

Where women spend their adult years either pregnant or breastfeeding, the absence of menstrual periods is unremarkable and the transition to post-menopause may occur without the woman even being aware of any change beyond a final freedom from the possibility of pregnancy. Where seclusion for women is enforced during the reproductive years, the transition to non-reproductive status may signify a freedom which is not permitted to women who menstruate, making menopause welcome.

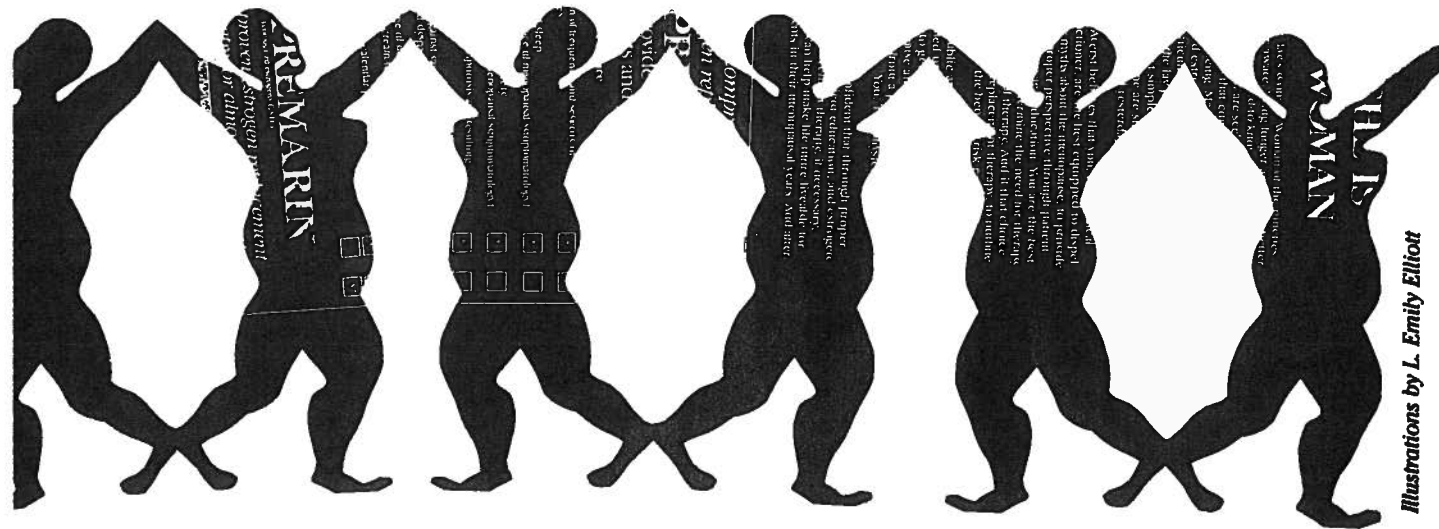
We have learned that in Japan, the onset of menopause is more likely to be marked by sore shoulders that by hot flashes. In fact, only a small minority of women even recognize

the term for hot flashes. We have learned that osteoporosis is a concern only in affluent, northern climates. Although there is a great deal yet to learn, we already know that the North American experience of menopause is by no means universal.

This growing body of knowledge about women's experience of menopause world-wide is central to a balanced understanding of the phenomenon, and offers a healthy antidote to the massive amounts of research which view menopause solely as a medical event. We may have information about what menopause does to a woman but we need a better understanding of what it means.

The following information represents an overview of current research on some of the most frequently discussed and important questions women ask about menopause:

Premature Ovarian Failure (Early Menopause): This is the term used for menopause, natural or otherwise, experienced before the age of 40 (the normal range being between the ages of 41 and 59). There is general consensus that, if at all possible, women who experience early menopause should be on supplementary estrogens until at least age 50 to protect against increased risks of osteoporosis and heart disease. There are a few studies looking at the possibility of inducing pregnancy in a woman who experiences natural menopause at an unexpectedly early age. To my knowledge, however, there are no studies looking



Illustrations by L. Emily Elliott

Beyond Menopause

The doctor prescribed "menopause" for the treatment of my severe endometriosis. The medications responsible for inducing my artificial menopause were Danazol and Lupron. At first, these treatments sounded promising. However, the sudden drop of estrogen levels caused overwhelming and extreme side effects typical of menopause.

Hot flashes and night sweats come four times a day, each flash lasting approximately 2 minutes. In the middle of every night my body feels unbearably hot - perspiration beads are on my hairline, under my breasts, down my back, and my night shirt and sheets are drenched. Severe night sweats are frequent, causing fatigue and depression. There are some severe psychological effects, specifically memory lapses.

Artificial menopause causes intense chemical and hormonal imbalances. Panic attacks are a new phenomenon and creep up unexpectedly. In addition, I have severe joint pain, numbness (pins and needles) in my fingers and toes, sensitive skin, a burning mouth beginning at midday and lasting for hours, increased drying of the eyes which looks like "pink eye" at the end of the day, and a very dry vagina that even makes walking uncomfortable.

Many of these problems are common in post-menopausal women who are between the ages of 55-60. I am 45 years old. My artificial menopause is beyond menopause. It is equal to castration.

Margaret de Souza



at the psychological and emotional turmoil experienced by many of these women.

PMS (Premenstrual Syndrome): The experience of many women suggests that increased problems with PMS in a woman's late 30s and early 40s signals a difficult menopause. This evidence has been supported by a Norwegian study which demonstrates that difficult menstrual periods are more likely to be followed by a difficult menopause. The use of progesterone to relieve PMS has not been found to be effective, so we await studies which will give us a better understanding of the reasons for PMS and ways in which it can be effectively alleviated. We also need research into the overlap between PMS and pre-menopause.

Hot Flashes: We still have no idea what actually causes hot flashes. Most women develop hot flashes before the last menstrual period and they may continue for some years. We don't know why some women have very severe flashes, including hot sweats, and some have few or none at all (although exercise, diet, cigarette, caffeine and alcohol use definitely play a part). Nor do we really understand how estrogen acts to reduce flashes. There is more appreciation of the fact that flashes recur, often severely, when estrogen is discontinued, and consequently more attention is being given to alternative remedies — clonidine (a medication for high blood pressure), vitamins E and C, dong quai, ginseng, herbal teas, etc. Research is being conducted in Europe and elsewhere on other medications which might provide relief.

Hysterectomy: After years of

regarding hysterectomy as a fairly routine operation, there is now growing acknowledgement that hysterectomy induces earlier-than-normal menopause in about 50 per cent of patients even when ovaries are intact. And women experiencing early menopause are at increased risk for osteoporosis and heart disease. We also know that the experience of menopause following surgery is not the same as natural menopause and that large numbers of hysterectomies are performed in North America unnecessarily. Unfortunately, there are no signs of medical associations or physicians organizing to promote or learn alternative procedures or to persuade their patients that hysterectomy should be an operation of last resort. (See *Healthsharing* Vol.11, No 3 for more on hysterectomy)

Oophorectomy (ovariectomy): For many years, surgeons routinely removed ovaries from women over the age of 40 "to prevent cancer". Some surgeons now use 45 as the cut-off (or cut-out) age. But there is growing recognition that ovaries should not be removed unless absolutely necessary, because their absence may contribute to problems which far outweigh the potential risk of ovarian cancer. It is also recognized that ovarian cysts are normal (most women develop them at some point in their lives) and that they are not sufficient reason to remove an ovary.

Sexuality: There is growing recognition that natural menopause may bring with it highly individual, and often fluctuating, feelings about sexual activity. To date, we have no more than guesses about the interaction of hor-

mone levels, self-esteem, physical fitness and sexual attitudes, as expressed in levels of desire and arousal during and after the menopause. In terms of surgically-induced menopause, we have new studies which demonstrate that, when ovaries are removed and testosterone production stops, serious consequences can result in terms of our ability to feel sexual desire and sexual arousal.

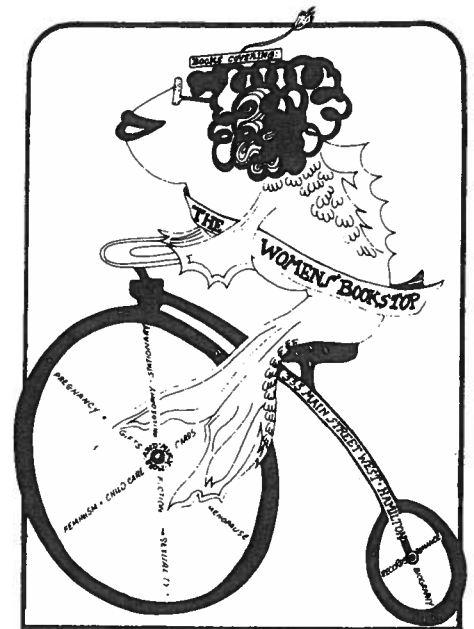
Osteoporosis: Mid-life women should maintain high calcium intake (1000-1500mg of elemental calcium daily) in conjunction with regular vigorous exercise. There is promising research on substances which add new bone as compared to estrogen, which merely halts bone loss. Fluoride has not proven to be as effective as hoped. Meanwhile, the statistics about numbers of women at risk are inflated and information about potential risk factors is not generally known, with the result that too many women are frightened into taking estrogen to halt bone loss. The actual probability of fractures associated with osteoporosis for women at standard risk is 9 per cent and, for those women in the 'high risk' profile, 23 per cent. A public-service campaign telling women about osteoporosis and how to prevent it — followed by an easily-accessible screening program (for women at high risk) is urgently needed.

Panic attacks, anxiety, depression: Recent research points to a clear association between hormone activity and brain chemistry. Feelings of panic, anxiety and depression can often be relieved by regular exercise and attention to proper diet. Antidepressants

appear to be more effective than tranquilizers (and less addictive) in relieving deep-seated depression. An earlier depressive episode (for instance, after childbirth) is the clearest predictor of menopausal depression. But, recent research suggests that depression is more likely due to family or work situations than to menopause itself, and that it is more frequent amongst women who have had hysterectomies or oophorectomies.

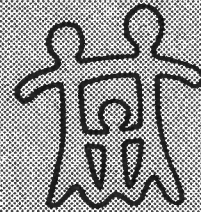
Cardiovascular Disease: Although cardiovascular disease (CDV) is usually thought of as a man's disease, women over the age of 55 are at equal or increased risk as compared to men, and estrogen supplementation may be one way of protecting women at risk. But even if estrogen protects, the addition of progesterone (contained in all hormone replacement therapy to prevent uterine cancer) may dilute that protection. For that reason, many experts are now reverting to prescribing estrogen alone, viewing the increased risk of endometrial cancer as small compared to the added protection given the heart. On the other hand, the American Heart Association does not recommend estrogen until more studies are conducted. This is a point of great controversy and additional research is eagerly awaited.

Breast Cancer: The relationship between use of supplementary hormones and risk of breast cancer has been debated for years but there now seems to be a general consensus that prolonged use of oral contraceptives (particularly when started at a young age) leads to increased risk of breast cancer. Menopausal hormones are pre-



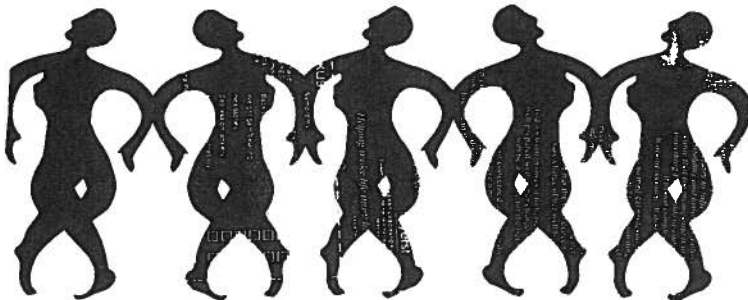
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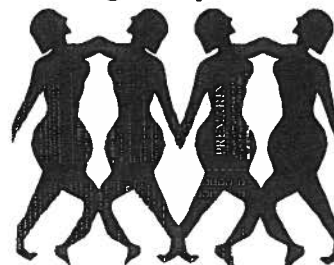
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scribed at much lower doses than oral contraceptives. Some researchers claim that there is no risk; others argue that there is increased risk, but that a modicum of risk is acceptable given the positive benefits of estrogen on bone density and heart health. This is currently the area of greatest controversy in menopausal research.

Onset: It has been established that heavy smokers will experience menopause up to two years earlier than non-smokers and that women who have never borne children will have their last menstrual period earlier than women with children: the more pregnancies, the later the menopause. Women with a history of closely-spaced menstrual periods tend to finish menstruating earlier than women with widely spaced menstrual periods. There appears to be a genetic tendency to earlier or later menopause, based on the maternal line, but there has been no association found between age at menarche (first menstrual period) and age at menopause.

Research has established that menopause is not seen as a significant event by the majority of women presently experiencing it or the women who have experienced it. Menopause is still seen as something mysterious and to be feared by many younger women and it continues to be the butt of jokes by the ignorant. As we learn more about the closure of a woman's reproductive life, we are better able to counteract outmoded prejudices and to openly welcome research which will help us to stay healthy for years to come.

Janine O'Leary Cobb is founder and publisher of A Friend Indeed, the national newsletter for women in menopause and mid-life and author of Understanding Menopause.



**Hormone
 Replacement Therapy**

Estrogen is a female sex hormone which is present in both men and women. More of the hormone is present in women. Estrogen is primarily produced in the ovaries and stimulates growth of the lining of the uterus. Progesterone is the other female sex hormone produced by the ovaries. It prepares the lining of the uterus for pregnancy during the second half of the menstrual cycle. Hormone Replacement Therapy (HRT) are hormones prescribed to women during the menopausal years and thereafter. These hormones can either be from a natural source such as an animal, or from a synthetic (chemical) source. Their usefulness, side effects and risks are similar. There are many hormone preparations available including estrogens with or without progesterone and testosterone (male hormone). These drugs can be administered by mouth, as a cream, as a transdermal patch, and injections. Some pills may contain a combination of estrogen and tranquilizers. Many women do not realize this.

What Can HRT Do?

Eliminate or reduce hot flashes • Improve vaginal dryness • Prevent Osteoporosis • May prevent coronary artery disease

What can HRT not do?

Eliminate anxiety or depression • Prevent or retard aging • Increase sexual desire and responsiveness • Increase physical attractiveness.

Who Should Not Take HRT?

Women with: cancer or a family history of breast cancer; heart condition or history of strokes; blood clots; undiagnosed vaginal bleeding • DES mothers and daughters • Caution is advised when a history of high blood pressure, obesity, heavy smoking, diabetes, gall bladder problems or benign breast disease is present.

Side Effects

Nausea vomiting • breast tenderness • depression • weight gain • cramps.

Zelda Abramson

HEALTHWISE

Hot Flashes

Ann Voda

What is a hot flash? Technically, a hot flash is defined as "vasomotor instability." This is a fancy term for describing blood vessels that open and then close with no relationship to normal temperature control. Research suggests that prior to a hot flash, peripheral blood vessels close or constrict, increasing internal body temperature. This is immediately followed by vasodilation, or opening of the blood vessels in order to cool down. Because body temperature has increased, another mechanism - sweating - is initiated to further cool the body by evaporation. The heat dissipation phase is the hot flash, and the cooling phase, enhanced by the sweat, is often described as a cold sweat. A variety of sensations are associated with hot flashes, as well as varying intensities which may range from mild to severe.

It is important for women to know that the hot flash is real; it is associated with an increase of up to three degrees centigrade in body heat radiating from within the body or from some part of the surface of the skin. It may affect only a portion of the body, or it may spread uniformly over the whole body. It may last less than 30 seconds or more than 12 minutes. Also, the flash may or may not be accompanied by a flush which is a change in skin colour, often on the head, neck and chest, which can range from pink to bright red.

How prevalent is the hot flash? Results of our research in the United States show that more than 88 per cent of menopausal women will experience the hot flash. It appears to be as universal in North America as the menopause itself. The high prevalence of the hot flash strongly suggests that it is a normal part of the menopause transition.

How long will they last? is the question asked most frequently by flashing menopausal women. Unfortunately, researchers do not yet know the answer. The good news, however, based on work done with colleagues in my laboratory, is that even though women can expect to experience hot flashes for 10 or more years, the frequency and the intensity of the experience decreases over time. Our research also strongly suggests that most women can expect to experience hot flashes throughout the menopause. I have had 30-year-old women as well as 80-year-old women report hot flashes. For 25 women I followed over a three-year period, the average duration of the hot flash experience was between eight and nine years. These results contradict what is found in the texts and journals which care providers consult when prescribing hormone replacement therapy (HRT). In textbooks the duration of the hot flash is reported as two to three years. Based on this erroneous information, some care providers encourage women to take HRT to "ride out the menopause and the hot flashes" and when the two years have passed, they take women off the hormone thinking that the menopause will be over.



We now know that HRT merely prolongs the transition and as soon as estrogen is withdrawn, the woman must then go through the menopause. This means she experiences the sensations and changes associated with the transition at an older age. And, going through the "change" at a later age may have important health implications.

Analysis of hot flash frequency for the women I studied shows that hot flash frequency does decrease over time. As frequency decreased, so did intensity. About a year after the start of menopause women can expect their bodies will settle into a new biological rhythm consistent with decreased levels of circulating estrogen, but they will still flash.

Obviously, the most important thing all women can do as they face their menopausal years and the spectre of hot flashes, is to learn as much as possible about the hot flash and the experiences of other women. The hot flash is not a disease nor is it a sign of emotional instability. It is a normal and a natural part of menopause. It may even begin while you are still menstruating. Worrying about it will not help because stress can be a trigger for a hot flash.

My research with women suggests that their feelings of control increased as they learned more about their bodies and about what they can expect. Women can control certain aspects of diet, dress and environment in order to find relief from hot flash discomfort. The first thing to do is to keep a record of hot flashes, their origin, spread, frequency, perceived intensity, trigger, etc. Most women I have worked with have been helped by this self-knowledge.

As a researcher and a woman who experiences hot flash warmth, I believe that the hot flash is telling us something very important about our bodies. I don't yet know precisely what the message is, but I'm not giving up. Nor should you. So buy fans, keep records and dress in layers.

Ann Voda teaches in and is the director of the Tremm Trust Research Program on Women's Health at the University of Utah and works with the College of Nursing.

Margaret de Souza

The Colours of Menopause

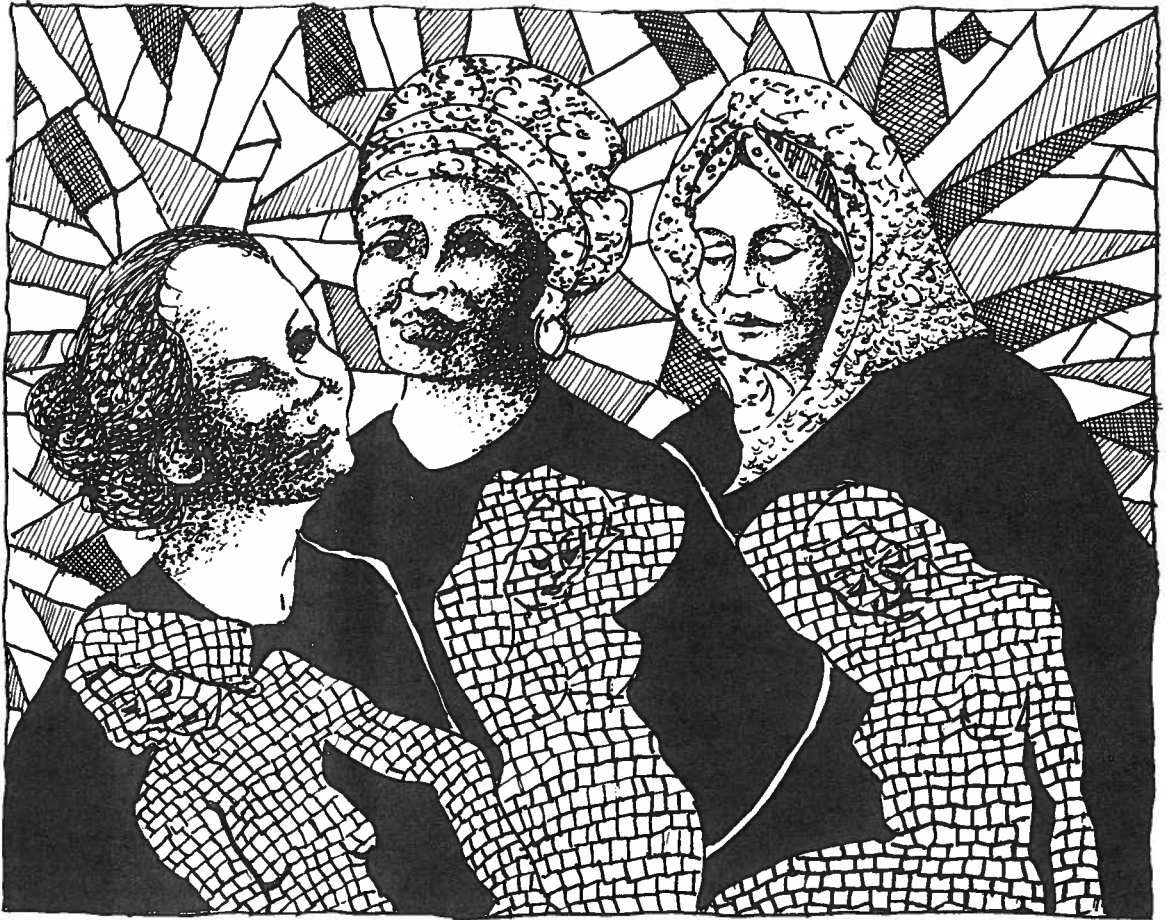


Illustration by Daphne Moore Van

Two centuries ago many women died around the time of menopause. Today, improved nutrition and disease control mean that women live an average of about 30 years beyond the menopause. Women now usually experience menopause between the ages of 48 and 52, depending on heredity, racial background and hormonal balance.

In North America, books, articles and newsletters on menopause provide support and information for the health needs of the dominant white middle class woman. Unfortunately, information and support is not geared for the Black, Asian, Latin American or Aboriginal woman in our multiracial/multicultural country. In working with women from different racial backgrounds I have observed their attitudes towards the "change of life" and how for some of them, their difficulties "adjusting" to the North American environment adds to the stress of their menopausal changes. There is a difference in the needs and expectations of non-white women going through menopause.

Understanding their attitude towards menopause will help in setting up better health care strategies which are different from those required by white, middle class, and dominant culture women and which will combat the assumption that immigrant women and women of colour are not capable of understanding, choosing or acting in accordance with their own health needs.

I am the family life counsellor at the Women's Health Centre at St. Joseph's Health Centre and have been involved with menopausal counselling for the past five years. The women I see at the centre are from many different backgrounds including Portuguese, Italian, South Asian, Polish, Chinese, Somalian, Latin American and Canadian.

I would like to share stories of menopause from these women—stories of increasing power and status, a time of positive change and fear of aging. Their fears and strengths are largely determined by their cultural background, family and community experiences and the level of support they have as women.

Most medical literature defines menopause as a deficiency and decline — a living decay. It has been created by the medical profession as a disease needing treatment. Rarely, are women seen as a whole. A hot flash or a mood swing is viewed in isolation, ignoring other possible causes. Particularly for non-white

women, how the social and political environment influences their lives must be understood and racist stereotypes dispelled.

There are also a myriad of physical and mental health problems caused by traumatic emigration experiences, cultural dislocation and loss of support systems. A 48 year old woman from El Salvador told me how she came to Canada as a torture victim and refugee with her three children a year ago. Her husband was taken as a political prisoner. She has missed her ESL (English as a Second Language) classes because of severe palpitations and chest pains. She thinks she is dying so she wants to see a cardiologist. She has had bladder infections, hot flashes, sleeplessness and sweating for the past 10 months. She used her own cultural drinks because she has no time to see a family doctor.

"No more babies! No periods! No birth control!" 51 year old Portuguese woman

In "western" culture our mental, physical and spiritual health is constantly under stress. In most non-western cultures there is no concept of stress because coping techniques are built into the culture. But it is difficult to transport them into another cultural environment; they cease to work and the dominant culture determines our health.

A 49 year old Chinese woman talks of her social life being disrupted with hot flashes and heavy periods. "I cannot concentrate, my joints ache, but my twin sister, who is a Tai Chi instructor back home, does not have any of these problems."

"Western" culture glorifies youth and menopause is viewed as a period of decline. In North America menopause is viewed as an aging disease needing medical intervention — either drugs, surgery or both. Some immigrants adopt this belief, but others will seek alternative health options or traditional medicine.

A 50 year old Sikh woman from India talks about how her mother dealt with menopause differently. "My mother never dyed her hair like I do. I have to take estrogen for

my sweats. My mother used to complain of a "hot fever" coming on and off with sweating. When the sweating got worse, she went to the folk doctor."

In Canada at the beginning of the century doctors hospitalized menopausal women for depression. Today, menopause continues to be treated with tranquilizers and hormones by physicians and psychiatrists.

An Italian woman describes her experience. "When I had those panic attacks my hot flashes got worse. My husband told me that this was the beginning of a nervous breakdown. He took me to a psychiatrist and I was given tranquilizers."

In dominant Canadian culture there is an emphasis on the "nuclear family." Stress due to the triple burden of the roles of wife/mother/worker can negatively effect menopausal changes.

"I could slaughter the kids!"

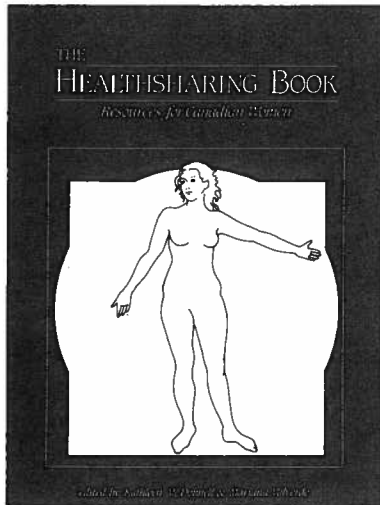
says a 47 year old Chinese woman. "I have a bad headache, hot flashes and these palpitations. I am leaving home! I am fed up of being a taxi driver and a housekeeper."

Some cultures that are influenced by "western culture" react to menopause with a sense of loss, a loss of their ability to bear children and their youthful image. A 48 year old Polish woman describes her pain. "I am sad so sad - no more babies! These hot flashes remind me that I am getting old."

Many cultures view this midlife phase as a healthy balance because menopause liberates a woman from the fear of pregnancy, the nuisance of birth control and offers her more leisure time and privacy for love making. A 52 year old Italian woman talked about how sex was better than before. "No birth control! No babies! We have a good sex life. We spend more time getting ready."

Some cultures have a positive view of menopause. The menopause stage gives women a rise in status of power, worth and privilege. Menopausal women are seen as con-

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fidants, advisors, decision-makers and leaders of extended family and community. The Chinese, Japanese, Somalians and South Asians celebrate menopause as a triumph — women move from being powerless to being respected as wise and powerful. A Somali woman described how her 54 year old mother is a "wise woman," who takes the young girls to initiation huts.

An effective multiracial/multi-cultural perspective brings important insights to the area of menopausal health. Creative approaches are needed and could also help all menopausal women to deal positively with this life change.

Healthy menopausal care can be achieved through a health care system which cooperates with com-

"Status of power, prestige and recognition." 53 year old Chinese woman

An Indian woman compares her menopause to that of her mother. "I am sitting at home with my hot flashes, joint pains and aches, but at my age my mother had no complaints. She became the village decision-maker and arranged prayer groups at the village temple."

Some religions and cultures view menstruation as "impure" and women are ostracized from their community, but these cultures view menopause with a positive goal. It is the end of their menstrual taboos and beginning of a new dimension.

"I can now socialize with my husband and his friends," says an Afghani woman from India. "I am free, no taboo. I can visit my friends in my community."

Accessible and culturally relevant health care for menopausal women from non-white cultures is crucial. Management of menopause depends on the total culture. The menopause experience for these women could be either a positive change or a crisis.

munity-based organizations to break down cultural barriers. Instead of menopausal women being the subjects of intervention by health care professionals, these women need the tools to advocate on their own behalf.

Women going through menopause can assume responsibility for our own health care by taking control. But only if we can make choices in our health care through education, information, self-help, support and interpretation.

Black, Asian, Latin American and immigrant women need knowledge about reproductive health care and non-medical remedies such as diet, exercise and relaxation techniques in their mother tongue. This brings it closer to home and combats fear. Health information centres should be community controlled by women with a strong consumer perspective. All health information and counselling should be available in easy to understand forms in different languages.

Food patterns and dietary

"No more menstrual taboos!" 48 year old East Indian (muslim) woman

But Black, Asian, and Latin American women living in Canada experience linguistic and cultural barriers to health services. These women bring with them different cultural beliefs, traditions and practices which are not generally understood or respected by the medical system. This causes racist and inappropriate responses from health services.

habits of women from different cultures must be respected. East and South Asians eat a lot of fish, sea weed, wholegrain and tofu — foods which are rich in calcium. These guard against loss of bone mass (osteoporosis) in later life. Herbal teas, herbs, licorice root, and Ginseng are used by European, Chinese, African and South Asian women for hot flashes, fatigue and



heavy periods which are symptoms of menopause. This optimum diet often changes through the process of emigration. Skilful health professionals can help women to avoid this change and it would be useful for all women to adopt dietary practices that prevent negative menopausal symptoms — practices that are more reliable than medical remedies.

“Becoming a wise woman.” 52 year old Somalian woman

Utilization of community based organizations and hospital resources geared to their needs will give women from diverse cultures the confidence to make choices. We will be able to choose our own doctor or health care giver who may practice holistic or traditional medicine. We will be able to take control of our own health needs by asking questions, finding options or questioning medical treatment. We will also be able to explore and possibly use non-medical remedies. Tai Chi is popular among Chinese and Philippine women, giving them vigour, flexibility and inner harmony. Relaxation techniques like yoga and meditation are popular among South Asian women, helping them to calm the mind and eliminate stress. These exercises and relaxation techniques can be incorpo-

rated in community programs for immigrant women.

Some Chinese, Japanese, and African women treat joint pain, muscle spasms, and menstrual cramps with alternative methods like accupressure, shiatsu, acupuncture and massage. Sometimes these non-medical approaches are provided by the experienced wise women of their community. These wise women channel their energy through their bodies and hands to heal the ailments women experience at menopause. Women will eventually learn to combine alternative approaches with conventional remedies to their advantage.

“Self-help” is invaluable for any woman going through menopause. A self-help group can offer courage, strength and ‘body’ information. This support can reduce the sense of isolation as we learn the social context of our common condition. “Sex talk,” for example, is taboo in many cultures, so the physiological changes of menopause cause misconceptions and misunderstanding in both men and women. Women misinterpret lack of lubrication as a sexual malfunction and men some-

times think that a longer time for sexual arousal is a sign of disinterest. Women in post-child bearing years will benefit from the knowledge on sexuality and communication they receive through participation in a self-help group.

Multicultural menopausal women can be strengthened and empowered by allowing them easy access to all resources for multicultural health care. If immigrant women are dissatisfied with their health care they can make a choice, they can shop around, thus assuming responsibility for their own health care by being in control.

Margaret de Souza is a Ugandan-born Canadian of East Indian origin who works as the head nurse of the Family Life Program at St. Joseph's Health Centre.

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Gail Weber

A Season for Sex



On this autumn day, I sit down to write about women's sexuality at menopause, and I am finding it difficult to do this from an academic, disinterested and dispassionate perspective. Issues about women, sexuality and life transitions, such as menopause are an important part of my work and my life at this time.

Thoughts on autumn...It is rich in colour and in texture and there is a sadness about it. There is a beauty in its variability, one day cold and crisp, the next wet and dark. And then, suddenly a day of such brilliant sunshine that it is enough to warm your heart, quicken your step and make you feel that you will indeed live forever.

Is this the autumn of my life, rich in colour and texture with a hint of sadness? Is this the autumn of my sexuality after the heat of summer?

Thoughts on 1990. What a year, what a decade, what a generation! Did time used to go so fast? Did things used to change so quickly and so dramatically? Since my adulthood, we have seen a social and sexual upheaval, a women's movement, the wall has come tumbling down, Meech Lake failed, the NDP won in Ontario. Things change, life happens. It may be confusing to be a teenager today, but it is just as puzzling to figure out how to be a woman today

when you are 50, single and sexual. As a woman who grew up in the 40s and 50s, married in the 60s, got "liberated" in the 70s, and spent the 80s trying to figure it all out, I question where I am now as women in terms of my sexuality in these "golden years."

Women of my vintage who were adolescent in the 50s, grew up with enormous social prohibitions about our sexuality. It was not okay to be sexual before marriage, and afterwards, we were not to initiate sex, take too active a role or enjoy it too much. How could you with all that guilt! Female sexuality was narrowly defined; you had to be with one man, never a woman, in marriage, monogamous, in bed, at night, lights out, in the male "superior" position. And all of this was to be forever and ever.

What goes around comes around. Even after the pill and a "sexual revolution" the old taboos that prohibited our sexuality as children and adolescents come back to haunt us. Somehow sex and seniority do not seem to mix. We never see older women in films or on television being sexual without looking ridiculous or embarrassing. We as a generation have been restricted to two sexual identities — in our youth we're portrayed as pure and virginal and as adults with sexual desire we're seen as whores. We have been taught that sex in midlife is okay, if you don't look your age and sex in later life is really strange.

I think about seeing the movie "The Graduate" back in the late 60s or early 70s and identifying with the young couple who overcame enormous obstacles, married and lived happily ever after. I saw it again several years ago and found, much to my delight, that I understood and was moved by Mrs. Robinson's plight. "So here's to you, Mrs. Robinson", I judged you so harshly from the narrow perspective of my youth. There has been change, personal and societal and these changes say something about being a woman, sexuality, aging and changing times. I am sorry Mrs. Robinson, I did not know your pain.

It seems strange that just when

some women finally get to a point in their lives when they feel a sense of personal independence and autonomy, and may want to express this new found self in a sexual way, that they invariably face one of life's ironic twists. Here she is finally free from concern about birth control and the kids barging in, and, yes you guessed it her partner of some 25-30 years is finding that he is too tired, uninterested or has slowed down in his sexual responsiveness. This is referred to as the "cross over effect." Talk about bad planning. Whoever designed us must have figured that we would be long dead before we had to worry about such problems.

Another of life's hard ironies. While I write about celebrating our sexuality, I feel the shadow of death of 14 young women in Montreal just a year ago. It is with us, it always will be. We may celebrate our sexuality and our feelings of female solidarity but until we, as women, are safe from the associations of sexuality and violence, we must be forever vigilant and not forget the dangerous side of sexuality and being women.

Janine O'Leary Cobb in a recent speech described sexuality as a



process that continues throughout the life cycle. Sexuality goes beyond sexual activity..."it is the look, smell, taste and feel of being a woman" and is more about how we feel about ourselves than it is about "being sexy" or involved in sexual activity.

She explored the thought that women's sexuality has, through time, been defined for us by men "who cannot imagine sexuality except at the service of penetration". Now, this penetration she describes may be necessary from an evolutionary point of view, but it certainly misses the point about women's sexuality. The intercourse imperative we have been socialized to accept as the norm is a narrow, constricted one that does not serve women well in later life or at any time in life.

I just finished boring my poor 26 year old son, on a long distance call to Boston. I wanted to get his thoughts on what I'd written so far. He very sensitively informed me that this "intercourse imperative," this macho sexuality does not serve men well either since the need for intimacy, closeness and playfulness expressed through our sexuality is part of our humanity and not our gender.

Sexuality can be expressed in a myriad of ways. We need to create a broader definition of sexuality that expresses itself through life in different ways. The image of sexuality as a moving stream is an apt one for it describes how sexuality flows through our lives. As young girls, it is narrow, and as we reach maturity it widens, is full and spilling over. As we age, it may narrow again but it never stops flowing.

Let us celebrate our sexuality by exploring how it changes, both qualitatively and quantitatively at the time of menopause and midlife. Menopause has been referred to as "The Change of Life" and yet we know that all of life is involved with change. From our birth until our last breath, we are aging and changing. Women's lives are biologically and socially involved with change.

The physical changes that take place in our bodies around the time of menopause are difficult to separate from the physical changes of

aging. After all, 50 years of wear and tear takes its toll in fatigue, poor health and stress related illnesses. The use of alcohol and coffee, and the effects of certain medications (such as tranquilizers, anti-histamines and blood pressure drugs) affect sexuality, usually in a negative way. We know that good nutrition, adequate exercise and a reduction in stress result in good health which is reflected in our sexuality.

The specific physical differences

have us believe that the use of HRT will keep us "young and sexy forever." However, it does not effect our libido, or our ability to be aroused except in so far as it does relieve hot flashes and severe vaginal dryness.

Women as well as men may notice in the middle years and beyond that the quality and quantity of orgasmic experiences change. Some women report that orgasms are less intense, less frequent and take longer to achieve. More cre-

we start to read the obituaries and even "a quickie" takes 45 minutes.

Women I see in counselling and in education/support groups give voice to the great individuality and variability in their experience of sexuality at midlife. There may be an increase in sexual fantasies and in desire or there may be a marked decrease in interest. They may experience a change in orgasmic experience or a change in sexual orientation. Our sexuality is not



that may affect sexuality are genital changes due to a decrease in the production of estrogen. These changes are relatively easy to deal with.

With menopause, there is a thinning of the vaginal walls, a loss of vaginal elasticity, a shortening of the vagina and a decrease in vaginal lubrication. All of this sounds pretty grim, but in fact, these changes do not create problems for most women. A longer and slower period of foreplay, with the goal of pleasuring and not performance, is important.

Vaginal lubricants in the form of massage oils, saliva, vegetable oils, or KY Jelly can be lovingly incorporated into lovemaking with or without a partner. If the vaginal changes are severe, the use of a prescribed estrogen cream may be helpful for a period of time.

Around the time of menopause, the clitoris becomes larger and more exposed. Direct stimulation may be uncomfortable and so lubrication is important. As well, clear communication with a partner about what feels good and what does not, is as always, important.

Some of the pharmaceutical and medical literature on hormone replacement therapy (HRT) would

active forms of lovemaking, unhurried, leisurely and playful are important. Sometimes "sexual burnout" can be a problem and perhaps the relationship itself needs replenishment. Other women find that they become orgasmic for the first time in middle and later life and are "turned on" most of the time. It is difficult to sort out social versus biological factors. However, it has been suggested that there is a shift in the estrogen/androgen ratio at menopause. With a decrease in estrogen, the effect of the male hormone, testosterone present in both men and women, is more evident in women and accounts for an increase in libido at midlife. Perhaps when we are more mature, more self-assured and confident about who we are and less influenced by social prohibitions, we are better able to express ourselves freely and genuinely. Perhaps it is the feeling that "at last, these years are mine and I can do as I please with my life."

The quality of the sexual experience changes as does everything else. We know we are in midlife when we don't look in the mirror as much,

separate from the rest of our lives.

In the final analysis, we likely do not know all the factors that account for changes in sexuality at midlife. It is a complex issue and needs to be studied more. And the data must come from women themselves and their experiences.

Social factors that affect sexuality at midlife involve societal attitudes of ageism, sexism, homophobia and a resurgence of puritanical thinking.

Women are seen as somewhat "deficient" if we do not live up to an idealized mass cultural image of youthful sexuality. Because we're surrounded by these powerful images, it's an uphill battle to be different. We internalize these harsh societal judgements and berate ourselves for our grey hair and extra weight. Our need to look like the stereotypical females in the beer commercials, keeps the gyms, and cosmetic industries booming

Lesbian Sex at Menopause: Better Than Ever

Three years ago, Ellen Cole and Esther Rothblum, co-editors of *Women and Therapy*: a feminist quarterly, interviewed forty-one menopausal lesbians in Vermont. Their interest was two-fold: to do a study of older women regardless of their experience of menopause; and to focus on lesbians. Previous published research on menopause is based on women who obtained help for difficult experiences with menopausal changes and generally presents menopause as a negative time of life. And there is no existing research on the experiences of lesbians in menopause.

They developed an open-ended questionnaire which was advertised in both local and national feminist and lesbian periodicals in the United States. Forty-one women responded and the results were published in the Fall/Winter 1989-90 issue of the *Vermont Psychologist*. Following is a condensed version of that article.

The mean age of the 41 women in our sample was 51.5, with a range from 43 to 68 years. Given the number of respondents, the survey results are thus based on two thousand thirteen years of combined experience. All the women in the study were caucasian.

Twenty-three women (56%) had consulted their regular gynecologist (and one her homeopathic practitioner, one a nurse practitioner and another an internist) for menopausal symptoms. The most frequent symptom for which the women sought professional help was hot flashes (16 women or 39%). Fourteen women (34%) were taking hormone replacement medication and one was taking homeopathic remedies.

Twenty-three women (56%) were currently in a committed relationship with a partner. All but nine women were currently engaged in sexual activity with other women. Frequency of sexual activity ranged considerably. Nineteen women (46%) stated that frequency of sexual activity had remained the same since the onset of menopause; six women (15%) stated that sexual activity had increased, and 11 (27%) said that it had decreased. Ten women (24%) indicated that there positive changes in the type of sexual activity since menopause and 29 women (71%) indicated that there was no change in the types of activi-

ties that they enjoyed since the onset of menopause.

Twelve women (29%) found no change in the quality of sexual activity since menopause. Eleven women (27%) indicated some decrease in quality such as not being able to get as wet or decrease in intensity of orgasms. Another 12 women (29%) expressed an increase in the quality of sex since menopause. Their comments indicated that sex was better and more fulfilling.

In terms of sexual desire since menopause, 16 women (39%) found no change. Three women indicated that their level of desire had always been great. Finally, 11 women (27%) felt that sexual desire had increased since menopause.

When asked about any changes in the sexual responsiveness of their partners, 22 women (54%) had not noticed any changes. Of the 9 women (22%) who had noticed a change, these varied widely. Some women related the changes to menopause and others were puzzled as to whether the changes were related to menopause or other factors.

In an attempt to rectify the focus on sickness during menopause, we specifically asked women about positive changes in their lives since menopause, including positive sexual changes. Many women wrote about the enjoyed absence of menstruation. Women also mentioned a variety of other changes including increased sex, increased orgasms, greater self-acceptance, coming out as a lesbian, feeling more free, positive change in body fat distribution, less driven, developing committed relationships. Only 9 women (22%) indicated that there had been no positive change following menopause.

There are some cautions in interpreting these findings. It is a small sample and may be biased toward health. To the best of our knowledge this is the first systematic survey of the sexual attitudes of lesbians at menopause.

Sex during and after menopause for lesbians does seem to be as good as or better than ever. If all women, lesbian and heterosexual, could be free of heterosexist hang-ups and fears about sexual functioning, the aging process and partner expectation, there would be many more reports of unchanged or better, more rewarding sex and deeper relationships in our 50s, 60s and beyond.

Amy Gottlieb

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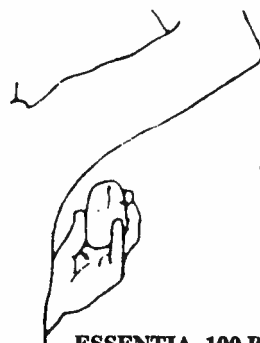
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in spite of recessions. It is often difficult to accept ourselves as aging and changing.

Today, women work at home and in the workplace to a greater degree than ever before. This may offer middle class women greater independence but being "superwoman" is hard on us. All women pay a price both physically and sexually for our double day of work. We suffer more than ever before from chronic fatigue-like syndromes.

Poor and immigrant women who work in factories, clean homes and toil in low paying, undervalued jobs struggle even more. Fatigue, poor nutrition and inadequate medical care take their toll on our lives. To be poor and 50 and to feel that we can never be as the media dictates, is to suffer a massive cultural denial of our womanhood.

In our society, heterosexual women typically have been partnered with men who are older. As a result many women at midlife are often widows and alone. Or alone as a result of his midlife madness which has him running off with a socially sanctioned younger woman. The worst part of this scenario is that we are subtly blamed for his "sexual boredom." His sexual inadequacies are somehow our fault. It's the old blame the victim routine.

In looking for ways to express our sexuality at this stage in life we can happily give up our prohibiting notions about age, race, religion and gender in seeking a partner. It is not uncommon for women to come out at midlife and enjoy a lesbian relationship which offers sexuality, companionship and understanding. Our knowledge of lesbian sexuality at midlife is scant but we do know that despite rampant homophobia there is more support for women who choose to lead an unconventional life.

The social and cultural constraints on our sexuality are great. We are told to "act your age" and to "use it or lose it." And as if all this were not enough to fret about, we now have to concern ourselves with the very real problems of sexually transmitted diseases.

Masturbation or self pleasuring may be an alternative to having a partner. With a partner, it is cer-

tainly an important aspect of love-making. Celibacy may be appropriate for periods of time or as a life commitment. There are many ways to express our sexuality and this is a choice that we make.

Psychological factors which affect us are the internalization of social labels such as "aging dyke", "dirty old lady", or the idea that we are too fat, too old, too whatever for loving. Negative judgements about our age probably affect our experience of sexuality more than all the hormones and glands in the world.

Our capacity for sexual enjoyment is dependent on our biological inheritance, our childhood upbringing and our life experiences. All of these factors come into play long before we come into menopause.

In spite of all the cultural and psychological factors that affect us at midlife, for many women it is a time of great emotional growth and liberation. Menopause is one of those marker events that gives us the opportunity to take stock, reaffirm where we are and make changes. It is a time of renewal. As we change at midlife there is the same opportunity for a renewal in our sexuality.

The good news is that there is sexuality after menopause. The sexuality of youth, of middle age and of later life is not the same and is not to be compared. If we try to hang onto the spring, we miss the summer. Each phase and stage of our lives and our sexuality is unique and perfect...like the changing seasons.

So, if indeed, this is the autumn of my sexuality, rich in colour and in texture, variable and with a hint of sadness, then let it be. I will hope to be ever open to the winter. But not just yet. I am still enjoying playing in the leaves.

Gail Weber is the coordinator of the Menopause Education Program at the Regional Women's Health Centre in Toronto.

Margaret Lock

MENOPAUSE IN JAPAN MEANS KŌNENKI

There has been a marked increase in the use of gynecological services by women in mid-life both in North America and Europe over the past thirty years. A considerable part of this can be accounted for by changing attitudes. The "change of life," once regarded as a very private event, is no longer a cause for extreme embarrassment; menopause is now a buzz word, positively "flashy" one might say, and women are actively encouraged to consult with their gynecologist about this part of the life-cycle.

Why should this be the case with an event which is certainly not life-threatening, nor even painful? Clearly some women experience symptoms which cause distress, but how wide spread is this? Why did one Montreal researcher have almost no response to an advertisement in which he wanted to contact women who were experiencing five or more hot flashes a morning as subjects in spite of a promise of good medical care in addition to payment for their services? Medical literature would have us believe that between 75 and 80% of women suffer distressing experiences as they go through menopause. And it is still widely accepted that, in addition to hot flashes and sweats, depression is associated with this life-cycle transition. But these assumptions are based on studies of women, most of whom have experienced a lot of

menopausal difficulties, and on the self-reported experiences of gynecologists. The experience of the distressed minority is used as a universal basis to define menopause and social, cultural and economic factors and personal experiences are ignored. As a result, our present "common sense" tells us that a "normal" menopause is a disease-like process which should be "managed" by the medical profession.

THE ACHING BODY: JAPANESE IMAGES OF MENOPAUSE While doing research in Japan I attended a public lecture given to a large audience of middle-aged women by a female gynecologist. Before she started her talk, the physician said that she would like to hear from the assembled women what they understood by the word menopause ("kōnenki" in Japanese), and secondly, what sort of problems they expected to have at this stage of the life cycle. Answers to the second question were along the following lines: "I think of things like migraines." "I hear a lot of women complaining about shoulder tension and stiffness." None of the women mentioned hot flashes or night sweats. This was no great surprise to me because I had obtained similar results through the use of both open ended interviews and a ques-

tionnaire. Of 105 Japanese women aged 45 to 55 who were interviewed in their homes, 78% of the responses were similar to the following: "I've had no problems at all, no headaches or anything like that...I've heard from other people their heads felt so heavy that they couldn't get up." "I started to have trouble sleeping when I was about 50; that was menopause, I think." "In my case my eyesight became weak. Some people get sensitive

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and have headaches." "The most common disorder I've heard about are headaches, shoulder stiffness and aching joints." "My shoulders feel as if they are pulled and I get tired easily."

A small number of women, twelve out of more than a hundred, made statements such as the following: "The most noticeable thing was that I would suddenly feel hot; it happened every day, three times or so. I didn't go to the doctor or take any medication, I wasn't embarrassed and I didn't feel strange. I thought that it was my age."

At the same time, a questionnaire was given to 1,300 Japanese women aged 45 to 55. A long culturally appropriate list of 57 items was presented to Japanese respondents who were asked if they had experienced any of those symptoms in the previous two weeks. The results showed that symptom reporting was very low, and, moreover, significantly different from a similar Canadian study done in Manitoba.

The symptoms most frequently reported by Japanese women, in descending order of frequency, were: shoulder stiffness, headaches, back pain, constipation, chilliness, irritability, insomnia, aches and pains in the joints, frequent colds, sore throat, feelings of numbness, and then, reported equally, loss of memory (9.5% of the entire sample), this followed closely by "heavy head," ringing in the ears, and eventually, towards the bottom of the list, night sweats (less than 4% of the sample).

Only 19.6% of the sample reported ever having a hot flash, in contrast to the Manitoba study where 64.6% of the women reported having had a hot flash at some time. In terms of severity, only 1.7% of Japanese women reported experiencing hot flashes almost daily in the previous two weeks, whereas 15% of Manitoban women reported a daily occurrence.

It seems, therefore, that the hot flash is much less frequently experienced in Japan than in Canada. In Japan, the incidence of night sweats is very low, and does not appear to be associated with menopausal status.

Menopause is not highly medicalized in Japan. There is no specific Japanese word for "hot flash" which is surprising for a language in which physical states of the body can usually be described with a lot of detail. This implies that because the experience of hot flashes is not linguistically marked that it is considered irrelevant to the health and well being of women. On the other hand, those women who have experienced hot flashes are not shy about describing them. There is a widely-shared understanding in modern Japan that it is "weak-minded" to go to a doctor with "trivial" matters such as menopausal problems. But, it is not embarrassing to experience hot flashes, provided that one tries

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to be "strong-willed" about them. It is clear that their incidence is considered purely physical with no moral or sexual connotations.

THE MEANING OF MENOPAUSE IN JAPAN For the majority of Japanese women "kōnenki" (menopause) is thought of as a

long gradual transition from one's late thirties or early forties until the late fifties. It was described by many women as the beginning of the process of getting old ("raka genshō"). The meaning of the word "kōnenki" is close to that of "change of life" in that it refers to a period of time. There is a technical word in Japanese for the end of menstruation ("heikel"), but its use is limited to medical literature and is not even part of daily language between doctors and patients. Most people think of the end of menstruation as one small part of the larger process of "kōnenki," but some people attribute almost no importance to the end of menstruation. Depression is not commonly associated with "kōnenki," and few women report experiencing it. (Studies indicate that the incidence of depression among Japanese women is only 25% of that reported for men).

Menopause is the time when a Japanese woman living in a traditional extended family, could expect her mother-in-law to retire and pass on the household management to her. At about the same time her son would bring home a young bride for her to "train" into the household routine. This included not merely doing housework but also contributing to the family occupation. Traditionally this was a good time for middle aged women. They would gradually withdraw from the daily grind and assume a position of power allotted to older women.

However, the majority of 50 year old women in Japan today live in a nuclear family. The privileges of middle age hardly exist any more. But, so far, this declining social status is not accompanied by an increase of ill health. By far the majority of middle aged Japanese women report themselves to be satisfied with life and are in good health. Nor is this declining status reflected in a growing sense of impending doom associated with the onset of menopause, an event which so far causes very little concern, although this may change since Japanese gynecologists are for the first time actively seeking to medicalize this part of the female life cycle.

A CHANGE OF LANGUAGE, A CHANGE OF LIFE Throughout North America menopause is the word used to describe this change in a woman's life. The term in itself is revealing because it is a technical term, an invention of European physicians of the last century who were attempting to standardize the female life cycle. Part of their motive was to justify their role in the care of the middle aged woman by appealing to the authority of science.

Several much older terms, including "change of life," "critical time," "climacteric," "turn of life," "age de retour," and so on, were in vogue prior to the creation of the word menopause. These terms referred to major transition points in the life cycle of both men and women. But, from the beginning of the last century in Europe and North America, their meaning was gradually confined to that "period of life (usually between the ages of 45 and 60) at which the vital forces begin to decline" (Oxford English Dictionary). However these terms were applied to men even more frequently than to women, and it was not until the middle of the 19th century that the concept of the climacteric came to be associated primarily with middle aged women.

When it was first applied, the word menopause was used interchangeably with that of climacteric and indicated a period of time lasting up to fifteen years during which gradual physical aging occurred. There was no technical word available in the mid 1800s for what women called "the dodging time" - that relatively short period of menstrual irregularity before the end of menstruation. In the early 1900s, after a rudimentary knowledge of the endocrine system was established, the meaning of the medical word menopause was deliberately narrowed, and gradually replaced the commonly used "dodging time." This change in vocabulary was not mere nit-picking about the precise use of words, but reflected a narrowing perspective as to how female midlife should best be understood. In the space of about one hundred years, a shift occurred from a position in which no sharp distinction was made

between the aging of men and women, to a narrow focus on the female, and the biological changes believed to be associated with her dropping estrogen levels in midlife.

The discovery of synthetic estrogen replacements in the early 1930s and their wide-spread marketing, particularly from the 1960s onwards, accounts in large part for the specific biological interest in middle-aged women. Despite the fact that estrogen replacement therapy has been one of the most widely prescribed medications over the past thirty years, it appears that the majority of women in North America do not seek out medical help at menopause. This part of the life cycle is still not medicalized to the

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same extent as child birth.

What can we learn from the Japanese experience? These findings must not be taken out of context and assigned simple moral judgements. We must not assume, for example, that because menopause is not medicalized in Japan that Japanese women deal with it better than North Americans; nor should we believe that North American women are more scientific about the subject, and therefore Japanese women must be ignoring a major problem

which affects their health.

More research needs to be done to see if the incidence of hot flashes is indeed considerably lower in Japan, or if this result is due to the fact that Japanese women do not recognize them. This is an extremely complex issue which will involve some careful research, especially because it has been shown that hot flashes are not linked in any simple way to estrogen levels in the blood.

My belief is that there may be significant physiological differences between distinct populations of women due to some combination of genetic variation, diet, and/or other biological factors. Whatever the reason, we should be aware that there is much more biological variation between individual women than has previously been acknowledged. A decrease in the production of estrogen by the ovaries apparently does not have the same effect on everyone, and for the majority of women produces no discomfort at all. It would be wise, therefore, to study why most women either experience no hot flashes or very few for a short time, rather than starting with the assumption that hot flashes are a universal experience. If we keep in mind the potential role of biological difference we also cannot make simple assumptions about the relationship of estrogen level to osteoporosis, heart disease, or even cancer.

Finally, I think we would do well to continue the process, already started by many thoughtful women in North America and Europe, of releasing the concept of menopause from its narrow biomedical strait-jacket. We need to broaden its popular meaning to that of mid life aging and maturity, of which the end of menstruation is only one small part; a position much closer to the current situation in Japan. Perhaps we should confine our use of the word menopause to the end of menstruation and return to one of the older terms for mid life. How about the "Turn of Life"?

Margaret Lock teaches in the Department of Humanities and Social Studies in Medicine at McGill University. She is currently doing research in Japan.

MENOPAUSE RESOURCES

Compiled by

Janine O'Leary Cobb

A Friend Indeed: For women in the prime of life, Janine O'Leary Cobb, Box 515, Place du Parc Station, Montreal, Canada H2W 2P1. Monthly newsletter of information, support and exchange for women in menopause or mid-life. Subscriptions are \$30.00 per year for ten issues (monthly except July and August).

Change of Life: The Menopause Handbook, Fawcett Columbine, New York 1986.

A good solid book of information about menopause and its effects.

How A Woman Ages: What to expect and what you can do about it, Robin Marants Henig, Ballantine Books, New York, 1985.

This is a companion volume to the *Esquire* magazine sponsored book, *How A Man Ages*. Both are handy reference works to have in the house.

Managing Your Menopause, Wulf H. Utian & Ruth S. Jacobowitz, Prentice Hall, N.J., 1990.

This book starts off very badly but recovers in time to present some clear information about menopause by a doctor highly respected in the field and fortunately for women, relatively conservative about such controversial subjects as removal of functioning ovaries and wholesale prescriptions of estrogen.

Menopause: A guide for women and the men who love them, Winnifred B. Cutler, Carlos-Ramon Garcia and David A. Edwards, W.W. Norton, New York, 1983.

Presents the conventional pro-estrogen viewpoint of gynecology but does argue strongly against the standard practice of removing healthy ovaries from women over

the ages of 40 or 45 who must undergo a hysterectomy.

Menopause: A positive approach, Rosetta Reitz, Penguin, Toronto, 1977. A pioneer work on the topic of menopause - honest, supportive of women, and tending to solutions other than those of the conventional medical model.

Menopause: A Well Woman Book, Montreal Health Press, Second Story Press, Toronto, 1990.

This is a paperback re-issue of the 50-page newsprint booklet originally issued by the Montreal Health Press in 1988. Crammed full of valuable information and leavened with an impressive selection of photographs and illustrations.

Menopause Naturally (2nd ed.), Sadja Greenwood, Volcano Press, San Francisco, 1988.

The first book written by a physician to treat menopause as a natural event, with medical intervention suggested only when the woman herself decides that it is needed. Includes a helpful questionnaire outlining benefits and liabilities of estrogen.

Menopause Without Medicine, Linda Ojeda, Hunter House, Claremont,

California, 1989

This is the first book which deals exclusively with alternative approaches to medicine, primarily for the benefit of women who want to prepare for menopause. As such, it is a welcome addition to the library despite some glaring lacks.

Menstruation and Menopause: The physiology and psychology, the myth and the reality (This book is also sold under another title). Paula Weideger, Dell Publishing, New York, 1977.

A compelling account of the concepts of menstruation and menopause as viewed in Western culture; the author asks us to examine our own attitudes toward these important events in our lives.

Mirror, Mirror: The terror of not being young, Elissa Melamed, Linden Press/Simon & Schuster, New York, 1983.

A provocative book on the cultural standards which make aging painful for women.

Ourselves Growing Older, Paula Brown Doress and Diana Laskin (and the Midlife and Older Women Book Project), Simon & Schuster, New York, 1987.

A spin-off from *Our Bodies, Ourselves*, this excellent book concentrates on health issues for the aging woman. Format and appearance is similar to its sourcebook.

Stay Cool Through Menopause, Melvin Frisch, M.D., The Body Press, L.A., 1989.

Presented in question and answer format, this evenhanded account of menopause provides information about some of the more worri-



some aspects of this time of life - e.g. heavy bleeding, birth control, alternatives to surgery, etc.

Taking Hormones and Women's Health: Choices, Risks and Benefits, National Women's Health Network, Washington D.C.: 1325 G Street N.W., 1989.

This is a 24-page position paper which carefully examines the claims of researchers and pharmaceutical companies in relation to estrogen replacement therapy. Available for \$5.00 + \$1.50 postage and handling (in U.S. funds) from the above address. Highly recommended.

The Menopause Kit, Vancouver Women's Health Collective, 1720 Grant St. 3rd floor, Vancouver B.C. V5L 3Y2.

Excellent kit containing a booklet on menopause and a number of relevant articles. Available for \$4.50 + \$1.00 for postage and handling. The Collective also has kits on Breast Health, Premenstrual Syndrome, etc.

The New Our Bodies, Ourselves: A book by and for women, Boston Women's Health Collective, Simon & Schuster, N.Y., 1984.

This dependable reference includes all aspects of women's health and is written from the point-of-view of women who are interested in, and willing to act on behalf of their own good health.

Understanding Menopause, Janine O'Leary Cobb, Key Porter Books, Toronto, 1988.

Written by a menopausal woman and based on the information requested of or provided to the national menopausal newsletter, *A Friend Indeed*, over the first four years of its existence.

Women and the Crisis in Sex Hormones, Barbara Seaman and Gideon Seaman, Bantam Books, New York, 1977.

This is the book which first argued against the prevalent view (still common among medical practitioners) that hormone therapy is without risks. According to these authors, hormone therapy has enormous costs.

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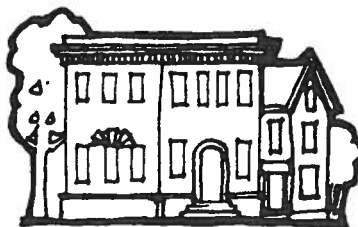
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Carolyn DeMarco

Take control of menopause

Do the Right Thing, Eat the Right Thing

ARE WOMEN STILL DREADING menopause? Or is it old age they are trying to avoid? And why in 1990, are women being heavily pressured into taking hormones not only to prevent osteoporosis but also to prevent heart disease?

In Prince Edward Island, where I recently gave a public talk on the topic, the conference organizer avoided mentioning the word menopause on the poster because she thought it might scare some women away. An earlier survey by the Women's Network in P.E.I. found that even members of women's groups were reticent to discuss how menopause had affected their lives.

How is this possible in this day and age? Haven't we overcome some of the previous taboos around menopause? I looked closely at my own attitudes toward menopause and how they have changed as I got older.

At age 25, I gave my first talk on menopause cheerily emphasizing the positive aspects of menopause and discussing the dangers of estrogen replacement.

At age 35, I organized a weekend workshop on menopause at my place. I was carried away by positive images of the old crone freed from all roles and responsibilities.

Now I have already seen in myself the signs of aging, the first wrinkles, the white hairs, a few more aches and pains, the two to



three weeks of disabling premenstrual symptoms, subtle changes in menstrual flow and taking days to recover from a late night. In fact, is it premenstrual syndrome or is it early menopause? Or is this another example of how we are avoiding using the term menopause?

Recently, I met a friend who attended my menopause workshop seven years ago. She experienced five years of severe and unrelenting premenstrual-like symptoms before her periods finally stopped altogether. Maybe this is one of the early menopausal signs which along with minor changes in a still regular menstrual flow are not yet described in the literature. All the hormonal cycles of our life probably overlap.

Now at age 42, I hardly feel anything positive about menopause.

When a close friend the same age as me said she thought she noticed signs of early menopause - all of which I had been experiencing - I immediately advised her that she was too young to be concerned about menopause. This shocked me as I had a lot of positive programming toward menopause in the past - at least on an intellectual level.

There is truth in what Janine O'Leary Cobb says - that most women in our society cannot welcome menopause. "Not because a woman will necessarily feel unwell," she states, "but because it requires her to face her own aging. And aging is not a pleasant prospect for a woman in this society." That really hit home for me.



Chilling Prospect

What do we as women have to look forward to about aging in our society? Dealing with teenagers, ailing parents, housework, partners retiring, death of close ones, separation and divorce, living alone, becoming dependent, becoming poorer and poorer, and having fewer job opportunities and choices. Worldwide, women are the poorest of the poor. In the United States, old women are the largest adult poverty group: 40.2 per cent of elderly African

Phyllis Wong Kun

American women are poor. Conditions inside nursing homes and old age homes where women predominate are often deplorable.

It is not only that aging for women in this society is a chilling prospect; women are also forced to suppress how they feel going through the immense changes that this period of life brings in order to function in a world defined by male values. Women are bombarded by ridiculous images of menopause.

The root cause of many of the problems of menopause and aging are the way women are treated in North American society - how our society, our religions and our medical institutions view women's bodies and how women's work is undervalued at home and in the workplace. Added to this of course is the role of drug companies, the multibillion dollar industries which seek to define menopause as a disease which only their drugs can remedy.

One of the big pushes by the drug companies is for the use of both calcium supplements and estrogen for the prevention of osteoporosis and heart disease. Osteoporosis is a serious condition each year causing 1.3 million fractures in the United States and 800,000 fractures in Canada. Up to 2.5 million Canadians may be at risk for fractures due to osteoporosis, according to one estimate. Studies into heart disease show that it is the main cause of death for women over 50. Researchers believe that the increased rate of heart disease in older women is linked to lower levels of estrogen. However, other causes such as smoking, diet, exercise and heredity are important risk factors that have not been researched among women.



Preventing Osteoporosis

In my office, women going through menopause need answers to practical questions such as: How can I prevent osteoporosis? Will estrogen help? Should I take calcium? How much?

Recent articles on osteoporosis suggest that doctors prescribe

estrogen to all women, starting within three years of menopause - to be continued indefinitely. Women who have had hysterectomies face at least double the risk of osteoporosis. But, the use of estrogen does not increase bone mass, it merely halts further bone loss. Moreover, as soon as estrogen is stopped, the rate of bone loss is accelerated. However, I believe that osteoporosis can be prevented through diet and exercise.

Recent research into the trace mineral, boron, indicates that this element may play a key role in the prevention of osteoporosis. Meat, fish, milk products and highly processed foods have a low boron content. Boron rich foods include non citrus fruits, green vegetables and beans. In one study, the addition of boron supplements caused calcium retention as well as increase in blood levels of estrogen and testosterone. Boron tablets can be taken at the dosage of 3 to 5 mg a day.

What is the optimal diet to prevent osteoporosis? John Robbins in his book, *Diet for a New America*, maintains that high protein diets inhibit the absorption of calcium. A study funded by the National Dairy Council in the U.S. had one group of women drink three eight ounce glasses of milk a day, in addition to their regular diet. The control group received no extra milk. Researchers found that the women who took the extra milk derived no benefit to their bone density from it.

High fat diets tend to counteract calcium absorption. Our need for high amounts of calcium is based on a "pathological dependency state, the result of our distorted diet," claims Dr. Gary Todd, author of *Nutrition, Health and Disease*. He goes on to say that calcium requirements increase in direct proportion to the amount of protein and fat in our diet.

Studies of different ethnic groups have shown that the higher the average intake of protein, the higher the rate of osteoporosis. What seems to be important is not the amount of calcium intake, but the amount that is absorbed.

For example, the Inuit consume a diet high in fat and protein based

on fish and animal meat and take in more than 2000 mg of calcium every day. Yet, they appear to have the highest rate of osteoporosis in the world.

In contrast, the Bantu tribes of central Africa have low protein, high vegetable and grain diets and take in only 300 mg of calcium a day. Osteoporosis is unknown among the Bantu, even in old age.

Japanese women who have a low protein diet with only 300 mg of calcium have a lower rate of osteoporosis than their American counterparts who take in an average of 800 mg of calcium a day.

On average, female meat eaters have lost 35 per cent of their bone mass by the age of 65. In contrast, female vegetarians have lost only 18 per cent of their bone mass by the same age.

If you are eating a low protein vegetable diet you will need a lot less calcium. I do recommend to my patients that they cut down on meat and dairy products.

A new drug for osteoporosis is now being tested - editronate cyclical therapy. In a paper published in the *New England Journal of Medicine*, researchers studied 429 postmenopausal women with osteoporosis. Results showed a significant increase in the bone mineral density of the spine within one year of treatment and a significant decrease in the rate of new vertebral fractures.

This drug is not yet available in Canada and long term effects are, of course, unknown. Personally I would not consider taking this drug unless you are in a crisis situation - losing a lot of bone and/or at high risk for fractures.



How Much?

What do I recommend for calcium supplementation? If people cannot change their high protein diets, I recommend 1500 mg to 1200 mg of calcium a day combined with half that amount of magnesium. I prefer to use liquid calcium and magnesium as I think they are better absorbed and I

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advise women to take the supplements at bedtime. Other high quality calcium - magnesium supplements include Nu-life Framework, Karuna's Osteonex and Osteoguard, and calcium-magnesium boron effervescent powder.

I feel women on pure vegetarian diets (no meat or dairy) can probably take half the above amount of calcium and magnesium. In addition, I suggest both groups take SISU silica. This is an extract of horsetail which contains large amounts of the trace mineral silicon. The body naturally changes silica into calcium in a very efficient manner.

These supplements may be difficult to get outside large cities. Check with your local health food store first. Otherwise, all the above supplements can be ordered from Supplements Plus through their toll free number 1(800)387-4761.

Vegetarian dietary sources of calcium include deep green vegetables, tahini, dulse, kelp, lime processed tortillas, tofu made with calcium sulphate, mashed sunflower and sesame seeds.



Preventing Heart Disease

If we cut down on our consumption of red meat and dairy, and move toward a low fat diet of fresh fruits and vegetables and whole grains, chicken and fish (deep ocean fish like cod, halibut and pollack, or freshwater fish from clean lakes are preferred), we will also be following current recommendations for the prevention of both heart disease and cancer.

Dr. Dean Ornish and his colleagues at the medical school in San Francisco have been conducting research on patients with severe coronary heart disease. Preliminary results so far indicate that severe heart disease can be reversed by comprehensively changing lifestyle without surgery or drugs. Lifestyle changes include moderate exercise and one hour a day of stress management techniques (including stretching, breathing, meditation, imagery and relaxation exercises

derived from yoga). Participants also stopped smoking and went on a low fat vegetarian diet with no animal products whatsoever except for small amounts of nonfat milk or yogurt daily.



A New Approach

This is the approach I use for any health problems relating to menopause:

- Tell yourself the truth about what you are experiencing, your hopes and fears about the whole process and the prospect of aging.
- Fight ageism in yourself, in women's groups, at work, everywhere. We have to establish our own standards, our own role models and our own language and images of aging.
- If you are having a health problem at menopause, use this problem as a message from your body to pay more attention to it.
- Seek out and create support for yourself. Solidify your network of family and friends.
- Make use of self-help groups or start your own. In many cases, these groups have been at the forefront of knowledge on many topics. They have accumulated more research than most doctors will ever find time to read. Often they investigate the natural alternatives as well as unusual or innovative treatments.
- Educate yourself. Read everything you can get your hands on, ask a lot of questions, find out, listen to tapes, go to courses, talk to as many women as you can, make use of local experts.
- Educate your doctor as well. Bring him or her appropriate reading materials, especially articles from the medical literature or pertinent textbooks.
- Play around with natural methods of healing until you find what works for you.

Carolyn DeMarco is a doctor who works as a holistic health consultant in Toronto and B.C.

Ellen Shearer

MOVING THROUGH MENOPAUSE

In her book, *Understanding Menopause*, Janine O'Leary Cobb remarks that "exercise is probably the most overlooked prescription for a problem-free menopause." She comments on its simplicity as a treatment: "Regular exercise needs only three basic components — a warm-up, an aerobic period, and a cool down." This is a lot simpler than taking a pill for insomnia, another for irritability and tension, as well as calcium supplements and hormones. In 1984, it seemed reasonable to the authors of *The New Our Bodies, Ourselves* that "exercise can produce in midlife many, if not all, of the things that estrogen literature of the early seventies claimed would follow estrogen intake, including the reduction of hot flashes."

They were not overstating the case for exercise. Yet it has taken a longer time for research studies to be conducted and published on the connection between exercise and health. It has taken even longer for anyone to make the link between healthy menopause and exercise.

Studies began to assess the effectiveness of exercise in the treatment and prevention of osteoporosis early in the 1980s. At the same time, other studies were showing the psychological benefits of exercise for older women. These studies also demonstrated that the effect of exercise is similar in pre- and post-menopausal women.

In 1988, one study reviewed the

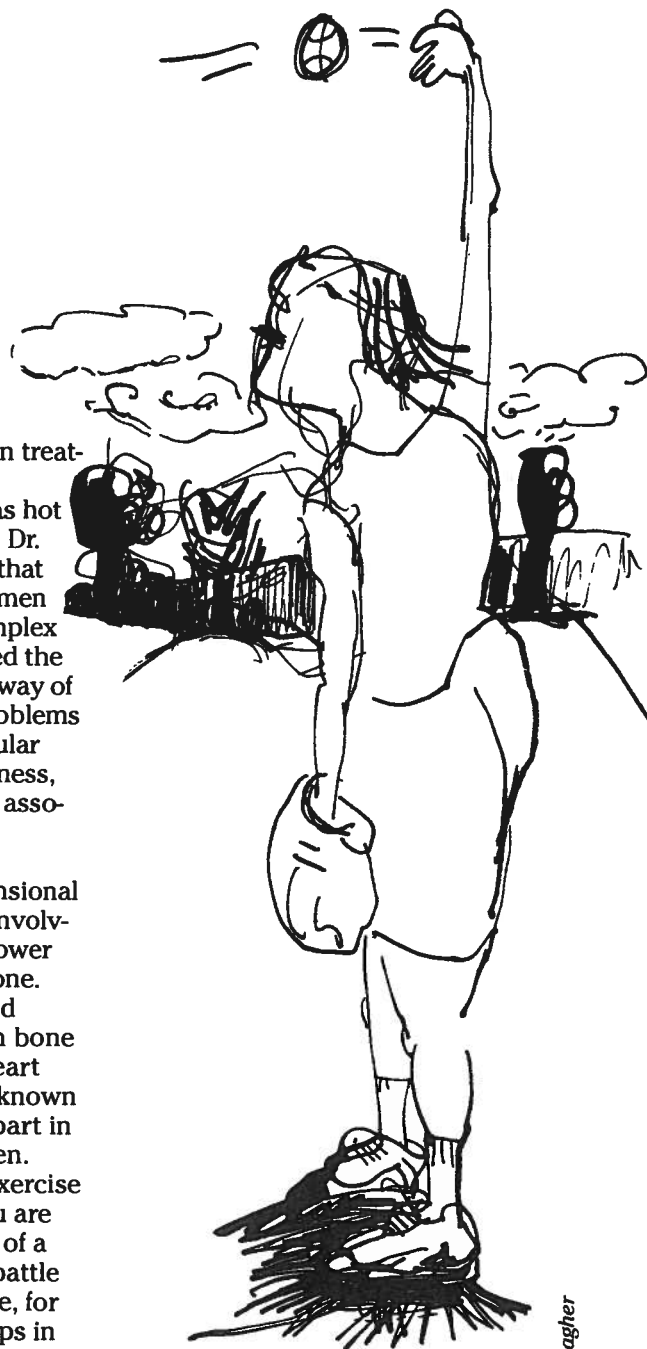
potential benefits of exercise in treating menstrual disorders and menopausal difficulties such as hot flashes. Finally, in March 1990, Dr. Mona M. Shangold suggested that the problems menopausal women face are in part due to the complex process of aging. She presented the case for aerobic exercise as a way of treating the whole range of problems and risks (such as cardiovascular disease, obesity, muscle weakness, osteoporosis and depression) associated with menopause.

We need to recognize that menopause is not a one-dimensional event, but a gradual process involving many kinds of change — lower levels of estrogen being only one.

For example, while reduced estrogen levels are a factor in bone loss and increased risk for heart disease and stroke, it is well known that lack of exercise plays a part in both— for women and for men.

In addition, following the exercise "prescription" means that you are tackling more than one cause of a given risk or problem. In the battle against cardiovascular disease, for example, aerobic exercise helps in three ways at once: it clears arteries, has a beneficial effect on blood cholesterol levels, and improves the efficiency of the heart, lungs and circulatory system.

Physical well-being and quality of life will improve if muscle strength can be maintained or increased through exercise. And



the same exercises which improve muscle strength are also beneficial for building bone density.

In addition, common causes of fractured bones in women with osteoporosis include poor balance, lack of coordination and poor muscle strength or tone. All these can

Illustrations by Dauna Gallagher

HEALTH WANTED

Attention Artists!

Healthsharing is looking for artwork for our upcoming special issue on Immigrant and Refugee Women's health. We welcome drawings, photographs, contact sheets, collages etc. We need your help to get this eagerly awaited issue to press! For more information, call or write Amy or Susan at Healthsharing, 14 Skey Lane, Toronto, ON, M6J 3S4, (416) 532-0812.

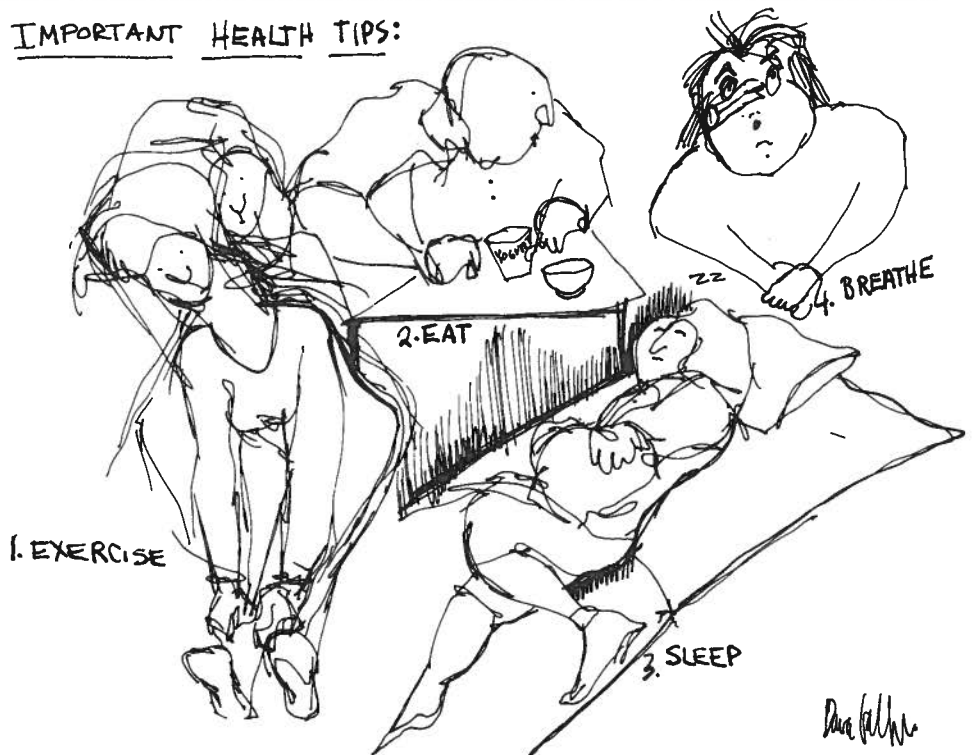
Speak Up! Speak Out!

Call for submissions for an international anthology documenting the voices and visions of women living with AIDS and HIV. Edited by two HIV+ women who believe that HIV+ women have experiences that are not being documented, this anthology offers us the opportunity to examine our differences and similarities and to compel our societies to listen to us. We are looking for fiction, poetry, pages from diaries, dreams, letters, photographs, drawings, cartoons, essays etc. Material submitted in languages other than English is welcome. Please send submissions (copies, not original work) and a brief biography by April 1, 1991 to Speak Up! Speak Out!, P.O.Box 471, Stn. "C", Toronto, ON, Canada, M6J 3P5. Call (416) 594-1445 or fax (416) 340-6521.

Invitation to Participate

"Sorrow and Strength: The Process" is a conference for adult survivors of childhood sexual abuse and for professional helpers, to be held April 11 & 12, 1991, in Winnipeg, Manitoba. We will share ideas and experiences, assert our strengths and commonalities, and explore ways to create connections in order to deepen and broaden our perspectives on healing the wounds of childhood sexual abuse. If you are interested in either presenting a paper or leading a workshop, please contact Sorrow and Strength Coordinating Committee, 160 Garfield St. S, Winnipeg, MB, R3G 2L8, or call (204) 786-1971.

IMPORTANT HEALTH TIPS:



be improved through a combination of weight training and other exercise. And accidents can be avoided by improving the physical environment in which women live.

The issue of osteoporosis (loss of bone mass) is complex. It is important to keep in mind that osteoporosis has three causes: decreased estrogen, negative calcium balance in the body, and physical inactivity. Much recent research has been devoted to discovering how effective exercise might be in overcoming this problem. While estrogen maintains bone mass and assists in the absorption of calcium, weight-bearing activities (walking, jogging, and any exercise which puts direct weight on bones) will stimulate bone building.

Is it possible to minimize loss of bone density in pre- and post-menopausal women with exercise and nutrition alone? Can a safe exercise program be custom-designed to help restore bone mass in women who already have a history of fractures?

Positive results came from a 1983 Swedish study of 16 healthy women ranging in age from 50 to 73, with differing levels of estrogen. These women had previously experienced a fractured arm. After an eight month exercise program

these women showed an increase in bone mass compared to a control group of 15 healthy non-exercising women. The most important aspect of this study is that the improvement occurred despite the variety of estrogen levels among the exercising women.

Evidence suggests that a lifelong involvement in physical activity, especially begun early in life, leads to increased bone mass in the third and fourth decades of life. Having more bone mass can delay the effects of osteoporosis.

In Toronto, a rehabilitation and prevention program at the Queen Elizabeth Hospital has made impressive headway in the treatment of established osteoporosis. Dr. Raphael K. Chow explains that the program is designed to prevent further bone loss and to restore or improve function. The program includes education and social support as well as carefully designed exercise group classes or supervised individual exercise programs. There was a 17 per cent increase in the bone mass of women with osteoporosis after one year of exercise, and a two to threefold decrease in back pain. A higher level of cardiovascular fitness was found to be directly related to greater bone mass.

Dr. Chow and his colleagues do not rule out the use of estrogen, in combination with progesterone, in advanced cases of osteoporosis. Dr. Chow stresses that hormone replacement therapy requires close monitoring. A daily intake of 1.5 grams of calcium helps maintain bones. At the same time it is important to avoid "bone robbers" such as caffeine, alcohol and smoking, which tend to deplete calcium levels. He emphasizes the success of the educational and social components of the program as illustrated in increased stamina, pain tolerance and confidence of its participants.

New evidence is also beginning to show the impact of physical activity on such problems as hot flashes. Dr. Jerilynn Prior at the University of British Columbia believes that hot flashes are related to decreased levels of estrogen, but that exercise can help to alleviate them. Her experience suggests that increasing the intensity of an exercise program will suppress the activity of the hypothalamus in the brain, the regulator of body heat.

By improving the body's ability to sweat and to manage changes in body temperature, regular exercise promotes more efficient control of hot flashes when they occur.

Often when the source of a problem is hormonal, exercise will have a positive effect. For example, mood changes in menopause attributed to changing levels of estrogens and/or lack of sleep caused by frequent night sweats, can be alleviated through exercise which stimulates the release of mood elevating chemicals (endorphins) in the brain.

The feeling of self-mastery which comes with a good physical conditioning program certainly affects the way a woman reacts to menopausal "symptoms" that seem hard to quantify — irritability, feelings of helplessness and loss of purpose.

Societal expectations and how we view ourselves as women play a major role in how we live our lives. Anthropologists studying menopause suggest that these expectations form a filter through which the physiological sensations arising from hormone fluctuations are understood. Some anthropolo-

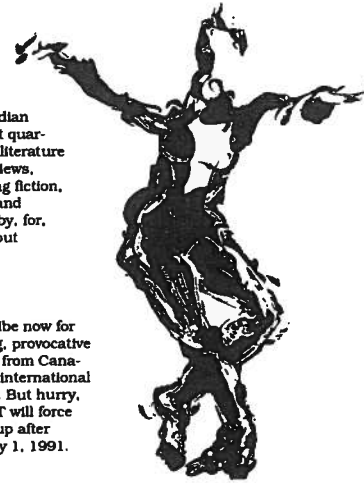
gists feel that hormone levels might actually fluctuate more widely among women whose lack of self-confidence makes them more susceptible to negative images of menopause. When I read about the ease with which women in some Third World cultures cope with menopausal headaches or fatigue, I am more convinced that these women's pain tolerance might be a response to the way their culture welcomes menopause as the gateway to their new roles within the community — roles not open during their childbearing years. The expectations of these women as they pass through menopause are of health, strength and readiness for new work.

Exercise as an alternative therapy for menopause has unique potential. It provides a higher level of overall health, which alters the impact of a whole range of risks and "symptoms." Undertaking an exercise program means taking responsibility for the direction of one's life.

Ellen Shearer is a former dancer and dance critic, and is working on a physical activity resource book for women over 40.

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Applications are invited for a tenure-stream appointment in an interdisciplinary programme in Health and Society, beginning July 1, 1991. Rank is at the assistant professor level.

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Send curriculum vitae and names of three references to: Paul Axelrod, Chair, Division of Social Science, Faculty of Arts, York University, North York, Ontario M3J 1P3.

Candidates are requested to have three letters of reference sent directly to the Chair.

Deadline for applications is February 15, 1991.

In accordance with Canadian immigration requirements, this advertisement is directed to Canadian citizens and permanent residents. York University is implementing a policy of employment equity, including affirmative action for women faculty.

MY STORY, OUR STORY

Why So Soon?

Megan Hutton

It is five thirty a.m. I have been lying beside my partner since two a.m. feeling her rhythmic breathing and listening to her soft murmurs. In less than two hours I will get up and try to go through another day with four hours sleep. She stirs and gathers me in her arms. The heat radiating from my body lies between us as a constant reminder. She brushes her lips across my forehead and drifts off again, saying in half sleep, "Are you ever hot, is there anything I can do." This is a familiar scene. Although I would like to stay I carefully remove myself from her arms. I roll over and allow my frustration to turn to tears. They roll sideways down the outer corners of my eyes. My hair is soon a mass of wet against my hot face. I have learned to cry silently and without movement.

When the alarm sounds my partner gathers me up again. It is a ritual. She always asks how I slept and how I feel today. I often say, fine, just fine. She crawls from her side of the bed where two quilts cover a cotton sheet. I slide naked from mine, where a single cotton sheet alternates between my body and the air. I fight the urge to say, "To hell with it," and crawl back into bed.

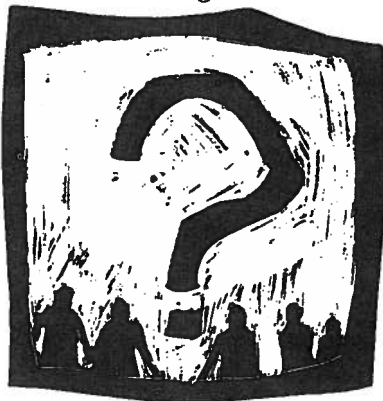
I am frustrated beyond words. I want my life back. Eight years ago, at 36, I diagnosed myself as a woman beginning menopause. Since then, I have become a master of disguises, a builder of walls and a keeper of silent desperation.

It is noon, and I'm having one of those days that happen too often. I'm in a class and the perspiration is running down between my breasts while my heart pounds erratically. Last week I was sure I was having a heart attack, but it was "just another facet of

menopause". I've waited four years to return to school, but now some days it is hard to be here. The hot "flashes" have been almost debilitating at times. The exhaustion I feel at the end of one of those days is evident in my life. When I have a break I hurry home and fall into bed. My body sinks quickly into oblivion. I don't have much extra energy for a social life and have gone through periods where I retreat for a while. Fatigue is a constant problem. I am angry at the timing. I was not ready for this.

My lesbian partner of five years is loving and supportive. I know she can't possibly understand what I am going through, but she is here for me. She has endured hot flashes, night sweats, leg cramps along with a myriad of other menopausal symptoms. She has been and continues to be a wonderful friend and lover. Through all of this, she has had one concern, do you think all these things are normal, and where is the information on it?

We both soon discovered it wasn't normal to discuss menopause. How do you explain to friends over for the evening that your partner is going to bed because she's having a bad time with menopause. My discomfort is inside me. Nothing looks broken



and I don't have signs of pain. Good health, strong bodies and iron wills are notable attributes. Not many of us are comfortable admitting weakness or pain. So we suffer in silence and pretend it doesn't exist.

My female doctor had empathy and expressed a desire to understand more about what I was going through. Although I wasn't happy with the only medical solution, hormone replacement therapy, I was desperate enough to try it last year. Initially it reduced the hot flashes but induced breakthrough bleeding for three weeks out of four. So much for a viable solution.

The herbal methods of controlling some of the symptoms work just as well. I'm in a high risk category for hormone replacement therapy and don't have the added pressure with the natural methods.

The gynecologist I visited told me to, "Flush the hormones down the toilet if they aren't working." As she walked out the door, she said, "I've seen three other women just like you, this morning."

Just like me? I was feeling too vulnerable to ask her what she meant. Getting older? Going through changes we need support with? What did she mean? Because she specializes in obstetrics I had a feeling I was at the wrong end of the life cycle for her to have any interest in my health.

Today, I am trying not to fight the obvious. At 44, I am entering into another phase as a woman. Menopause has been part of my life for eight years. I am trying to live in harmony with it. The acknowledgment that women are experiencing menopause earlier is upon us. Now we need to talk about it. We need validation that we are still O.K. the way we are. Information and support are essential for all of us. I recently joined an early menopause support and information group. For the first time in a long while I feel "normal." I finally found an answer to my question, "where are all those other women like me?"

Megan Hutton is a freelance writer from British Columbia presently living in Toronto.

RESOURCES & EVENTS

Broomstick

Broomstick is a unique, quarterly feminist political magazine by, for and about women over forty, full of personal experiences and positive images of ourselves and our struggles; a network of over-forty women who are committed to opposing ageism and sexism and to developing an understanding of our lives.

Sample copy \$5, yearly subscription \$20 (US funds), Overseas and Institutions \$25 (US funds), free to incarcerated women. 3543 18th St. #3, San Francisco, CA 94110.

Lupus Phone

Lupus is an autoimmune disease affecting approximately 50,000 Canadians, 90 per cent of whom are women. Lupus patients need current and sound medical information and the support of others who have similar experiences. Lupus Canada now operates a toll free telephone line to provide information services and referral to the nearest provincial lupus organization for new patients and their families.

Call toll free 1 (800) 661-1468 for more information.

Organizing Against Violence

MATCH International Centre has produced a resource kit linking women's global struggles to end violence. Women from developing countries and Canada share their experiences in a collection of materials examining the global dimension of violence. The kit includes international statistics on violence, personal accounts, profiles of groups around the world, poetry and art, reading list and a bumper sticker "Real Men Don't Abuse Women."

Send \$15 per kit (Cost includes postage and handling, discounts available for orders of over 10,

Third World Women's groups: free. All orders must be prepaid.) Payable to MATCH International Centre, 1102)200 Elgin Street, Ottawa, ON, K2P 1L5.

The Canadian PID Society

Pelvic Inflammatory Disease (PID) is an infection or inflammation of a woman's pelvic organs (uterus, fallopian tubes, ovaries). PID is epidemic in Canada) and the consequences are serious. PID can cause scarring that leads to infertility, recurring infections, ectopic pregnancy, chronic pain, disability and death. The Canadian PID Society provides information and support to women with PID and their families, promotes public awareness, offers referrals, counseling and resources.

Membership is \$5 (\$2 for unemployed, \$10 for organizations). Contact The Canadian PID Society, Box 33804, Station D, Vancouver, BC, V6J 4L6, (604) 684-5704.

Long Distance Delivery

Long Distance Delivery - A Guide to Travelling Away from Home to Give Birth is a 144 page book published by the Northwestern Ontario Women's Health Information Network and the Red Lake Women's Information Group as part of The Project on Out of Town Birth (see *Healthsharing*, Winter 1988). With chapters on planning, tips for travel and coping with emergency transfers, this book is invaluable for women living in Northwestern Ontario and other isolated regions of Canada.

For 1-3 copies, please send \$2.50 postage and handling; for 4-6 copies, send \$4.50; for 8-10 copies, send \$6.50; payable to Women's Health Information network, 4A South Court Street, Thunder Bay, ON, P7A 2W4 (807) 345-1410.

No Choice

No Choice is a five minute documentary film that deals with the complex issue of abortion and how it relates to women living in poverty. Produced, directed and edited by Christene Browne as part of the Five Feminist Minutes Program of the NFB Studio D.

Available for rental or purchase from: Canadian Filmmakers Distribution Centre, 67A Portland, Toronto, ON, M5V 2M9, (416) 593-1808.

Literacy and Health Project

The Ontario Public Health Association has a number of resources for rent or sale as part of their Literacy and Health Project. Materials include discussion papers on the relationship between limited reading and writing skills and poor health and a slide presentation designed to increase awareness of literacy and health.

Available from The Literacy and Health Project, OPHA, 468 Queen Street East, Suite 202, Toronto, On, M5A 1T7, (416) 367-3313.

Reproductive Tech and Disability

Four Discussion Papers on New Reproductive Technologies have been prepared by the Canadian Disability Rights Council (CDRC) and the DisAbled Women's Network Canada (DAWN).

Available from DAWN Toronto, 5430 Yonge Street, #610, North York, ON, M2N 6J9.

Gender and Economic Restructuring

An International Seminar on Gender and Economic Restructuring will be held May 5 to 10, 1991, at the University of Waterloo, Waterloo, Ontario. Possible topics to be considered are gender and the environment, reproduction and production, gender and the provision of social services (e.g. health care, child care).

For more information contact: Mary Clare, Director of Women's Studies, University of Waterloo, Waterloo, ON, N2L 3G1, (519) 885-1211 x6886.

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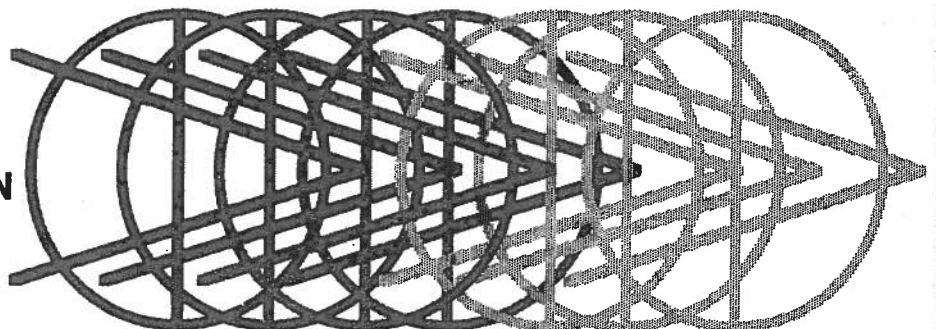
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with Riane Eisler, author of "The Chalice & the Blade" March 15 - 17, 1991 Toronto

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