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Lesbians' Experiences of Menopause

Jennifer Mary Kelly, RN, RM, BN,
Grad. Dip. Ed. (Adult)
MA (Women's Studies)

This thesis is submitted in total fulfilment of the requirements for the degree of Doctor of Philosophy

Faculty of Arts
Deakin University
August 2003
I certify that the thesis entitled: ‘Lesbians’ Experiences of Menopause’

submitted for the degree of: Doctor of Philosophy

is the result of my own work and that where reference is made to the work of others, due acknowledgment is given.

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Abstract

This thesis examines the menopausal experiences of a non-clinical sample of lesbians living in Australia. Research on menopause to date has largely been conducted from a medicalised and heterosexual perspective: thus lesbians’ experiences remain unknown and invisible. Using a qualitative feminist multiple method research methodology combining content analysis and questionnaire/interview research, two hundred questionnaires were posted upon request to self-identified lesbians living in every Australian state and territory. Follow up in-depth interviews were conducted with twenty lesbians. Responses were grouped into four major themes: body image, sex and sexuality, hormone replacement therapy and health services and homophobia.

The findings show that lesbians at menopause face some different and additional issues from those experienced by heterosexual midlife women. For many of the study participants, commonly discussed concerns at menopause such as weight gain and other physical signs of ageing, decreased fertility, lack of libido, sexual difficulties and hormone replacement therapy were of little relevance and importance. Lesbians in this study frequently raised other issues such as the universal assumption of heterosexuality and homophobia experienced when interacting with health professionals, which led to less than satisfactory health care and reinforced feelings of invisibility.

In the Conclusion I argue that the study participants’ views and experiences challenge negative, stereotypical views of both lesbians and menopause. The data thus add a new dimension to the presently narrow, heterosexist and medicalised view of women at midlife and contribute new knowledge to the body of literature on menopause. This thesis is a first important step in recording the experiences of lesbians regarding menopause in Australia. I include recommendations for further research in the area of lesbian health and improved practice, and discuss old and new obstacles lesbians face in a heteropatriarchal society in which lesbians continue to be invisible.
Acknowledgements

There are many people who have assisted, encouraged and nurtured me over the past four years whilst I was working on this thesis. I wish to express my heartfelt gratitude to them. To all of the lesbians who participated in this study I owe a special thank you. It is due to their participation that this research project was possible. Without their honesty and willingness to ‘talk’ to a total stranger this thesis could not have been written. Their courage, determination and the positive feedback they have given me encouraged me to continue. They confirmed that what I was doing was extremely important for lesbians and needed to be done.

I extend my sincere thanks to my principal supervisor, Renate Klein, who encouraged me to embark on this journey many years ago. She has been a friend, mentor and supervisor and has taught me a great deal about commitment and dedication to our students. These teachings I will carry with me for the rest of my life. Her belief in my ability and the passion she displayed for my topic were a constant source of inspiration and motivation. Without her guidance, expertise and support I would not have completed this project. She is indeed a very special woman. I also thank Lynne Hillier, my associate supervisor, who provided encouragement and constructive feedback throughout the process.

I wish to thank LINC for awarding me a small grant in 2001. This financial assistance enabled me to spread the word about my study findings at various conferences throughout the country. Thanks also to the Deakin University library staff, in particular, the women from the interlibrary and off campus loans, who managed to locate texts from all over the globe for me. The Arts Faculty at Deakin provided me with a space from which to work and other resources. Special thanks are also extended to Alicia Byworth who assisted me with many administrative tasks.

My family and friends deserve a special than you for listening to years of talk about menopausal lesbians and always being there for me. In particular I thank Monica Hingston who helped me in more ways than I can acknowledge here. To the other PhD students who have inspired and encouraged me along the way I extend my thanks. I wish to thank Mel Ireyi and Laurel Guymre for their support and intellectual debate.
Meg Gulbin from absolutely women’s health at the Royal Women’s Hospital, Melbourne has been a great supporter of my work and lesbian health generally. Meg, as well as the many other women who continue to work at the coalface to improve the world for lesbians, despite enormous opposition, deserve a special acknowledgement. Diane Brown agreed to proofread the thesis and I thank her for her thorough work in picking up inconsistencies. Those that may have slipped through remain my responsibility.

To my parents, Judy and John Kelly who instilled in me a strong sense of social conscience I thank you for that and many other things. My mother introduced me to feminism a long time ago, not through texts, but through her own life experiences. This remains a special gift she has given me. My parents’ love and support enriches my life.

Last, but certainly not least, I thank my partner, Lesley Higgs for her patience, love, and support as well as doing my share of the housework for a very long time. I am extremely fortunate to share my life with her.

Finally to lesbians everywhere-this thesis is for you.
Chapter One

Introduction

At the beginning of the 21st century menopause is a frequent and hotly debated issue both in society at large and within health specific discussions. Nevertheless, despite the prominence that menopause receives, the unquestioned assumption in discussions about this stage in a woman's life is that midlife women are all heterosexual. Put differently, as I will show throughout this thesis, lesbians and their experiences of menopause are invisibilised within the menopause discourse in the western(ised) world.

It is the primary aim of my thesis to redress the lack of information on lesbians and menopause, through exploring and documenting midlife lesbians' experiences of menopause. I also hope to make visible the problematic effects of heterosexist assumptions on the lives of lesbians experiencing menopause and I offer suggestions for further research and recommendations to improve the invisibility of lesbians' experiences of, and their concerns about, menopause.

The interest in this research stems from my own experiences as both a middle-aged lesbian feminist and a long-standing women's health advocate in my work as a nurse and midwife. For years I have been concerned about the ways in which many health professionals assume all their clients, and in particular old(er) women, are heterosexual. The heterosexist and indeed homophobic nature of the information they present to women on the topic of menopause has long concerned and frustrated me. In this study I examine these issues, as they relate to midlife lesbians, with the aim to provide an understanding of lesbians' experiences of menopause in relation to their general health and wellbeing. By making lesbians' experiences visible through exploring the issues that are important and unique to them at this time of their lives, I hope will contribute to challenging heterosexism and homophobia within the health

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1 This discussion takes place mainly in western(ised) countries. Throughout this thesis I use the term western(ised) rather than western as in addition to Europe, the US, and Canada, it allows me to include industrialised capitalist countries such as Australia and New Zealand that are geographically located in the South. I acknowledge that the menopausal experiences of women in other cultures may differ (see Lock et al. 1988; Kaufer 1986; Berger 1999).

2 Heterosexism is the belief that heterosexuality is the only acceptable form of sexuality (Gruskin 1999).
system and society at large. The following sections will introduce key concepts integral to my study.

1.1 The Social Context of Women’s Lives

Throughout this thesis, I acknowledge that women’s experiences of menopause do not occur in a vacuum. Every facet of a woman’s life is multifactorial and influenced by the socio-political and cultural context in which she lives and menopause is no exception. For the purpose of this study, I focus on a group of lesbians currently living in Australia. To my knowledge this is the first research project to focus on lesbians living in this country and I draw on the experiences of 116 midlife lesbians. (see Chapter Two for details on research methodology).

Interestingly, in spite of the clear invisibility of lesbians in menopause discourse and literature, during the course of my research I was frequently asked why my thesis is concerned with lesbians’ experiences of menopause? This question was then followed up with the statement that since lesbians are women, surely, lesbians’ experiences of menopause would be the same as heterosexual women’s. Whilst this assertion may be true in terms of physiological functions, my study looks beyond the biological aspects of menopause and investigates this transition in lesbians’ lives within a wider socio-political context. Nevertheless, even after explaining this rationale, some people – academic colleagues included – still persisted in asking why I would anticipate any differences between the experiences of heterosexual women and lesbians? I contend that such disbelief highlights a profound lack of understanding of the social construction of women’s different sexualities and how they influence most aspects of women’s lives. I believe that these views clearly show the necessity for this research project, as well as many more studies on different aspects of lesbians’ lives. Indeed, I assert they reflect the precise essence of the dominant (heterosexual) cultural beliefs which invisibilise and discriminate against anybody who does not fit this norm (Hawthorne 2002).

It is the social contexts in which lesbians live that must be considered and addressed as they provide a structure for understanding the complexities of lesbians’ lives

---

3 Homophobia is the irrational fear of, aversion to, or discrimination against homosexuality/homosexuals (Merriam-Webster 1993, 556).
Homosexuality was only declassified as a mental illness in 1973\(^4\) (Dworkin and Gutierrez 1989). Prior to 1973, lesbians and gay men were looked upon as sick and deviant and, consequently, were subjected to a range of humiliating and harmful interventions in an attempt to ‘treat’ and ‘cure’ their homosexuality (Wilton 1995). Although today homosexuality is no longer officially regarded as an illness or deviance, lesbians still experience discrimination and prejudice as a result of this earlier biological determinist model of homosexuality. As Tamsin Wilton puts it, ‘... it is difficult to have faith or trust in anyone whose treatment of you is informed by her/his continued belief that your closest intimate relationships are sick, dysfunctional or abnormal’ (Wilton, cited in Doyal 1998, 153). Clearly, heterosexual women do not inhabit the same social context and it may thus be reasonably surmised that the menopausal experiences of lesbians and heterosexual women will be different. The experiences of 116 lesbian participants will be explored in detail in Chapters Seven and Eight.

However, this thesis is not a comparative analysis of heterosexual women and lesbians’ experiences of menopause. To write such a thesis would place lesbians at the margin and ‘measure’ them against heterosexual women whom mainstream society deems to be the ‘norm’. Conversely, my thesis places lesbians at the centre and identifies their menopausal experiences - some of which are similar to heterosexual women’s - as well as those that are unique to lesbians. I also realise that neither heterosexual women nor lesbians are a homogenous group and as a consequence, I make no absolute claims for generalisation and/or representation.

1.2 The Social Construction of Lesbianism

A detailed and thorough examination of the different theories of homosexuality is beyond the scope of this thesis\(^5\). However, I briefly present an overview of the social construction of lesbianism in an attempt to contextualise my study. In doing so I follow radical feminist theory which problematises the political nature of sexuality. A fundamental premise of radical feminism is ‘that women as a social group, are oppressed by men as a social group and that this oppression is the primary oppression for women’ (Rowland and Klein 1996, 11). This oppression is maintained

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\(^4\) This issue is discussed further in Chapter Six.

\(^5\) For further information on the social construction of sexuality see Jeffreys 1987; Coveney et al. 1984; Jackson 1994; Jackson and Scott 1996; Gottschalk 2000.
vis-à-vis heteropatriarchal institutions and structures that include the law, medicine, family, religious institutions and marriage (idem). Radical lesbian feminists reject the idea that heterosexuality is 'natural' and assert that it is a social and political institution which restricts women’s sexual self-determination and freedom (Jeffreys 1993). For lesbian feminists, lesbianism is both a choice and an act of resistance (Jeffreys 2003). Cheryl Clarke explains that for any woman to be a lesbian in a society that is male-supremacist, misogynist, capitalist, racist, homophobic and imperialist, this is indeed an act of bravery. As she puts it:

*No matter how a woman lives out her lesbianism – in the closet, in the state legislature, in the bedroom – she has rebelled against becoming the slave master’s concubine, viz. the male-dependent female, the female heterosexual. This rebellion is dangerous in patriarchy. Men at all levels of privilege, of all classes and colours have the potential to act out legalistically, morally, and violently when they cannot colonize women, when they cannot circumscribe our sexual, productive, reproductive, creative prerogatives and energies. And the lesbian ... has succeeded in resisting the slave master’s imperialism in that one sphere of her life (1981, 128).*

As a radical lesbian feminist, I argue that a range of socio-cultural and political factors, rather than simply biological factors alone, shape human sexuality. This social constructionist approach rejects notions of sexuality as a fixed, biological natural state and instead acknowledges that the meanings applied to sexuality differ depending upon social and historical contexts (Saraga 1998). This view rejects biological determinist and essentialist explanations, such as defective ‘gay’ genes, latent homosexuality, and other alleged ‘causes’ of homosexuality. Lesbian feminism in the 1970s, according to Sheila Jeffreys ‘... transformed lesbianism from a stigmatised sexual practice into an idea and a political practice that posed a challenge to male supremacy and its basic institution of heterosexuality'(1993, ix).

Unfortunately, evidence of this threat to male supremacy continues to exist even today, as I will argue in this thesis (see Chapters Seven and Eight).

The issue of defining ‘lesbian’ as a category deserves some attention in this introduction. The lack of a standard accepted definition of the term ‘lesbian’ has often been used as a means to dismiss or refute findings from research conducted with lesbians. Definitions of lesbian differ, depending upon where and how the study samples were obtained (Solarz 1999) and the term ‘lesbian’ embraces sexual behaviour as well as identity (Carroll 1999). One of the most widely accepted definitions of lesbian is that lesbians are ‘...women whose primary emotional and
sexual relationships are with other women’ (Harrison 1996, 10). Some women may
embrace the term ‘lesbian’, whilst others will not identify themselves as lesbians
because of the associated stigma or fear of discrimination or other harms (Martin and
Knox 2000). As I will discuss in this thesis, the category of ‘lesbian’ is, I contend,
becoming further invisibilised under the guise of the category ‘queer’ (see
Conclusion).

British lesbian feminists Celia Kitzinger and Rachel Perkins (1993) remind us that
naming is a political act. These authors assert that the labels we choose to define
ourselves reflect and constitute our politics. They explain: ‘To call us ‘lesbians’ is to
make one kind of political statement; to call us ‘gay women’ or ‘female
homosexuals’ is to make a different kind of statement’ (1993, 35). In an attempt to
avoid the dilemmas and controversies associated with the lack of a standardised
definition of the word ‘lesbian’, I decided early in the research process that my study
would include only women who self-identified as lesbian. As a consequence I did not
include data from women who identified as other than lesbian – such as bisexual,
homosexual or gay (see Chapter Two for further details on research methodology).

1.3 The Medicalisation of Women’s Lives

Feminists have for a long time been aware and critical of the medicalisation of
women’s lives. It appears that every major stage in a woman’s life is now under the
gaze of the medical ‘experts’ (Crock et al. 1999). Evidence of this medicalisation is
already seen in adolescence where young women are frequently prescribed
contraceptives. The medical rationale is to regulate their periods or enable them to
engage in heterosexual sex without the risk of pregnancy. However, at the same time
these young women are exposed to sexually transmitted diseases. Further,
medicalisation takes place in dangerous and costly infertility treatments to ‘assist’
infertile heterosexual ‘couples’ (yet these drugs and treatments are given to women,
not men). Healthy pregnancies and childbirth are routinely ‘monitored’ by high
technological and invasive procedures. And finally, hormone replacement is
prescribed to alleviate the ‘symptoms’ of menopause in peri- as well as
postmenopausal women.

---

6 For example see Greer 1984; Greer 1999; Corea 1985; Corea et al. 1987; Coney 1993; Sherwin
1992; Klein, 1992; Klein and Dumble 1994; Klein, 1996; McKie 1995; Oakley 1993; Oakley 1998;
Rowland 1992; Raymond 1994; Daly 1978; Boston Women’s Health Collective 1971; Levy 1992;
Worcester and Whatley 1988; Worcester and Whatley 2000; National Women’s Health Network
2002.
More than a decade ago feminist writers began to criticise the medicalisation of menopause. Sandra Coney writes that the midlife woman is now, ‘... a prime target for the new prevention-orientated general practice’ (1993, 15). She asserts that the medicalisation of menopause has created a new industry which enables the general practitioner (GP)⁷ to feel ‘active useful and effective’ (idem). She explains:

*Research careers are being built around her, and there are doctors and medical entrepreneurs who wish to measure her bones, her breasts, the cells on her cervix and her hormone levels. People build machines that can scan, photograph, xray, and magnify the most intimate parts of her body. The pharmaceutical companies have a veritable chocolate box of pills, patches, pessaries, and implants for the midlife woman. She can swallow them, have them sewn into her flesh, or even insert them into her vagina – from where the magic hormones will course through her body transforming everything they touch* (1993, 15).

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

With the increasing medicalisation of women’s lives comes pressure on women to ‘take control’ of their health. Nancy Worcester and Marianne Whatley (2000) point out how the focus on preventative health care is a shift away from the ‘sick care model’ to a more individualistic, self-care model where women are targeted as major consumers of the preventative services (ibid, 318). Health screening is heavily promoted as the responsible course of action for women to take. Indeed women are made to feel guilty if they do not avail themselves of modern technological ‘advances’, which cover a wide range of tests, drugs, and medical procedures (Daly 1991). Some of these ‘advances’ aimed at women at midlife and beyond, include bone density assessments for the detection of osteoporosis and free ‘breast screening’ for the early detection of breast cancer, as well as new hormonal preparations to

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⁷ A General Practitioner (GP) is a medical doctor who does not specialise in any particular area and works in a general medical practice.
alleviate the distressing 'symptoms' of menopause (Crock et al. 1999). Worcester and Whatley (2000) argue that the successful marketing of hormones to menopausal and postmenopausal women plays on the 'fear factor.' According to these authors: '... fear can become an important selling point for either true prevention or early detection tests' (ibid, 318). They point out that fear is created not only by conjuring up debilitating diseases but also in terms of women's fear of ageing. Growing older for women in an ageist and heterosexist society such as ours is not usually a pleasant experience. Presently it is not known if lesbians internalise these negative fears of ageing. This is an aspect that I will examine in my study (see Chapter Seven). The use of Hormone Replacement Therapy (HRT) is also queried (see Chapter Six). Many lesbians in this study articulated views that are antithetical to the medical model. Menopause as discussed in Chapter Seven, based on participants' views and experiences, is regarded as simply a stage in a woman's life.

As this thesis will argue, lesbians are reported to be less likely to utilise preventative health services. Feminists are aware that women lack power in health care institutions and have highlighted the negative impacts this has upon women accessing health care services (Doyal 1995). In this thesis, I reveal additional problems, such as homophobia and heterosexism, which lesbians frequently encounter when accessing health services (see Chapter Six). The negative impact this has on their health and well-being is also addressed in this chapter. It is not known if lesbians are more likely to use complementary or alternative medicine in preference to the western medical model. The literature suggests this may well be the case and my study explores this issue (see Chapter Six).

Despite a growing interest in the field of women's health research, until recently very little attention has been paid to lesbian health research. A lack of literature and research on lesbian health and the specific needs of lesbians may result in a belief that lesbian health needs and issues are the same as other women's and, as a consequence, lead to further invisibility of lesbians (Bradford and White 2000, 64). I hope that my study will shed new knowledge on lesbian health and lesbian lives.

---

8 I wish to point out that menopause does not equal old age; however, menopause is a stage that usually coincides with women's midlife (see Cruikshank 2003).

9 Exceptions to the dearth of literature on lesbian health will be discussed in Chapter Two and Chapter Six.
1.4 Thesis Structure

This thesis consists of eight chapters. Chapter One introduces the research question: lesbians’ experiences of menopause. This introduction states the aims and rationale for the present study and introduces concepts that are central to the thesis.

Chapter Two introduces the theoretical framework informing this study: radical feminism. Radical feminism is the only feminist theory that is 'by and for women' (Rowland and Klein 1996, 113). A radical feminist framework places women’s experiences at the centre which enables women’s voices to be heard (Klein 1983). In Chapter Two I also present an overview of the feminist research principles which inform my research methodology. I introduce and discuss the 'multiple methods of inquiry' (Reinharz 1992) I use in this study: content analysis, questionnaires and interview research. I also provide an explanation for the selection of study participants and address the ethical considerations involved in this work. The triangulated data collection and analysis methods are presented. The need for lesbian health research is addressed as well as the methodological barriers to conducting such research.

Chapter Three is the first of four chapters that provide a context for my empirical data. There is an abundance of studies and literature on menopause but this research is overwhelmingly medicalised and heterosexist in its focus. Lesbians are rarely, if ever, acknowledged. In this chapter I examine the issue of body image for women at the time of menopause and show how lesbians- particularly older lesbians- have virtually been ignored in studies on women and body image. Frequently, study samples are drawn from young, white, heterosexual women. When studies have been conducted with perimenopausal/ menopausal women on the topic of body image, heterosexuality is invariably taken for granted.

In Chapter Four, I review the literature on the topics of sex and sexuality\textsuperscript{10} in relation to menopause. Despite extensive searching I could locate only two other studies on lesbians and menopause. As I show in this chapter, when discussed in both mainstream and medical literature, sexuality almost always pertains to heterosexuality and consequently lesbians’ experiences remain unknown and

\textsuperscript{10} It is important to distinguish between the terms sex and sexuality. Throughout this thesis I use these terms as defined by Stevi Jackson where ‘sex’ refers to sexual activity, and ‘sexuality’ is not restricted to genital activity. ‘Sexuality’ includes all of the attitudes, beliefs, values and behaviours which are frequently seen to have sexual significance in our society (Jackson and Scott 1996, 2).
invisible. Data from the two lesbian studies reviewed challenge the mainstream views of women and sex at menopause.

Hormone Replacement Therapy (HRT) is the topic of Chapter Five. In this chapter I present an historical overview of HRT and discuss the many controversies raised by HRT as well as the role HRT plays today in midlife women’s lives. Once again I show how the HRT user discussed in the literature is, invariably, assumed to be heterosexual. It is, therefore, not known what percentage of lesbians use HRT. These issues are examined and critically discussed in this chapter.

In Chapter Six I introduce the issues of health services and homophobia. There is a growing body of knowledge emerging from the US and Australia regarding lesbians’ dissatisfaction with the western(ised) medical model of health care. Issues such as lesbians’ health seeking behaviours, health professionals’ knowledge and attitudes towards lesbian health, lesbians’ access to health services as well as lesbian health issues are outlined in this chapter. From the literature reviewed, I assert that menopausal lesbians are invisible within mainstream health services.

In Chapter Seven I present the findings from the 116 questionnaires and twenty follow-up interviews and discuss the study participants’ views and experiences in light of the literature reviewed in Chapters Three to Six. The findings highlight some unique issues lesbians experience at the time of menopause. This chapter is divided into six sections, which allows for a discussion of each theme identified in the study. The first section draws upon the demographic information gathered from the questionnaire and describes the study participants. The following five sections present the voices of several of the participants addressing the identified themes of body image, sex and sexuality, hormone replacement therapy, health services and homophobia and other unique issues identified by lesbians in this study, that have not been addressed elsewhere in the thesis.

In Chapter Eight, the Conclusion, I present a summary of the study’s findings and make recommendations for future research. I also outline and discuss the problematic nature of current ideas of ‘queering’ lesbian existence and reducing it to ‘same-sex attraction’, thereby further invisibilising lesbians. Given the positive findings of my study, I consider factors that prevent more women from exploring lesbian identity
and I review the forces at work to maintain compulsory heterosexuality and patriarchy. I suggest that if women were free from societal pressure to choose how to live their lives, menopause would not be the negative experience it is currently for many women. As a consequence, I believe, women’s power would increase and the medicalisation of women’s lives would decrease. The information collected from lesbians in this study thus adds a new perspective to the prevailing medical model of menopause.

In the next chapter I explain my choice of research design and methodology as well as the feminist theory used.
CHAPTER TWO

Research Design and Methodology

In this chapter I explain the research design and methodology used in this study. The theoretical framework underpinning my research – feminist theory and research – will also be examined and detailed.

2.1 Background to the Study

The following is a brief description of why I decided to conduct this project and my rationale for using a feminist framework. Feminist researchers must ask which topics are investigated and which topics are neglected. Whose interests are being pursued by researching certain topics as well as whose interests are ignored and why (Sherwin 1992, 159)? A basic tenet of feminism is that ‘the personal is political’ and, as Liz Stanley and Sue Wise (1983, 205) recognise, feminist research must begin with this understanding. Stanley and Wise explain that ‘the personal’ must be included in research as ‘... understanding our experience of our every day lives is crucial in understanding our oppression’ (ibid, 195). Feminist research aims to pose social policy questions and create social change (Reinharz 1992). One of the aims of this study is to challenge traditional ways of conceptualising menopause and as a consequence, through new knowledge generated by this work, suggest policy recommendations for health authorities and health providers.

This study evolved from my personal, everyday experience as a lesbian living in a homophobic society. Starting with an issue or problem that concerns us personally is a common experience for many feminist researchers. Reinharz states ‘... being an insider of the experience’ enables the researcher to understand the issue in a way an outsider could not (1992, 260). This ‘starting point’ is the antithesis of traditional research where the researcher is asked to be neutral, detached and objective (ibid, 261). In mainstream research, the use of personal experience is seen to ‘contaminate a project’s objectivity,’ whereas in feminist research it is seen to ‘repair the project’s pseudo-objectivity’ (ibid, 258).

I decided to research lesbians’ experiences of menopause as over the past years I had become increasingly concerned, and often angered, by the multitude of ‘expert’ advice available on menopause which unquestionably assumes that all women are
heterosexual. I wanted to know, where is the information that speaks to me and other lesbians? The mainstream literature on menopause and women’s self-image at midlife paints a rather depressing picture. Whilst working as a women’s health nurse and giving talks about menopause to women’s groups, heterosexual women often told me how they were dreading this time in their life and how they feared experiencing the distressing ‘symptoms’ they had read about. I wondered if this depressing picture was also internalised by lesbians. However, as I was never given the opportunity to run menopause sessions for lesbians, I did not know. This depressing picture was certainly not my experience, nor did I see it reflected in the beliefs held by many of my (middle-aged) lesbian friends.

When I searched for menopause literature, specifically for work that might reject the notion of universal heterosexuality and propose another view, I found very few examples. I thus decided to embark on research into lesbians’ experiences of menopause. Using a radical feminist framework for my research was the obvious choice as radical feminism is women-centred and stresses both the ‘personal as political’ as well as the need for collective action and responsibility (Rowland and Klein 1996, 113). Radical feminism is the only feminist theory which specifically emphasises that it is by and for women (ibid, 10). A radical feminist framework places women at the centre, thereby giving voice to women and redressing the imbalance created by androcentric, mainstream research in which the normality of heterosexuality as the dominant framework is assumed (Klein 1983).

2.2 Feminist Research Methodologies

For the past twenty years, feminist researchers have critiqued positivist research for its role in perpetuating sexist ideology and gender blindness (Jayaratne 1983). Renate Klein (1983, 89) argues that there is no one ‘correct’ feminist methodology. There are, however, several principles underlying feminist research that distinguish it from positivist research. Social scientist Shulamit Reinharz identifies the following principles of feminist research

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11 Due to the large number of menopause related enquiries to the health information line at the women’s health service where I worked from 1998 to 1999, I suggested we run a menopause program specifically for lesbians. Other services were running mainstream menopause programs which were always well attended. However, the manager of the service did not see menopause programs for lesbians as an issue to be explored and so it did not eventuate. The service has since conducted a lesbian health needs analysis and is now developing lesbian specific programs.
Feminist research involves an ongoing criticism of non-feminist research

Feminist researchers are constantly looking out for and disclosing patriarchal bias in research. Reinharz explains that ‘feminist distrust’ stops us from blindly accepting the rules of any academic discipline and allows feminist researchers to see and understand the ways information has been misrepresented by androcentrism (1992, 247).

Feminist research is guided by feminist theory

Reinharz contends that feminist researchers nearly always use feminist theory to frame their research questions and interpret the data. Instead of investigating men versus women or women in relation to men, it is women’s experience that counts. The reasons for utilising feminist theory, according to Reinharz, is that other theoretical approaches minimalise or ignore the interconnection of gender and power (1992, 249).

Feminist research is often transdisciplinary

Feminist researchers are not afraid to venture out of the disciplines in which they were originally educated. My thesis draws on work from the disciplines of women’s studies, nursing, medicine, sociology and other health sciences. This transdisciplinary approach has become a feature of much feminist research.

Feminist research is committed to creating social change

Many feminists believe that research is compelled to lead to social change (1992, 251). Reinharz suggests that when a feminist performs ‘basic’ research, it is common practice for her to suggest to readers a way of using the research findings (idem). This direct link to social change, Reinharz contends, ensures that feminist research is practical as well as academic (1992, 252). My study aims to create social change by challenging heterosexism and homophobia through consciousness-raising and the creation of new knowledge, and by suggesting recommendations to policy makers.

Feminist research strives to recognise diversity

Feminists criticise mainstream research that fails to acknowledge women’s diversity. Reinharz asserts that feminist research has moved from ‘… earlier reflecting variations of race, class, age etc. to the current goal of showing intersections’ of these
variables (1992, 253). Feminist researchers who fail to include diversity in their sample are often criticised for this omission\(^{12}\) (ibid, 254).

\* Feminist research rejects the traditional relationship between the 'expert' researcher and the researched, in favour of a more egalitarian relationship

Feminist researchers usually develop a strong relationship with the research participants. This relationship often extends beyond the length of the study (Reinharz 1992, 263). Renate Klein suggests that a methodology which allows for women studying women without the mainstream 'object/subject' split between the researcher and the researched will stop the exploitation of women as research objects (1983, 95). Klein further asserts that this characteristic of feminist research 'transforms a psychology/sociology/biology OF women to a psychology/sociology/ biology FOR women' (idem).

Feminist researchers tend to favour qualitative methodologies over quantitative ones. As Joy Higgs (1997, 8) explains, 'quantitative research is used to describe empirico-analytical or positivist research since it commonly utilises experimentation, observation and mathematical/statistical analysis of data.' Conversely, qualitative research, Higgs writes, 'is a term used to imply a reliance upon qualitative (non-mathematical) judgements' (ibid, 9). Some researchers argue that a combination of both quantitative and qualitative methodologies be utilised in research projects (Jayaratne 1983).

2.2.1 Multiple Research Methods

In this study I decided to use a multiple method of inquiry as this allows for a deeper level of analysis. As Shulamit Reinharz comments, '... multiple methods work to enhance understanding by adding layers of information and by using one type of data to validate or refine another' (Reinharz 1992, 201). Many feminist researchers use multiple methods, as such an inquiry allows participants to be studied from a variety of perspectives thereby enhancing the richness of the findings (ibid, 213).

Kathleen Barry found that the use of multiple methods in her study of prostitution and trafficking in women enabled her to link the individual woman's experience with the broader socio-political and economic context and thus prevented prostitution from being regarded as a woman's 'personal problem' (Reinharz 1992, 204). There

\(^{12}\) See page 23 for further discussion about diversity.
is also a commitment to thoroughness with multiple methods and consequently the credibility and research findings' utility is increased (ibid, 197).

The use of multiple research methods in a given study is also referred to as *triangulation*. Triangulation often involves using at least one quantitative and one qualitative method so that findings from each may complement the other (Cook 1983). The multiple methods I have used in my study are content analysis, questionnaires and follow-up interviews.

Shulamit Reinharz (1992, 148) contends that there is a variety of terminology used to describe content analysis which varies from discipline to discipline. These terms include: archival research, text analysis, discourse analysis, feminist deconstruction and literary criticism. Notwithstanding the different terms, content analysis remains a vital method for feminist researchers. For the purpose of this thesis, I drew heavily on the existing medical, scientific, sociological and feminist literature on menopause. I carried out extensive searches using a multitude of databases, journals articles, conference papers, books, websites and women's health pamphlets and publications. Reinharz (1992, 149-150) writes:

*Scholars in many fields use the term 'literature review' to refer to an interpretation of relevant literature on a given subject matter.*

*Feminist literature reviews both summarize the salient findings of pertinent studies and question the assumptions of the paradigm underlying the studies.*

Content analysis enabled me to draw themes from the mainstream literature and explore them in further detail. Content analysis allows us to identify texts or topics that are missing, as well as study those that are there (ibid, 163). In the very early stages of my searching, it became apparent to me that lesbians were noticeably absent from the texts I studied.

I decided to use a questionnaire as a starting point for my study from which interviews would later provide points of clarification and follow-up of issues identified. My main aim in the questionnaire was to gather statistical and some other general information. The questionnaire enabled study participants to describe their experiences and express their opinions. The follow-up interview allowed for clarification, validation and explanations of the responses given in the questionnaire. This process is discussed in detail in the section on data collection (see pp. 24-27).
2.2.2 Ethical Considerations

Feminist researchers are concerned with ethical issues in the research process (Cook and Fonow 1990). Lesbian researchers conducting research with other lesbians may face additional ethical predicaments in terms of confidentiality and anonymity as well as professional boundaries (Woodman et al. 1995, 62). When designing this study, the consideration I paid to safeguarding the anonymity and confidentiality of the participants was paramount.

Research conducted with people from marginalised and minority groups pose additional challenges for the researcher to consider and address. As a member of the lesbian community I have access to that community, which is largely inaccessible to heterosexual women (idcm). This may provide me with the added advantage of gaining trust more easily from the participants. Celia Kitzinger, when interviewing lesbians for her study on the social construction of lesbianism, was told by several of her participants that they would not have participated had she not been a lesbian (Kitzinger 1987, 74). Similarly, some of the participants in my study have also given me this feedback. It is essential that I, as a lesbian researcher, acknowledge the privileged and powerful position I am occupying and ensure that I do not abuse this power in any way. This acknowledgement is necessary in order to conduct ethical research with the lesbian community (Woodman et al. 1995).

Conversely, as I belong to the close-knit lesbian community in Victoria, there is every chance I will know and meet some of my participants in social situations. This may raise additional issues of trust and security for the participants. For lesbians living in remote and rural locations who may not feel safe being ‘out’ this issue may be of even greater significance. For these reasons I was intent from the start on taking extra precautions in an attempt to ensure participants’ anonymity and confidentiality. I decided to number code the questionnaires and I also asked women to select their own pseudonym. Real names and exact geographical locations have not been used in the write-up of this study.\(^1\)

\(^1\) Three of the participants in this study expressed the desire for me to use their real names in the writing up of this thesis. However, as I had stated in my ethics application that real names would not be used, I have, with the participants’ agreement, used pseudonyms for all interviewees.
Another ethical issue to be considered is the question of exploitation. Lesbians, as well as other members of minority groups, are justifiably wary of researchers who might exploit them in an attempt to advance their own careers. Not surprisingly, this has led to the issue of mistrust of some researchers (Jacobson 1995). Feminist researchers are committed to avoiding exploitation of the participants and consequently need to devise strategies to ensure that this does not happen. One way by which this risk is minimised is through the adoption of a reciprocal relationship between the researcher and the participant. Denise Connors illustrates this point well in her study of Irish working class women who were over 90 years of age. Connors became a part of the women’s daily lives in order to make them ‘real’ for her. She writes:

_Whenever possible I spent time with them as they went about their daily routines. In the process I met and interacted with families, friends, neighbors and acquaintances. We went shopping and out to eat together, we went on walks, to the bank, the library, the welfare department, drove by their old workplaces, visited their friends in their own homes and nursing homes, and went on tours of local attractions_ (cited in Reinhartz 1992, 51).

This ‘blurring of the distinction’ between the researcher and the participant is a common feature of much feminist research\(^{14}\) (ibid, 263).

Another component of ethical research concerns the issue of disclosure (Reinhartz 1992). Researcher self-disclosure, ‘… initiates true dialogue by allowing participants to become co-researchers’ (ibid, 33). Pauline Bart (1988, 50) reminds us that it is important to be honest about who we are. She argues that it is unethical for heterosexual women to pass as bisexual or lesbian when conducting research. Related to my study, this meant that I informed potential participants of my background, interest in the study and disclosed that I am a lesbian feminist. This information was clearly written in the Plain Language Statement (see Appendix One).

Feminist researchers attempt to avoid causing harm to research participants at all costs. I considered that some participants might find some of the questions too personal, invasive or distressing. In the unexpected case of a woman becoming emotionally distressed as a result of completing the questionnaire, I had established a

\(^{14}\) I have sent a summary of the research findings to all of the study participants.
link with a lesbian counsellor who was willing to provide one-off crisis counselling. I am pleased to report that this precautionary measure has not been utilised (see Data Collection pp. 24-27).

2.2.3 Recruitment of Participants

As this is the first Australian study into lesbians’ experiences of menopause, I was determined to involve a broad group of lesbians. I recruited self-identified lesbians aged 39-65 years through a variety of sources. These sources included lesbian networks, lesbian dances, lesbian social groups, lesbian festivals, and lesbian and gay publications. In addition to recruiting participants from these sources I decided to also recruit women through women’s health services across the country. From my personal experience of working in such a service, I know that many lesbians are associated with women’s health services either as workers, members of management committees, or as service users. Initially I sent an email to the manager/director of each women’s health service in Victoria. This email was then followed up with a letter and/or telephone contact. The aim of the email was to inform the manager of my study and ask if the service would help promote my study by:

- authorising me to write a short article for the service newsletter about my research
- allowing me to present an overview of my research to staff as a professional development activity.

As a result of this strategy, I visited two regional women’s health services in Victoria upon their request and presented an overview of the study to interested staff. This was followed up with a short article about my study being published in the services’ newsletters. Out of the ten women’s health services contacted, nine were supportive. One regional women’s health service, Women’s Health in the South East (WHISE) in Victoria has a lesbian specific health program.\(^{15}\) I placed a notice asking for research participants in the WHISE newsletter. This proved to be an effective recruitment strategy.

Following on from this success, I decided to extend the process interstate. Links were established with lesbian organisations, lesbian and gay publications, lesbian groups,

\(^{15}\) In March 2002, Women’s Health in the South East (WHISE) was the only women’s health service in Victoria that offered a specific lesbian health program. This ongoing program attracts lesbians from all locations throughout Victoria.
and/or women's health services throughout the country. Women's health services in New South Wales (NSW), Australian Capital Territory (ACT), Queensland (Qld), Western Australia (WA), South Australia (SA) and Tasmania (Tas) were contacted and informed of my study. I visited a women's health service in Queensland and presented an overview of my research to the women's health workers. This was followed up with a short article published in a number of Queensland services' newsletters and several women contacted me as a result. In the Northern Territory, I made contact with the women's health advisor, who informed women's health workers and lesbian clients about my project.

Another strategy I employed in an attempt to recruit lesbians, who might be isolated and not aware of my study, was through the Divisions of General Practice Victoria. Whilst I was not looking for a 'clinical sample', I acknowledge that many women, regardless of their sexual orientation, visit a doctor for some reason. I reasoned that for lesbians who may be living in conservative, rural environments and are not connected to the lesbian community, a doctor's practice might be the only place where they may hear of the study. A letter was sent to all Victorian country Divisions of General Practice (fifteen), with the aim of informing General Practitioners throughout Victoria of my research. I asked for a notice about my study to be placed in the waiting rooms of all medical practices in rural Victoria and/or a short article to be published in their newsletters and/or email bulletins. Regrettably, from the fifteen divisions contacted, I received only three responses: two positive and one negative. A short article was published in one Division's newsletter. Interestingly, I did not recruit any participants as a result of this strategy.

It is impossible to say if the lack of response to my request is due to overwork of the medical professionals, or various shades of homophobia from General Practitioners (GPs) who deemed my study irrelevant or threatening. Perhaps the lack of response is also related to the fact that I am a non-medical person looking into the issue of

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16 General Practice Division Victoria is the peak body for divisions of general practice and general practice in Victoria. GPDV seeks to empower GPs through divisions to improve the quality and organisation of general practice. Divisions of General Practice have been established Australia-wide.

17 This negative reply stated that they were unable to assist me and suggested that I contact a Gay and Lesbian Support Group.
menopause, which many regard as the ‘territory of medical experts’ (see Introduction).

I was also invited to present an overview of my study at a lesbian health research forum in Melbourne\textsuperscript{18}. Some of the Australian Lesbian Medical Association (ALMA) members requested questionnaires to be sent to them so that they could promote my study and recruit lesbians for me. Again this strategy did not prove to be an effective one and once more I am left wondering if this is due to homophobia, overwork, disinterest in my research or treading on medical turf as a non-medical expert.

Despite receiving completed questionnaires from every Australian state and territory, I acknowledge that my study is not fully representative. It is a self-selected (non-probability) sample and for this reason I make no claims of representation. As I analysed the responses it became evident that the majority of participants in this study are white, educated working class\textsuperscript{10} and feminists. Women with a higher educational level may be more aware of the importance and value of research and therefore more likely to complete a questionnaire. The study notices asked for women who self-identify as lesbians and, as noted by Andrea Solarz, only lesbians relatively open and comfortable about their sexual orientation are likely to request, complete and return such a questionnaire (Solarz 1999, 120). Whilst there may appear to be a feminist ‘bias’ in this sample, I suggest that the fact that the study called for women who identified as lesbians may account for the large percentage of feminists. Some participants have also remarked that it is not often they have the chance to participate in such an important and lesbian focussed study and consequently they were keen to have their voices heard.

Celia Kitzinger, a British lesbian researcher, also encountered this ‘problem’ in her study of the social construction of lesbianism. Kitzinger interviewed 120 lesbians using a snowball technique which began with her friends. Despite anticipating

\textsuperscript{18} The Lesbian Health Research Forum was held at the Royal Women’s Hospital, Carlton on September 14, 2001 and was the first gathering of lesbian health researchers, interested community members and health professionals in Victoria. Many members of the Australian Lesbian Medical Association (ALMA) attended. ALMA is a national association for lesbian doctors and medical students, promoting visibility of lesbian doctors and education regarding lesbian health issues.

\textsuperscript{10} This term was coined by Pat Mahony and Christine Zmroczek (1997) as a way of including and acknowledging women from working-class backgrounds who have participated in higher education or self-education and are able to live in several worlds at the same time. These women are aware of the ignorant and insulting nature of attitudes towards working-class women. For these reasons I have chosen not to use the term middle-class.
considerable diversity among her sample, Kitzinger’s final sample did not reflect a
diverse group. Celia Kitzinger writes:

*Despite my efforts to obtain a diverse group of participants, there is a
strong white, middle class bias; only four black women and twenty
self-defined ‘working class’ women participated in the research. Also
only two Jewish lesbians were interviewed. This was, in part, their
choice: politically conscious black lesbians I approached refused to
be interviewed by a white woman, and radical working class women
decided to cooperate with the work of a hierarchical academic
system from whose benefits they are systemically excluded (Kitzinger
1987, 87-8).*

Nevertheless as my research is the first Australian study to examine lesbians’
experiences of menopause, I contend that the findings, even from a more
homogenous group of lesbians than I had wished for, are significant. It is a first
important step in recording the experiences of lesbians regarding menopause in
Australia. It is my hope that as a result of this initial study, more research will be
conducted (and funded) on this topic and will include a wider range of participants.

I published short articles explaining my study in a number of lesbian publications,
women’s health newsletters, and professional affiliations throughout the country.
These included *Lesbian Network, Lesbians on the Loose, Shout (WA)*, Melbourne
Community Voice, Geelong Lesbian Group Newsletter, Central Victorian Lesbian
Network Newsletter, Women’s Health West Newsletter, Women’s Health in the
South East Newsletter, Women’s Health Victoria (website), Surfcoast Women’s
Network Newsletter, OWLS Women’s Social Club (Qld), Centre for Research for
Women (WA) **STATE**ing Women’s Health (SA), Women’s Health Queensland
Wide, Mackay Women’s Health and Information Centre (Qld), Centrelines (Tas),
What’s on for Women (NSW), Women Out West (WA), Mountain Lesbian News
(NSW), Queensland Women’s Health Network, Instinct (Vic), Women’s Health
Nurse Association (Vic) the *Australian Nursing Journal*, Australian Women’s
Health Network News and the Loddon Mallee Women’s Health newsletter. The
number of responses I received really overwhelmed me. When women contacted me
for further details of the study, they were often requesting additional questionnaires
to be sent to their partners and friends. Some health workers from women’s health
services and medical services requested a number of questionnaires be sent to them
for distributing to interested lesbians, and I posted multiple copies of the
questionnaire to a limited number of health professionals for this purpose. It is
interesting to note however, that out of the twenty questionnaires sent to health professionals (mostly nurses) who requested them, only two were completed and returned\(^{20}\). When I contacted the health workers about this, I was frequently told that the questionnaires were not distributed, as they were not seeing as many lesbians in their practice as they thought they would. Once more I am left wondering about the level of latent homophobia amongst many health professionals and/or the fear of disclosure among clients.

Another recruitment strategy I employed was an electronic mail list. As a lesbian health worker I belong to a national lesbian health workers’ email list. A short notice was posted on this list and resulted in a number of women contacting me and requesting questionnaires.

I invited participants to pass my contact details on to any other lesbians who might be ‘eligible’ to participate in the study. I was inundated with phone calls and emails from women unknown to me requesting further information about the study and requesting a questionnaire. This ‘snowballing’ technique proved highly effective. One participant, previously unknown to me, offered and distributed questionnaires at an interstate lesbian gathering on my behalf. Three women returned questionnaires as a result of her action.

2.2.4 Inclusion Criteria

Initially my study called for participants who identified as lesbian, were aged between 45 and 55 years and had noticed some changes in their menstrual cycle over the past two years. I later broadened this criterion as several lesbians outside this age group contacted me wanting to know why I was excluding their voices and experiences. Fourteen lesbians who were older than 55 but still had vivid memories of their menopause were keen to be included. Due to the fact that this is the first Australian study to focus on lesbians and menopause, I believe it is important not to exclude lesbians who wanted to share their experiences of menopause with me. I also thought that another benefit of widening the criteria to enable older lesbians to participate lies in providing insights and experiences that younger lesbians and health service providers could learn from and indeed, including the voices and experiences of these women has enriched and strengthened the data.

\(^{20}\) As the consent forms were number coded I could track them and thus I was able to see which questionnaires were not returned.
Age 45 was chosen as the lower limit and 55 as the upper limit, as this is the time when most women experience menopause (Australasian Menopause Society nd, 3). The Australasian Menopause Society suggests that approximately one per cent of Australian women experience menopause before 45 (idem). For this reason if women were younger than 45 but experiencing menopausal related changes, I also welcomed their participation in the study. The mean age of participants in my study is 49.7 years. I also asked participants to name which ‘stage’ of menopause they felt applied to them. I defined perimenopausal as ‘having irregular and/or heavier or lighter periods than usual’ and postmenopausal as ‘no period for twelve months or longer’.

2.2.5 Diversity of Sample

I attempted to interview women from a range of ages, views, experiences and representing different stages of menopause. Whilst my sample is more homogenous than I would have liked, there still exists a wide range of viewpoints and experiences amongst the study group. Participants who completed and returned the questionnaire ranged in age from 39 to 64 years. Interviewees were aged from 46 to 60 years. Of the twenty women interviewed, eight women identified themselves as being perimenopausal and twelve women postmenopausal. Twelve women identified as feminists and one stated she did not know if she was a feminist or not. Interviewees were from metropolitan and rural locations. Seventeen of the twenty women interviewed were not currently taking Hormone Replacement Therapy (HRT). Eleven of the interviewees have their own biological children and fourteen (out of twenty) lesbians interviewed indicated they were in lesbian relationships at the time of completing the questionnaire.

2.2.6 Data Collection

The data collection comprised two stages: initially a questionnaire was distributed to 200 potential participants throughout Australia. Potential participants were sent a Plain Language Statement (Appendix One) explaining the background, rationale and aims of the study. I asked interested women to sign a coded consent form (Appendix Two) and return it with the completed questionnaire. I received a total of 124 (62 percent response rate) completed questionnaires (Appendix Three). Eight women identified as other than lesbian (gay, bisexual, homosexual) and, consequently, I did

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21 Sixteen lesbians who were surgically menopausal were included in this study. Of these six were taking HRT.

22 A total of nineteen lesbians in this study were taking HRT.
not use their data in my study. The final sample consists of 116 self-identified lesbians. The questionnaire data collection was followed up with twenty in-depth interviews.

Questionnaires, as a part of survey research, are seen by some to be ‘the most rigorous and scientifically sound’ research method (Reinharz 1992, 76). Shulamit Reinharz acknowledges that there is a widespread community acceptance of the objectivity of survey research findings (idem). However, many feminist researchers have challenged this view of objectivity and rigour (Oakley 1981; Jayaratne 1983). Toby Jayaratne comments that the ‘objective’ aura around traditional research makes it influential and convincing, with the undesirable effect that findings which are often the result of poor methodology and sexist bias are accepted by the general public as fact (Jayaratne 1983, 146). Despite these criticisms, survey research does hold value for feminist researchers in that it enables us to develop appropriate quantitative evidence to counter the quantitative sexist bias, which often exists in the social sciences (idem). Questionnaires and other forms of statistical research have the advantage of showing how common a particular problem is. For example, Betty Friedan in The Feminine Mystique (1963, 9) utilised ‘an intensive questionnaire’ to demonstrate the dissatisfaction experienced by many middle-class white American housewives and consequently developed an understanding of the ‘problem that has no name’ (cited in Reinharz 1992, 80). Statistical information relating to areas such as sexual harassment, differentials in employment opportunities and rates of pay for women and men, Caesarean section rates at different hospitals, all demonstrate inequalities and highlight areas where social change is needed. This may lead to closer scrutiny of current practices and policies and to legislative and other changes (Reinharz 1992, 81).

I decided to use a questionnaire because I believe it to be an excellent starting point for my study from which follow-up interviews would later provide further clarification and discussion of issues identified. I drafted an initial questionnaire and trialed it with a small pilot group of lesbians. This trial resulted in grammatical and other changes being made to the draft prior to designing the final questionnaire (Appendix Three). The questionnaire was divided into six distinct parts: socio-

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23 I chose a feminist interview method rather than narrative inquiry, although I acknowledge that this study would have been suited to both methods.
demographic details, reproductive and menopausal health, body image, hormone replacement therapy, sex and sexuality, and health services and homophobia. I chose the first four themes, as these themes were frequently discussed in the existing literature on menopause. However, feminist researchers also acknowledge that women's experiences are inextricably linked to the wider socio-political environment and, therefore, investigations must be situated in the broader context in order to understand women's lives (Hall and Stevens 1991, 18). For this reason, I felt it was essential to include an additional theme focusing specifically on health services and homophobia. I believe that information gathered on these topics will benefit lesbians by challenging homophobia and heterosexism within the health professions and ultimately improve lesbians' access to health services.

As noted by Reinharz (1992, 19) '... interviewing offers researchers access to people's ideas, thoughts, and memories in their own words rather than in the words of the researcher'. This is a particularly appropriate method to use in this research project as it is the first Australian study of lesbians' experiences of menopause. Semi-structured in-depth interviews enabled me to learn more about the issues of importance to the women in my study. Issues that were identified on the questionnaire could be clarified and explored in further detail in the interviews.

Renate Klein (1989) found in her study of women's experiences with in-vitro-fertilisation that it is often only after a personal relationship has been established between the interviewer and the interviewee that the words on paper are given real meaning. My experiences of interviewing women in this study confirmed this observation. Once engaged in an in-depth interview, women's comments and explanations frequently appeared far more radical and reflective than their initial comments on the questionnaire. The interview enabled their words to come 'alive'. It also allowed for discussion and elaboration of issues raised on the questionnaire.

Shulamit Reinharz explains that when feminist researchers interview women, they often talk about issues that are not part of mainstream discourse yet are meaningful to women. Lesbians' experiences of menopause is such an example. Marjorie De Vault notes that language is often unavailable to explain and describe women's lives and experiences and consequently feminist researchers need to '... work around toward listening around and beyond words in order to recover these aspects of women's experiences' (1987, 33). De Vault further suggests that when women
interview women, they use a different type of communication. This type of communication is known as ‘woman talk’ (Spender 1980, 106). Similarly, it is my contention that when interviewing lesbians, in order to be fully understood it may be necessary to be interviewed by another lesbian. Whilst I reject essentialist notions of lesbianism, I do acknowledge there is a socially constructed understanding and experience of oppression that lesbians share.

Lesbians have told me how pleased they are that I am conducting this study and how important it is that they are listened to and acknowledged as lesbians. Many have also remarked how vital it is that a lesbian researcher conducts this type of research. Several women have indicated that they would not have participated had I been a heterosexual woman. I have been inspired and motivated to continue with this project largely as a result of the feedback I constantly receive from women in (and out of) my study.

I conducted twenty interviews with lesbians from Victoria, New South Wales and the ACT. Out of 124 participants who returned questionnaires, 110 (89 percent) were willing to be contacted and interviewed. I was overwhelmed by the responses from lesbians I did not know and their willingness, and in some cases, eagerness to be interviewed.

Originally I planned to travel around the state and interview twenty lesbians from both metropolitan and rural Victoria. I was awarded a small grant from Lesbians Incorporated (LINC) to enable me to travel to every health department region in Victoria. However, despite efforts to recruit lesbians from all regions of Victoria, I was unsuccessful in my attempts. Moreover, when I did manage to recruit women from rural areas and attempted to make arrangements for an interview, the women commonly expressed the desire to travel to the city to be interviewed, rather than me travelling to them. Consequently face-to-face interviews were conducted in a room at the Royal Women’s Hospital, Carlton. The Women’s Hospital recently conducted the Lesbian Health Information Project: More Than Lip Service and at the time of

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24 Eight out of the fourteen women who did not wish to be interviewed are well known to me and possibly did not wish to be interviewed for this reason.

25 The Department of Human Services has nine regional offices responsible for the distribution and purchase of health services within Victoria.
writing this thesis, it is attempting to make the institution more accessible to lesbians. Whilst I favour a social model of health\textsuperscript{27} over the medical model, this location was selected as a suitable venue for the interviews. The Women's Hospital is a space many Victorian women know and feel comfortable in. It is also close to the city, accessible by public transport, has ample car parking facilities and many restaurants and bookshops nearby. The rooms were provided for the interviews free of charge. Women were given the option of another venue if they did not wish to be interviewed in a medical institution. None of the interviewees took this option. Telephone interviews were also conducted in ten cases as some of the interviewees lived interstate, and for others, because this was their preference.

2.2.7 Limitations of the Study

As I have previously mentioned, the lesbians who returned completed questionnaires from every state and territory in Australia, are not fully representative of lesbians living in Australia. Raymond Berger (1984) points out that the lack of a clearly defined definition of lesbian prohibits a sample from being fully representative. Gaining a truly representative sample remains a constant challenge for researchers studying groups that are marginalised and stigmatised (Martin and Knox 2000).

Lesbians in my sample were volunteers and all self-identified as lesbian. As discussed on page 20, lesbians likely to participate in such a study are usually more ‘out’ and comfortable with their sexual orientation than other lesbians (Solarz 1999, 120).

Participants in my study were fairly homogenous. Lesbians are, of course, as diverse as women generally, however my sample did not reflect such diversity. It is worth noting that there were no Asian lesbians and only one lesbian indicated that she was of Aboriginal descent. Seventy-six percent of participants were tertiary educated and almost 40 percent of participants were employed in health-related occupations. These occupations include women working as medical receptionists, social workers, welfare workers, personal carers as well as nurses, doctors, physiotherapists.

\textsuperscript{26} The Royal Women’s Hospital (RWH), Carlton, Victoria in 2000 undertook the ‘Lesbian Health Information Project’ (LHIP) in an attempt to assess the literature and health experiences of lesbians with the view to (a) inform future hospital directions, (b) improve existing services and (c) expand the services to ensure access for lesbians.

\textsuperscript{27} A social model of health acknowledges that health is more than the absence of disease. The World Health Organization (WHO), defines health as ‘... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO 1948).
occupational therapists, counsellors and other allied health professionals. As many participants are well educated and employed in the field, it might be suggested that their level of knowledge and attitudes may differ from lesbians without tertiary education and those employed in other areas. Clearly, more studies need to be conducted with a larger sample size and with lesbians from differing race, ethnicity and socio-economic levels. On the positive side, given the many critical comments regarding the medicalisation of menopause and homophobia in the health system (see Introduction and Chapter Six), I believe the high number of participants working as 'insiders' in health related occupations, lends extra weight to these findings.

2.3 Data Analysis

This study draws upon original material that I collected from 116 questionnaires and follow-up in-depth interviews with twenty self-identified lesbians who nominated themselves on the questionnaire as being either peri or post menopausal. I wanted to learn of the ways in which lesbians experience menopause and how, if at all, these women identify with mainstream depictions of menopause and midlife, which I contend, after an in-depth literature review, reflects a heterosexist bias.

Qualitative data analysis and interpretation occurred throughout the entire research process (Rice and Ezzy 1999; Ramazanoğlu 2002). My analysis began with the return of the first completed questionnaire. Full-scale analysis, however, was not possible until I was totally familiar with my data (Minichiello et al. 1995). This familiarity resulted from reading and re-reading the questionnaire data and interview transcripts. Glaser and Strauss' (1965) analytic induction method was employed to analyse and interpret the data. Inductive methods are well suited to research questions when the territory is unknown and the aim is exploratory and descriptive (Miles and Huberman 1994).

The inductive process was used to generate empirical data that provides a great deal of new information on the topic of lesbians' experiences of menopause. I chose the analytic inductive method as it enables the research to develop in line with emerging themes and concepts (Minichiello et al. 1995). Very early in the data collection phase, common themes began to emerge. Lesbians from different parts of Australia were articulating similar issues, which I had not previously found in the mainstream menopause discourse. As the questionnaires were returned, I began to manually
code, discover and group common themes together. This grouping of themes enabled me to develop propositions to be later explored. It also assisted me in choosing twenty women to interview. The emergent themes, in some ways, both mirrored and lent themselves to comparison with the themes I had identified in the Literature Review.

I made a decision not to use a computer assisted analysis package as the information gained from the questionnaire and interviews began to organically organise itself into themes. Whilst I acknowledge that data analysis may be supported by the use of a qualitative computer assisted package, as pointed out by Rice and Ezzy (1999, 204), the computer package itself does not do the analysis. By manually coding, grouping, reading and re-reading common themes, I became extremely familiar with my data.

In selecting twenty participants to interview, I focussed mainly, although not exclusively, on women who identified issues for lesbians that differed from the mainstream literature. I did, however, interview some lesbians who did not see any different issues from those discussed in the literature review. As these women are also lesbian, I did not want to exclude their experiences.

Each interview was audio taped with the participant’s permission and transcribed at a later date. Immediately after each interview, I wrote notes recalling the main points discussed during the interview and reflected upon the participant’s non-verbal cues. Participants were sent a copy of the typed transcript and asked to return it in the enclosed reply paid envelope with any necessary changes within one month of the postage date. This allowed for the data to be ‘checked’ by the participant before progressing to the next stage of analysis. I explained in the accompanying letter that if I did not receive a reply from the participant within one month, it would be assumed that she was satisfied that the transcript was an accurate representation of the interview. Seventeen out of twenty participants returned their transcripts with minor editorial changes. Upon return of the transcripts I selected relevant quotes and cut and pasted them into word documents under thematic headings. I have used verbatim quotes frequently throughout this study. These direct quotes have been included as they give insights into the participants’ experiences and perceptions in their words, rather than mine. Also by keeping the participants’ own words I was able to gain a deeper level of understanding of their experiences of menopause. The
thematic grouping enabled me to make sense of the data and to make connections and comparisons between each transcript and between the women's views and the mainstream literature. At this stage I was able to modify, revise and expand the research propositions in light of the emerging data (Minichiello et al. 1995).

The next stage involved returning to the Literature Review and looking for similarities and/or differences from my data. This was also the stage when I came across new themes not previously covered. These identified issues were incorporated into separate word documents marked for further discussion and explanation in the final write-up of thesis chapters.

In the final stage of the analysis, the grouped themes were used to categorise and explore accounts of the respondents' experiences. The findings were located and discussed within the context of the Literature Review. Lesbians' unique experiences of menopause, which were highlighted, are explained in the findings and discussion (see Chapter Seven).

2.4 Why Lesbian Health Research?

In order to improve the quality of health care experienced by lesbians, I contend it is essential that lesbian health research be conducted. Presently many myths and stereotypes abound regarding lesbians' health risks and health status. Judith Bradford and Jocelyn White (2000, 64) assert that the identification of specific health risks for lesbians and learning how their risks differ from those of other women, will assist lesbians and health professionals in promoting healthy lives for this group of women. The insights gained from this knowledge, Bradford and White suggest, may lead to improved health outcomes for all women (idem).

It is difficult to obtain accurate and reliable evidence on lesbian health as very few studies have included separate studies of health care issues for lesbians (Rosser 1993, 183). Furthermore, even where separate studies for lesbians have been conducted, lesbians are usually only included as a subgroup of women in which heterosexual women are the 'norm' against which lesbians are measured (idem).
In 2000, the Victorian State Government convened a Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH). The then Victorian Minister for Health, John Thwaites, announced that the Committee would identify specific issues affecting gay and lesbian health and find effective ways to address them. At the time of writing up this thesis the MACGLH has concluded consultations with community members in an attempt to inform the development of a draft Gay Lesbian Bisexual Transgender Intersex (GLBTI) health action plan. A final version of the draft action plan has been written based upon the findings from the community consultations (pers.comm.). The action plan was launched in Melbourne on July 29, 2003.

In her article, ‘Ignored, Overlooked or Subsumed: Research on Lesbian Health and Health Care’, US feminist scientist and health researcher, Sue Rosser (1993, 185) explains how the focus of women’s health centres is on ‘procreation and heterosexual activity’. The medical specialties of obstetrics and gynaecology, Rosser asserts, always describe women’s health in terms of their sexual relationships with men (idem). She points out how it is common practice for many women to consult gynaecologists/obstetricians once they are contemplating sexual activity with men. This, according to Rosser, is often the beginning of a long relationship with these medical specialists. Rosser writes, ‘... for many women, the obstetrician/gynaecologist becomes the primary care physician and reproduction becomes a major focus for health care’ (idem). She argues that considerable resources are poured into women’s health issues when they are directly related to men’s interests in controlling reproduction; contraception, infertility, pregnancy and childbirth are examples, which clearly illustrate her point. However, when the health issue is not directly related to men’s interests, there is a lack of attention and lack of adequate funding to other equally important areas of women’s health. Other areas are often neglected as a result of this restrictive definition of women’s health. Two examples of this neglect, Rosser writes, are the issues of incontinence and nutrition in older women (ibid, 186). Similarly, Canadian feminist academic, Susan Sherwin asserts that by defining women in terms of their childbearing function, the research and medical community contributes to the perpetuation of women’s oppression.

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28 The Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) provides advice to the Minister for Health on matters relating to the health and wellbeing of gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians.
(1992,167). Given these feminist analyses, it is not surprising that the area of lesbian health - and specifically the question of menopause in lesbian lives - has been virtually ignored.

As I will detail in Chapter Six, health professionals today are often seeing lesbian clients in their practice without any knowledge or training about lesbian health or the contexts of lesbian lives. Many health professionals do not believe there are different issues for lesbians and have little, if any, understanding of lesbian life. Some Australian health professionals claim they do not need to know about lesbian health, as they never see any lesbians (McNair and Dyson 1999). A women’s health worker recently told me that the women’s health service where she is employed didn’t see any lesbian clients. This is despite the fact that the service is located in the heart of a large lesbian community in an inner suburb of a capital city. This women’s health worker also said she did not know what lesbian health issues might be. When I quizzed her as to how she knew that lesbians were not accessing the service she replied, ‘well they don’t tell us they are lesbian’ (pers.comm.).

Patricia Stevens (1992) reviewed the existing literature on lesbian health research conducted between 1970 and 1990. Prior to this review, she concluded, ‘... no thorough, scholarly review of the empirical literature about lesbians’ experiences as health care clients has been done’ (ibid, 2). Stevens located only 28 studies, all of which were conducted in the United States. Nine of these studies examined health care providers’ attitudes towards lesbian clients and nineteen studies focussed on lesbians’ views of their health care interactions. Only one of the studies reviewed by Stevens was geared towards older lesbians (Deevey 1990). Findings from these studies revealed that prejudice and homophobic attitudes were apparent and indeed widespread in the health care professionals’ behaviours (Stevens, 1992). Lesbians, when speaking of their health care interactions, commonly described environments of ‘intimidation and humiliation’ (ibid, 19). Lesbians in these studies reported that as a result of disclosing their sexual orientation, they frequently experienced inappropriate actions and even mistreatment. Many lesbians experienced their health care interactions as abusive and were consequently reluctant to seek further health care (ibid, 24). More recent overseas and Australian research, including this study, confirms Stevens’ findings (see Chapter Six for further discussion).
2.5 Methodological Barriers to Conducting Lesbian Research

There are many barriers preventing researchers from studying lesbian issues. One major barrier confronting researchers conducting lesbian research is the discrimination factor. Most lesbian-related research to date has been conducted by lesbian researchers (Solarz 1999). Andrea Solarz points out that career opportunities may be adversely affected as a result of homophobia against openly ‘out’ lesbian researchers (ibid, 136). In 1996, An Uncommon Legacy Foundation funded a postal survey in the US, with the aim of determining lesbian researchers’ interest in joining a network to provide each other with peer support. Almost 300 lesbian researchers from 41 states and 13 countries completed and returned questionnaires which asked specific questions about their experiences of being a lesbian researcher and conducting lesbian research (Bradford and White 2000, 68). Just over one quarter of the lesbian researchers surveyed (29 percent) reported having a supportive environment in which to conduct their research. Twenty-six percent of respondents reported difficulties securing grants and twenty-three percent reported negative effects on career opportunities (Solarz 1999, 137). The findings revealed that being a lesbian, rather than merely conducting lesbian-related research, resulted in more negative career options and opportunities (idem). Interestingly, the majority of lesbian researchers who conducted lesbian specific research reported that despite working in often hostile and unsupportive environments, they believed they gained positive insights from their work. For example, one respondent commented, ‘it helped me realize the importance of being out if change is to occur’ and similarly, ‘all of the research we do in the area of lesbian issues will open doors for lesbians’ (cited in Bradford and White 2000, 68).

These sentiments reflect my own experience of conducting this study. Whilst I often feel unsupported by professional colleagues and peers, I have been overwhelmed by the interest and gratitude displayed by so many lesbians, most of whom are unknown to me. Some of the participants have included personal letters with their questionnaires, thanking me for giving them the opportunity to write of their experiences of menopause from a lesbian perspective. Others have written encouraging and supportive remarks such as, ‘...good luck with the project; it’s a big one and great that you are doing it!’; ‘thank you Jenny for the opportunity’, also ‘...studies such as yours help to reduce homophobia and improve the health system’. Several women have requested copies of my findings. These positive
responses, I believe, demonstrate the relevance and importance of lesbian related research. It also highlights the invisibility of lesbians in terms of mainstream research and illustrates how willing and prepared lesbians are to participate in research on/about/for and by lesbians, which challenges patriarchal concepts.

Researchers are encouraged to research topics that will attract funding. Susan Sherwin (1992, 171) explains that often the need to gain funding determines which projects will be researched thus research topics are linked to the interests of the funding sources. She contends that funding bodies and research institutions are not representative of the general community. Rather, Sherwin explains, ‘they are controlled by members of the dominant class of society, and the values they pursue inevitably reflect the class, gender and racial backgrounds of the powerful’ (ibid, 172). For these reasons, it is easy to see why lesbian health is not high on the national and/or international research agenda.

Another challenge or barrier to conducting lesbian research is that there is not one standard definition of lesbian (Solarz 1999, 97). Definitions of who is and who is not a lesbian vary from study to study and thus pose problems for researchers. Researchers conducting research with lesbians must adopt a working definition of lesbian for their projects. Some researchers may identify lesbians according to the Laumann distribution which defines lesbians ‘... as all women who report any level of response to any of the three dimensions measured, i.e. current desire, current or past same sex behaviour, current identity as homosexual or bisexual’ (Bradford and White 2000, 64). Other researchers define lesbians as women who have sex with women or women who identify or somewhere in between (ibid, 65). The challenge for researchers is to design research instruments that will allow and encourage lesbians to discuss their sexual orientation whilst at the same time, ensuring that confidentiality is maintained (Solarz 1999). As there is no one standard definition, it is important for researchers to define the population they wish to sample in a way that fits the purpose of the study (Rothblum 1994). For the purpose of my research, I have recruited women who self-identify as lesbian. This self-identification is common to much lesbian related research and it overcomes the lack of standard definition issues.
Summary

In this chapter I described the methodology and methods I used in this study. My rationale for choosing feminist multiple research methods has been stated along with my personal interest in this study. The participant recruitment and inclusion criteria have been detailed. I have discussed the research instruments used in the data collection and my data analysis has been explained. This chapter has also highlighted the ethical considerations and methodological barriers lesbian researchers encounter when conducting lesbian related research. The following chapter begins the Literature Review and begins with an exploration of body image and menopause.
CHAPTER THREE

Body Image and Menopause

Whilst in the 21st century there is an abundance of research on menopause, a review of the relevant literature showed this research to be overwhelmingly heterosexist in its focus. Lesbians are rarely, if ever, acknowledged in studies and literature on menopause. The heterosexist nature of the existing literature will be highlighted and discussed in the following three chapters. In this chapter I review the existing literature on menopause focusing on the issue of body image.

3.1 Women and Body Image

When examining the issue of women and body image, it is essential to acknowledge the socio-cultural context in which women live. Under the rules of patriarchy, women and men undergo very different socialisation processes. As Sari Dworkin explains, ‘… from early childhood women are taught that their appearance is a crucial part of their lives whereas men are taught that their accomplishments are what counts’ (1989, 27). Sadly, these early messages are internalised and often lead women to experience a negative body image for the remainder of their lives.

3.2 Patriarchy and the ‘Culture of Thinness’

Many feminists have highlighted the ways in which women are vulnerable to the ‘culture of thinness’ that is so pervasive in western society (Gilbert and Thompson 1996). The ‘culture of thinness’, it has been suggested, arose as a means by which patriarchy could effectively oppress women (Wolf, 1991; Wooley 1995 cited in Thompson et al, 1999).

Naomi Wolf (1991) contends that the mass media is the primary means of communicating the ‘culture of thinness.’ She further suggests that the media has a vested interest in retaining this culture as it generates multi-billion dollar industries from women’s insecurity about their physical appearance (cited in Thompson et al. 2000, 215). Susan Faludi (1992) concurs with Wolf and blames the media, in part, for influencing women to become obsessed with food, weight and appearance.

Patriarchy is ‘the manifestation and institutionalization of male dominance over women and children in the family and the extension of male dominance over women in society in general. It implies that men hold power in all the important institutions of society and women are deprived of access to such power’ (Lerner 1986, 239).
The media is said to be the 'barometer' that women will use as the standard against which to measure themselves (Striegel-Moore et al. 1986). Women are constantly exposed to messages about ideal body weight, shape and what is deemed to be attractive. As a consequence a large gap exists for most females between the desired and the real body (Ludwig and Brownell, 1999). Maryanne Ludwig and Kelly Brownell hypothesize that it might be possible for a subculture to oppose pressures and protect its members against such damaging messages (idem). Lesbians are such a subculture, yet to date, very few studies have examined the issue of body image amongst a non-clinical sample of healthy lesbians.

Laura S. Brown (1987, 297) developed a set of rules about food consumption and body size to which she considers women conform. Brown believes it is the conflict between the ‘...adherence to these rules and strivings for health’ which result in fear of fat and body image distortions among women (idem). These rules, according to Brown, focus on ways of being a woman under patriarchy. Brown suggests the first rule is that small is beautiful. To be small, Brown explains, is to occupy less space, be less visible and use fewer resources. ‘Women are valued by their adherence to this rule, although the precise dimensions of correct smallness have varied across time according to the whims of various social control agents’ (idem).

Sari Dworkin (1989, 28) supports this view and writes, ‘men in our society attempt to expand, enlarge and become more powerful; and women attempt to grow smaller, more dependent and invisible’. The second rule, according to Brown, is that weakness of body is valued. Brown explains how ‘...women’s physical weakness helps to keep in place patriarchal norms of male dominance of women’ (ibid, 297). Gilbert and Thompson (1996) support Brown’s rule and suggest that the ways in which emaciated, waif-like girls are seen as the desired or ideal woman is an example of patriarchal society’s rewarding the weak and incapable woman. Thompson et al. (1999, 216) suggest that ‘by displaying women who meet at least some of the diagnostic criteria for anorexia nervosa as society’s ideal, patriarchal society promotes inferior, powerless women as perfection’.

Research has also demonstrated that dissatisfaction with one’s body is much more common in women than men (Brand et al. 1992). This dissatisfaction among women is so common that this phenomenon has been given a name. Many women now
suffer from 'normative discontent' (Rodin et al. 1985) and 'body dysmorpohobia' (Slade, 1994). Body dysmorpohobia, Peter Slade explains, 'is a highly specific problem concerning body image concern which is viewed as involving a delusional misperception' (1994, 497).

A review of the literature on body image reveals a heavy bias towards clinical samples of young women with eating disorders (Cash and Brown 1989; Thompson 1990; Slade 1994). When investigating concerns of weight, participants are frequently drawn from student populations and consequently restricted to young, white - assumed to be - heterosexual women (Stevens and Tiggemann 1998). There is very little information on body image in aging populations (Janelli 1986) and even less focusing on the body image issues of women at midlife. Women are assumed to be heterosexual as sexual orientation is rarely mentioned. Elizabeth Banister (1999) contends that when research has examined the issues of body image and midlife women, it has, with few exceptions only included the experiences of heterosexual women.

Body image describes a complex phenomenon that may include issues of esteem, identity and cultural mores (Asher and Asher 1999, 136). Similarly Riggs and Turner explain body image as a social construct which is incorporated into the individual’s self identity and sense of self worth (1999, 206). Many studies exploring body image focus on issues relating to weight and physical appearance. Joan Chirsler and Laurie Ghiz (1993, 67) remind us that body image provides a basis for our identity.

### 3.3 Body Image and Midlife Women

The majority of research that has looked at the issue of body image and midlife women has focused on body mass index and fat composition (Deeks, 1999). A review of the literature on weight changes during the menopausal years reveals many inconsistencies. Some studies report that weight gain at the time of menopause is not directly related to menopause per se, whilst others suggest that menopause may have a direct effect on weight (Crawford et al. 2000).

Very few of the studies have explored women's perceptions of their changing bodies. Crawford et al. (2000), drawing on data from the Massachusetts Women's Health Study, assessed the relationship between menopause and weight and the link between Hormone Replacement Therapy (HRT) and weight. The findings suggest that
menopause transition was not consistently associated with increased weight. Nor, according to these researchers, is HRT use associated with increased weight. In their analysis, weight gain was found to be more strongly related to behavioural factors such as lack of physical exercise and alcohol consumption (2000, 96; see also Chapter Five on HRT).

Women's physical appearance changes as a result of the ageing process (Chrisler and Ghiz 1993, 69). As a result of the body's basal metabolic rate slowing with age, lean body tissue is decreased and an increase in body fat results (idem). An early study of women aged between thirty and seventy years of age found an increase in body fat after the age of 40 (Young et al. 1963). Women in their 40s had a mean percentage of 23 percent body fat, 46 percent for women in their 50s and women in their 60s, 55 percent body fat (cited in Chrisler and Ghiz 1993, 69). Women have a tendency to gain weight at each reproductive milestone and at menopause weight is commonly redistributed resulting in a changed body shape (idem).

A study conducted by Voda, Christy and Morgan (1991) found that women experience weight gain from the onset of menopause and this weight shifts from lower to upper body (1991, 88). This study included 33 perimenopausal women and revealed that 30 out of 33 women experienced an increase in the subscapular skinfold. Similarly waist measurements increased in the majority of women in this study. The authors conclude that their findings suggest that the redistributed weight was fat. However, no generalisations can be drawn from such a small, convenience sample. In addition, in this study women were not asked about their attitudes towards their changing bodies.

Chrisler and Ghiz (1993, 70) suggest that regardless of whether the cessation of menses is seen as a positive or negative occurrence, menopause undoubtedly changes how women perceive their bodies. Furthermore, these authors propose that physiological changes of menopause such as hot flushes and night sweats, may affect a woman's body image. Similarly, Royda Crose highlights some of the physical changes that an ageing woman may experience and states, ‘... the thickening of her waistline, the widening of her hips, and the graying of her hair are changes that affect the way she views her own attractiveness and the way she is viewed by others’ (Crose 1999, 61). When these age-related changes are combined with those that chronic illnesses may bring, such as incontinence and osteoporosis, Crose argues that
it is more difficult for older women than younger women, to maintain a good body image. However, Crose makes the point that more studies are needed to investigate how women themselves feel about these changes (idem).

Elizabeth Banister conducted a study on women’s own interpretations of their changing bodies (1999). In this Canadian study, she examined the meaning of midlife experiences in relation to women’s own interpretations of their changing bodies. Acknowledging the misconceptions that exist around women’s midlife period and the effects of ageism and sexism, Banister interviewed 11 women aged 40-53 years, exploring the physiological and socio-cultural factors underlying their experiences. Banister chose an ethnographic research methodology for her study due to ‘... its ability to evoke rich descriptions from the participants’ (1999, 521).

Although this was a small sample, by using a purposive sampling procedure that involved variation in socio-cultural demographics, it allowed for the collection of a wide a range of information as possible within such a small sample and consequently included women who are generally under-represented in health research. In terms of racial background, nine women identified as white, one as Aboriginal, and one as Asian. Five of the participants were married, one had never married, and five were divorced or separated. Two of the participants were lesbians. Except for one woman, all participants had children (ibid, 522).

The findings indicated that although physical health matters are important at this stage of life, it is actually the socio-cultural context in which these issues are understood that is problematic (1999, 531). Banister explains, ‘this context defines the ways in which midlife women engage with their health issues… and women often seek to involve health care professionals in this process’ (idem). Banister points out the necessity of health professionals to be aware of the meaning of the cultural and historical context and its effects on midlife women in order to provide appropriate and quality health care to this group. She suggests that health professionals need to examine their own biases and assumptions of midlife women as this can influence the attitudes toward, and treatment of, these women. Banister contends that if health professionals increase their knowledge about midlife women’s health issues within a socio-cultural and historical context, they will gain a greater understanding of their clients in a more informed way (1999, 531).
She explains that by understanding the effects of ageism - and I would add heterosexism - and how it impacts on women’s wellbeing at midlife, health professionals can work with the woman and develop ways to acknowledge, counteract and challenge the prevailing stereotypes that add to women’s feelings of powerlessness at this time of their lives (idem). These findings have particular relevance and implications for health professionals working with lesbians at midlife.

In a South Australian community study conducted by Claire Stevens and Marika Tiggemann (1998), previous research findings which demonstrate that women in the general population are dissatisfied with their bodies and desire to be thinner, were supported. This study found that women’s dissatisfaction with their bodies was constant across the ages of 18 to 59 years of age and factors such as marital status, education level and occupational status did not affect the level of dissatisfaction. The authors acknowledge the bias inherent in their study as ‘...nearly all of the participants were Caucasian’ (1998, 100). Participants were not asked about their sexual orientation and the researchers noted only that 71 percent were married, 21 were living with a partner and 31 described themselves as single (1998, 96). Marital status was viewed as an important variable in determining the emphasis placed on attractiveness as ‘... single women are more likely than their married counterparts to try to be attractive to men’ (idem). Heterosexual bias is thus obvious, yet remains unacknowledged. Clearly, further studies exploring the issues with lesbians is needed.

In the few studies of body image that have been conducted with older women, researchers have found that women over 50 generally seem more accepting of heavier bodies and are more concerned with bodily functions rather than physical appearance (Lamb et al. 1993; Hart 1998, cited in Crose 1999, 64). Studies have shown that the difference between actual and desired weight is less among older women than among younger women.

Thomas Cash, Barbara Winstead and Louis Janda (1986) revealed in a US study, that as women progress through middle age, they became less interested in their physical appearance. This finding, however, does not apply to women over 60 years of age. Women over 60 were found to be just as concerned about their appearance as younger women. The authors did not cite a reason for this and the reader is left to
draw her/his own conclusions. Interestingly, Cash et al. (1986) found that older women were equally dissatisfied with their bodies as younger women (Deeks 1999).

Madhulika Gupta and Nicholas Schork (1993) examined the relationship between aging-related concerns and body image issues related to body weight and shape in a non-clinical sample of men and women (71 men and 102 women) in Canada. This study showed that women in mid and late life were concerned about their skin showing signs of aging. The researchers suggest that 'the concern about wrinkles becomes greater in mid and late life, as the skin begins to show more signs of aging and also perhaps as the time and energy invested in the career and family plateaus' (1993, 485). The study showed that women who are more concerned about their aging appearance than men, tended to be more preoccupied with losing weight as they believed that weight loss resulted in youthful looks (ibid, 484).

Some researchers have suggested that women who identify as feminists would be less likely to submit to the 'culture of thinness' and negative body image (Dionne et al. 1995). However research that explores the link between body image and feminist ideology is scarce. Studies which have explored this connection have not supported the notion that a feminist ideology leads to a more positive body image (Dionne et al. 1995; Kelson et al. 1990). This is one issue I explore in this thesis.

3.4 Lesbians and Body Image: Is There a Difference?

Studies that have included sexual orientation, suggest that lesbians may have a better body image than their heterosexual counterparts (Getelman and Thompson 1993). However, much of the research on lesbians and body image is in relation to lesbians with eating disorders (Brown 1987; Heffernan 1996; Herzog et al. 1992). Research comparing heterosexual women with lesbians has revealed differences and often, conflicting results. Laura Brown (1987, 295) contends that lesbians appear less likely to have eating disorders than women generally. The literature on this issue, however, is scarce and it is clear that more studies need to be conducted with healthy, non-clinical samples of lesbians at midlife and across the lifespan.

When compared with heterosexual women, Getelman and Thompson (1993) found that lesbians were less concerned with weight, dieting and issues of body image.

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30 For instance some studies report there are no differences between the ways in which lesbians and heterosexual women perceive their changing bodies, yet other studies suggest lesbians have a healthier body image than their heterosexual counterparts.
This study aimed to gauge differences among homosexual and heterosexual males and females on issues of body image disturbance and concern about weight gain and eating disturbance (1993, 551). The study sample comprised 32 homosexual males, 32 homosexual females, 32 heterosexual males and 32 heterosexual females. Study participants were drawn from student organisations and undergraduate courses in psychology and women’s studies. Concerns regarding dieting and weight along with measures of body image disturbance were obtained from the sample. Findings indicated that heterosexual females, along with homosexual males, displayed greater anxiety with appearance, weight, dieting and had greater body image disturbances compared to heterosexual males and homosexual females (ibid, 545). Lesbians in this study reported fewer body image problems than heterosexual females and homosexual males. These findings are consistent with those of other published studies (Cash and Brown 1989; Herzog et al. 1992; Siever 1994; Rothblum 1994).

Heterosexual women displayed the greatest anxiety about being overweight and diets were common amongst this group in Gettelman and Thompson’s study. This group also displayed the highest level of eating disturbances compared with all other groups. The authors state that as previous research comparing heterosexual and homosexual females on measures of body image and disturbance is inconsistent, it is not possible to draw definite conclusions as to why lesbians have fewer body image and dieting problems (ibid, 551). The authors offer a possible explanation, that lesbians may have different physical standards that they endeavour to achieve than those held by heterosexual women. It is further suggested that in establishing a lesbian identity, lesbians may ‘... refuse to accept this culturally (heterosexual) prescribed mold for themselves, which many believe to be indicative of male oppression, and instead accept a wider range of personal appearance styles and tastes’ (idem).

Similarly, Michael D. Siever (1994) conducted a study to investigate beliefs about the significance of physical attractiveness, body satisfaction and eating behaviours and attitudes in samples of lesbians, gay men, heterosexual women and heterosexual men (1994, 253). The research hypothesised that gay men and heterosexual women share a vulnerability to eating disorders and body image disturbances based on their common desire to attract and please men.
The sample consisted of two hundred and fifty US college students and including 53 lesbians, 59 gay men, 62 heterosexual women and 63 heterosexual men aged between 21 and 28 years. The majority of participants identified as White (76.6 percent), 18 percent identified as Asian, 2.4 percent as Native American, 2 percent as Latino, and 1.2 percent as African-American (ibid, 254).

Siever acknowledges that the differences noted between the groups were ‘highly significant and appear to confirm the research hypotheses’ (1994, 256). Gay men and heterosexual women showed the highest concern for physical attractiveness. Heterosexual men, who showed the least concern about their own appearances, were the group who expressed the most concern over the appearance of their potential female partners (idem). Lesbians were least concerned about their own physical attractiveness and did not regard it as important in terms of assessment of their partners. Lesbians in this study reported a lower incidence of body image disturbances and behaviours associated with eating disorders than heterosexual women. Siever explains the difference between the groups ‘… by the degree to which people experience sexual objectification by their sexual or romantic partners’ (idem).

Siever asserts that the results of his study suggest that socio-cultural factors - which I suggest are patriarchal and heterosexist - may have an immunising effect on lesbians. Because of the decreased emphasis placed on physical appearance in the lesbian community, lesbians are less vulnerable to the attitudes and behaviours that accompany eating disorders (ibid, 257). These findings support Siever’s research hypotheses. I will also explore this issue in my study.

In another study which assessed weight concerns and disordered eating in samples of US lesbians, gay men, heterosexual women and men, Brand, Rothblum and Solomon (1992) reported interesting results. Lesbians had a higher ideal body weight than their heterosexual counterparts. The authors concluded that body dissatisfaction and behaviours associated with eating disorders were most strongly related to gender. All women, they assert, have been influenced by the cultural pressure to be thin, however, this pressure appears to be internalised, to a greater degree, by heterosexual women, rather than lesbians.

Esther Rothblum (1994) explains how women’s physical attractiveness is important for women in sexual relationships with men, and as lesbians are not sexually
available to men, physical attractiveness is not such an issue. It is interesting to note that the two groups who are sexually active with men, gay men and heterosexual women, place more emphasis on physical attractiveness, are more concerned about their weight, and have lower ideal body weights than lesbians and heterosexual men (ibid, 87).

It has been proposed that a lesbian identity may protect lesbians from the devastating effects of a society which pressures women to be thin (Bergeron and Senn 1998). The authors compared the attitudes of lesbians and heterosexual women towards their bodies and investigated the relationship between body dissatisfaction and the ways in which women internalised socio-cultural standards (1998, 395). In this Canadian study, 243 out of 396 women who agreed to participate returned a completed questionnaire (61 percent). The final sample consisted of 108 lesbians and 116 heterosexual women. Women who identified as ‘bisexual’ or ‘not sure’ were not included in the sample. Over 95 percent of the sample was White and four percent were women of colour. No significant differences were found between lesbians and heterosexual women in terms of age, education or income. The age of the women ranged from 18 to 58 years (ibid, 390).

The results support previous research which states that lesbians are generally less dissatisfied with their bodies than their heterosexual counterparts (Herzog et al. 1992; Siever 1994). The authors found that heterosexual women had a thinner body ideal than lesbians and that lesbians ‘felt stronger and more fit than heterosexual women’ (1998, 396). Lesbians were less concerned with the size of their thighs and buttocks than the heterosexual women, which the researchers claim is ‘... the result of lesbians’ resistance to social norms about this part of their bodies’ (ibid, 397). Bergeron and Senn conclude by stating that ‘there is support for the contention that lesbian status does not work as an immunizing factor, but rather as a buffer, moderating but not entirely preventing the internalisation of norms’ (ibid, 398).

A small, qualitative study that explored the experiences of menopause for seven lesbians living in the US (Davis 1993), found that being a lesbian gave women relative freedom from male standards of beauty. In this sense, participants in Heather Davis’ study regarded being a lesbian as liberating as it enabled them to reject the male defined standards of beauty (ibid, 26).
Maryanne Ludwig and Kelly Brownell (1999) conducted an internet based study to determine how self-identification as ‘masculine’, ‘feminine’ or ‘androgynous’ affects body image in lesbians. The authors hypothesised that:

- Masculine and androgynous lesbians would be more satisfied with their bodies than feminine lesbians.
- Lesbians and bisexual women who have friends that share their gender as well as sexual orientation would be more satisfied with their bodies than those who did not.

One hundred and eighty-eight lesbians and bisexual women participated in the study. The study does not differentiate between lesbians and bisexual women. Women were recruited through the Internet and email and they ranged in ages from 21 to 55 years. The findings revealed significant differences in body satisfaction between women who perceived themselves as masculine, androgynous and feminine. Women who rated their appearance as feminine had greater body dissatisfaction than those identifying as masculine and androgynous. The authors propose that feminine women may be more susceptible to cultural appearance pressures than others in the lesbian culture. Furthermore, they contend that masculine and androgynous women may be more capable of rejecting social pressures exerted on women to conform to society’s image of what a woman should look like (ibid, 95).

Women who had mostly lesbian and bisexual women friends, rather than those with mostly heterosexual female friends, experienced the highest level of body satisfaction. The authors suggest that this is due to the fact that women with mostly heterosexual friends are socialising in a group whose principles closely reflect mainstream values, whereas lesbians and bisexual women are more likely to reject and challenge the culturally prescribed notions of ‘thinness’ for women (ibid, 96).

**Summary**

Body image describes a complex phenomenon that may include issues of esteem, identity and cultural mores (Asher and Asher 1999, 136). The vast majority of existing studies on body image have been conducted with young, white, college educated, heterosexual women with eating disorders. Little research has investigated the issues of body image for healthy, midlife lesbians. Those that include or focus on lesbians suggest that lesbians may have different relationships to body image.
The lack of research and the assumed heterosexuality of women need to be rectified. Clearly, empirical studies need to be conducted with midlife lesbians investigating the connections between body image, sexual orientation and physical and psychological changes associated with menopause. It is one of the issues I will explore in this study. In the following chapter I will examine the issues of sex and sexuality.
CHAPTER FOUR

Sex, Sexuality and Menopause

The vast majority of women, if they live long enough, will experience menopause. Reviewing the literature, however, gives one the impression that menopause is a heterosexual phenomenon only. Until recently, very few studies have looked at menopause from women’s personal experiences and even fewer, from a lesbian perspective. Many studies have been conducted on menopause and sexuality, yet very few have included lesbians’ experiences. Norma McCoy (1998, 56) writes, ‘...it is of note that there are no studies of menopause and its effects on the sexuality of lesbian women’. As the aim of my research is to change the heterosexist focus and enable lesbians to articulate issues as they relate to them as women, in this chapter I look at the literature on midlife lesbians and sexuality. I present an overview of the current research on the issues of sex and sexuality at menopause. The lack of research with lesbians and the effects on sexuality at the time of midlife are highlighted and attempts to correct this situation will be discussed.

4.1 (Hetero) Sexual Disinterest or Sexual Dysfunction?

A review of the literature on (heterosexual) women’s sexual experiences at menopause reveals a concern with issues of sexual functioning (usually referred to as dysfunction), arousal time and dry vaginas. Male partners’ sexual problems feature prominently in many studies of women and sex at menopause.\(^{31}\)

Morris Gelfand in *Sexuality Among Older Women* (2000, S17) claims that there is ‘a wide variation in the prevalence of sexual dysfunction in menopausal women’. He estimates the prevalence of sexual dysfunction in women to be between 25 percent and 63 percent (2000, S20). Gelfand acknowledges that this difference is based on whether the studies are community-based or conducted with women attending menopause clinics. He cites several factors that may have a negative impact on sexual activity in menopausal women and the first one discussed is partner (male) availability. The fact that women are outliving men (‘84 men for every 100 women aged between 65-69 years’ 2000, S19) according to Gelfand, appears to be a major

contributor to negative sexual feeling experienced by women. He cites other contributing factors to women’s negative feelings around (hetero)sexual activity and these include: impotence in men, alterations in libido, issues of poor general health, depression and effects of medication, dyspareunia\textsuperscript{32} in women and decreased hormone levels (idem). There is no consideration given to the fact that some women may choose to abstain from sexual intercourse, regardless of the interest and performance level of their male partners (Gannon 1999, 122). As Linda Gannon asks ‘... can a woman choose to abstain from sex without being diagnosed as suffering from a physical or psychological illness?’ (idem).

In these studies it is implied that all midlife women need or even desire a male partner in order to have a healthy sex life. It is seldom considered in the literature that some older women actually prefer to have sexual relationships with women. Yet again it appears there is only one form of sexuality which is ‘compulsory heterosexuality’ (Rich 1980).

In a study by Mary Riege Laner, Growing Older Female: Heterosexual and Homosexual (1997), ‘personal’ advertisements placed by both heterosexual women and lesbians were analysed for their age-related content. An unexpected difference was found in relation to those who revealed their age. More than 98 percent of the lesbians placing personal advertisements stated their age, compared with 75 percent of heterosexual women. Laner suggests that the reluctance by many heterosexual women to disclose their age, may be indicative of the negative attitudes associated with aging in the heterosexual world (ibid, 91). She asserts that the findings of this study suggest that lesbians have an advantage over heterosexual women in terms of aging. The age of a lesbian’s partner is not as important as it is for heterosexual women who typically seek out older male partners (ibid, 93).

\textbf{4.2 Methodological Problems of Past Research on Sexuality and Menopause}

Norma McCoy (1998) asserts that large studies which have considered the effects of menopause on sexuality are uncommon and have included only a small number of variables. Her study provides a critique of existing research and points out that the large postal questionnaires typically include ‘only one or two sexual questions’ (ibid, 51). Although McCoy in her study ‘Methodological Problems in the Study of’

\footnote{Dyspareunia refers to painful sexual intercourse.}
Sexuality and the Menopause’ (1998) acknowledges that no studies have been conducted with lesbians about the effects of menopause and sexuality, she too falls into the same heterosexual trap as she writes:

*When studying sexuality, essential subject variables are presence or absence of a sexual partner, length and quality of the relationship, age and erectile capacity of the partner, marital status, and whether the partner lives with the subject. Variables known to affect sexuality including sex hormones should be measured and if the study is longitudinal, repeated measurement is in order (ibid, 53).*

No mention is given to the sexual preference of the woman at midlife. Once again there is only one valid form of sexuality: heterosexuality.

Celia Kitzinger argues that the development of the ‘disease theory’ of lesbianism may be regarded as ‘... an attempt to replace women’s developing political analysis of gender and sexuality, with a personalized and pathologized alternative’ (1987, 40). The medical profession portrayed lesbians until the late 1970s as sick and in need of ‘cure’ (Stevens and Hall 1991). As discussed in the Introduction, it was not until 1973 that the American Psychiatric Association decided that homosexuality did not constitute pathology and consequently removed it from the second edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 1973). Lesbians were reported to be ‘... the products of disturbed upbringings or the perverted results of genetic mishaps’ (Kitzinger 1987, 39). As a result of this pathologisation, lesbians were subjected to cruel and dehumanising ‘treatments’ in an attempt to ‘cure’ their homosexuality. Such treatments included aversion therapy, psychiatric confinement, electric shock therapy, genital mutilation, hormonal injection, psychosurgery, and psychotropic chemotherapy (Stevens 1992, 1). Patricia Stevens suggests that it is due to this history, that lesbians are still in vulnerable situations as health care consumers today (ibid, 2). This idea will be explored in further detail in the section on health services and homophobia (see Chapter Six).

Ellen Cole and Esther Rothblum (1990) highlight two major problems associated with menopause research. They are concerned with the type of language used and the pathological and heterosexist bias in the scientific literature. Studies have shown that fewer than half of menopausal women seek treatment for menopausal-related
concerns and those who do, tend to suffer more from life stress anxiety, clinical depression and psychological symptoms (Morse et al. 1994; Ballinger 1985).

Despite this, medical issues continue to dominate the scientific literature more than ten years after Cole and Rothblum’s important comments. They believe that the major biases in menopause research occur as a result of using clinical samples and the issue of ‘across-the-board assumption that all respondents are heterosexual’ (1990, 510). As I ask lesbians themselves about their experiences, my research will add a new dimension to the present heterosexual research focus on menopause.

4.3 Sexuality and the Effects of Hormones

The study of the relationship between a woman’s hormonal status and her sexuality has been a popular theme for many decades. Feminists are well aware of how patriarchy gains from ‘maintaining women as pure biological entities governed primarily by their hormones’ (Gannon 1999, 118). From menarche through to menopause, a woman is seen to be at the mercy of her hormones – which are often blamed for her ‘emotional’ or ‘irrational’ behaviour. It is not surprising then that much of the current research on menopause and sexuality focuses on the role hormones play at this stage of life (see Introduction).

Philip Sarrel (2000, S25) suggests that altered sexual function in postmenopausal women is ‘... at least in part due to hormone deficiency’. He argues that as the majority of women experience changes in their sexual function at the time during which hormonal production is diminishing, there is reason to believe hormones are partly responsible. Furthermore, he claims that ‘HRT has the potential for restoring previous levels of sexual function and desire’ (idem). However, in another study by Sarrel et al. (1997, cited in Sarrel 2000), 252 naturally menopausal women were evaluated for the efficacy of HRT use on vaginal dryness, dyspareunia and decreased libido. The results showed that ‘...the incidence of sexual complaints was similar between women currently taking HRT and those who were not.’ The authors point out that none of the women were using androgen (testosterone) therapy (2000, S28). Sarrel concludes that women who use androgen replacement therapy, might experience significant higher rates of sexual desire, arousal, fantasies and frequency of coitus and orgasm than women using oestrogen alone (ibid, S29).

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33 See Chapter Five for an in-depth discussion of HRT.
Conversely, Bancroft (1984) asserts that there is no clear evidence to link alterations in sexual desire to menopausal-related hormonal changes.

In an Australian study conducted by Susan Davis (1998), the effects of estradiol alone versus estradiol and testosterone implants in thirty-three postmenopausal women were compared over a two-year period. Women receiving the combined estradiol and testosterone implants reported improved sexual satisfaction, pleasure and orgasm compared with women given estradiol alone. However, Davis cautions that testosterone therapy 'is only of benefit in terms of sexuality to women who have a significant hormonal component to their sexual dysfunction' (ibid, 157). Davis suggests from anecdotal experience that the woman’s own explanation of the likely causes of her sexual dysfunction is 'an extremely reliable guide and determinant of the likelihood of response to testosterone replacement' (ibid, 158). Davis reports that further research is underway exploring the long-term effects of androgen on sexual desire in women. But again no questions about sexual orientation are being asked (pers.comm.).

Lorraine Dennerstein et al. (1980) had earlier studied the effects of oestrogen treatment and other hormones on the effect of Australian women's sexual interest, responsiveness and coital frequency. They found that decreased oestrogen had a negative impact on sexual interest and activity, and oestrogen therapy had a positive impact on sexual interest and sexual response. Dennerstein et al. did not, however, find an increase in coital frequency as a result of oestrogen therapy and suggests that further attention needs to be given to the male partner when assessing issues of frequency of sexual intercourse. However, in a more recent study, Dennerstein et al. (1999, 260) found that

... no relationship was evident between HRT use and any of the parameters of sexual functioning, even vaginal dryness/dyspareunia. This may well suggest that the type of HRT used may not be well adapted towards providing optimal sexual outcomes.

The authors conclude that 'the hormonal changes of the menopausal transition are relatively weak in their effects on wellbeing and sexuality' (idcm).
In late 2002, the Jean Hailes Foundation\textsuperscript{34} was recruiting participants for a large study to evaluate the responses of women to a sexual satisfaction questionnaire, and determine whether this questionnaire could differentiate women who are sexually satisfied from women who are sexually dissatisfied. The Subject Information Sheet [sic] reads:

\begin{quote}
Women who are sexually active (in some form) on average once a fortnight may participate in this study. We will not inquire as to the specific nature of your sexual activity. What is important for us to determine is whether or not the experience is pleasurable and satisfying. We also will not inquire about the gender of your partner or the quality of your relationship as our primary focus is to develop a measure of the isolated sexual experience. We aim to recruit 200 premenopausal and 200 postmenopausal women.
\end{quote}

The study’s research co-ordinator explained, that by not asking for information regarding partners’ gender or quality of relationship, the study is respecting the women’s privacy and the study outcome will not be affected (pers. comm.). She did not regard this deliberate omission as an example of heterosexism or homophobia. Similarly, she did not regard the inclusion of qualitative information, such as the woman’s feelings towards her partner (if there is a partner) or the social context in which the woman lives, as necessary variables to include. I contend that the failure to contextualise women’s sexual ‘satisfaction’ and to specifically acknowledge lesbians as distinct from heterosexual women, contributes to lesbian invisibility and is likely to provide inaccurate and misleading research findings. In all of the studies discussed above, heterosexuality is taken for granted. When sexuality is mentioned and investigated, it is invariably heterosexuality.

Decreasing oestrogen levels seem to be a cause of loss of vaginal lubrication in some women at midlife. Surprisingly, given this information, Hunter (1990) reported that less than half of postmenopausal women experienced vaginal dryness as a problem during intercourse and only a quarter of pre- and perimenopausal women noted this as a concern (Gannon 1999, 117). Another determinant of vaginal lubrication as noted by Gannon is the frequency and regularity of sexual activity. Rosetta Reitz (1977, 118) claims that women who masturbate regularly, as compared to those who

\textsuperscript{34} The Jean Hailes Foundation is a leading provider of women’s health services in Australia. Although located in Victoria, it is now providing women’s health services nationally. Its primary focus is the health and wellbeing of 3.3 million Australian women aged between 35 and 65.
masturbate occasionally, report increased vaginal lubrication with a partner and decreased pain due to dryness. It could be argued that too often various forms of HRT are considered as the first line of 'treatment' for vaginal dryness when other non-hormonal preparations also prove effective (Gannon 1999).

Walling et al. (1990), in a review of published studies on the effects of hormone therapy on sexual outcomes in postmenopausal women, found that oestrogen supplements were better than other products for vaginal lubrication. Oestrogen was not, however, useful in increasing women’s sexual desire, frequency or satisfaction. The authors also found that oestrogen combined with progesterone was not associated with any improvement in sexual outcomes (cited in Gannon 1999, 118).

4.4 Menopausal Age or Stage?

Many studies have concluded that in general, sexual activity declines with advancing age. However, there is little, if any, consensus about the cause of this decline. Some authors argue that this is based on biological factors, others on hormonal, and yet others on an interaction of a variety of factors including the social context in which women live their lives. A major problem with these studies is that they have mostly been conducted with heterosexual women. As I pointed out earlier, very few studies exploring the relationship between menopause and sexuality have been conducted with lesbians.

Alfred Kinsey et al. (1953) investigated changes in sexual activity among a group of 127 menopausal women. Out of a group of 127 menopausal women who were sexually active prior to menopause, 39 percent reported no change in sexual activities and responses, 13 percent stated their responses had increased, while 48 percent stated their responses had decreased. For those women who reported a decrease in sexual activity, the change was due to their (male) partners’ declining interest in sex. Other more recent studies have reported similar findings.

Nancy Avis et al. (2000) conducted a study to determine if there is an association between menopause status and various aspects of sexual functioning. The sample was taken from a sub study of the Massachusetts Women’s Health Study and consisted of 200 women, naturally menopausal and not taking HRT. The average age of the women in the sample was 54 years. One-third of the sample was
premenopausal, one-quarter perimenopausal and the remainder, postmenopausal (ibid, 301).

All of the women in this study had current sexual partners and 89.5 percent were married. The authors acknowledge the heterosexist bias in their sample and state, 'the sample mostly included heterosexual women based on marital status and living with a male partner' (ibid, 307). This is not surprising given that many of the questions focused on issues surrounding 'sexual intercourse'. Findings indicated that postmenopausal women were more likely to believe that sexual interest declines with age and reported decreased arousal. Married women in this study reported a decreased sexual arousal at this time in their lives, compared with when they were in their 40s (ibid, 304). The authors point out that their results are consistent with other studies.

Myra Hunter et al. (1986) found that peri and postmenopausal women reported a lower interest in sex than did premenopausal women. Hallstrom and Samuelsson (1990) also found that 29 percent of women aged 60 reported a lack of sexual desire. Both these studies noted that sexual activity in midlife and older women was highly correlated with issues other than menopausal status. These issues included presence of a partner, physical and/or psychological health problems and lack of emotional support from a spouse (Gannon 1999).

Similarly, Keith Hawton et al. (1994), in a randomly selected community sample of women in the UK, found that the age of the woman and her male sexual partner were significant predictors of sexual frequency. This study found that women enjoyed sexual relationships less as they aged and many found it to be 'unpleasant'. Older women commonly preferred less sexual activity. Duration of the sexual relationship also played a role in the level of women's enjoyment in sexual activities. Sexual enjoyment decreased along with the duration of the relationship. The authors suggested that advancing age was associated with increased reporting of sexual dysfunction significantly more than of menopausal status. These findings are consistent with other findings, which also report a decrease in sexual interest, enjoyment and activity with age (Segraves and Segraves 1995; Hallstrom and Samuelsson 1990).

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35 The topic of female sexual dysfunction will be discussed in more detail in Chapter Five.
However, other studies have shown that menopausal status rather than advancing age influence sexual interest. Hallstrom (1977) found that declining interest in sexual activity was related to menopausal stage rather than age. Hallstrom's study used a large community-based sample of women with the same age but different menopausal status to explore the issues of sexual function in women. The results concluded that declining sexual interest in women occurred as a result of menopause and was unrelated to the partner's level of desire.

Denncrstein et al. (1999), in a population-based sample of 45 to 55 year old, Australian born women in Melbourne, asked if there had been a change in women's sexual interest during the last 12 months. The majority of women (62 percent) reported no change in sexual interest; however 31 percent reported a decrease. Feelings towards the sexual partner, frequency of sexual activity and sexual receptivity, all decreased with time. As with other findings, postmenopausal women were again most likely to report less interest in sex. This study concluded that the major factors affecting (heterosexual) women's sexuality during midlife are '... feelings for the partner, partner problems, well-being and experience of a number of symptoms' (ibid, 260).

A US study conducted by Mansfield et al. (1995) documented changes in pre and perimenopausal heterosexual women's sexual responsiveness in relation to 'desire, sexual enjoyment with a partner and ease of experiencing orgasm' (ibid, 11). The authors examined the relationships among these changes and aging, menopausal status and context. The participants consisted of 391 women aged 35 to 55 years who were middle class, highly educated, married and employed in mostly professional work. The authors eliminated women from the sample who were postmenopausal (either naturally or surgically n = 66), taking HRT (n = 65) and lesbians (n = 7). Almost half of the women in this study stated that sexual response in the past year seemed different. The most commonly reported change was experiencing less sexual desire (ibid, 14).

Interestingly, a significant predictor of change in sexual desire was being married rather than single. 'Being married, being older and experiencing vaginal dryness were all predictive of less enjoyment' (idem). It will be interesting to see if lesbians in long-term relationships in my study report similar findings.
4.5 Menopause, Marriage and Sexual Activity

In a more recent study, Phyllis Mansfield et al. (1998) examined the relationship between particular sexual qualities women at midlife desired in themselves and their husbands, and the changes they were experiencing in sexual responses. The sample consisted of 280 women participating in the US Midlife Women’s Health Survey. The authors note that only married women were included as their previous research (Mansfield et al. 1995) showed that ‘... being married was a significant predictor of certain sexual-response changes’ (1998, 289).

The authors point out that 60 percent of the women in their more recent study did not report any changes in sexual responses over the past year. Of the 40 percent of women who did report a change, these changes were mostly in decline: in desire, frequency, enjoyment, arousal and ease of orgasm. An interesting and perhaps surprising finding, revealed that ‘one fifth of the women reported increased desire for non-genital sexual expression (e.g. cuddling, hugging, kissing)’ (1998, 297). The authors suggest three possible explanations for the increased desire for non-genital sexual expression. Firstly, they believe that women may be desiring more non-genital sexual expression in an attempt to ‘facilitate their sexual responsiveness to intercourse, including arousal and passion’ (idem). The implication here is that such behaviours may be a precursor toward more fulfilling sexual intercourse!

A second explanation is that women are seeking more non-genital sexual expression as a means of enhancing ‘their feelings of physical and emotional intimacy’ with their husbands (ibid, 298). The authors highlight how physical affection and non-genital intimacy are constantly valued in women’s lives and how men’s and women’s expressions of intimacy differ.

The third explanation proposes that married women at midlife may desire more non-genital forms of sexual expression instead of sexual intercourse. Anecdotal evidence collected by the researchers suggests that these women ‘... are more likely to seek out non-genital sexual expression in order to enhance feelings of intimacy, and that they prefer this form of sexual expression to sexual intercourse’ (idem). One woman stated the following: ‘Sometimes I feel I could live without sexual intercourse. But, I do enjoy holding one another – embracing, lying in bed together’ (idem).
The authors conclude that these findings may reflect the expectations of how midlife women believe they should be performing sexually rather than expressing their personal sexual preferences. It is suggested that women experiencing decreased sexual responsiveness at midlife may feel guilt and anxiety as they believe their husbands still want - and perhaps deserve - the same level of genital intercourse as before. The following quote from Mansfield et al.'s research illustrates the point well: 'I wish my drive matched my husband's. I feel guilty telling him "No" so often. He accepts the answer, but I know he'd enjoy it more frequently' (1998, 299).

This might be very different for lesbians at midlife who are not concerned about societal expectations of 'appropriate' sexual behaviour at this stage of their lives. The authors acknowledge the limitations of their sample and '... encourage the extension of this research to more diverse populations of women, especially lesbians and women of color' (ibid, 301).

Philip Sarrel (1982), in a study of the sexuality of 50 married couples presenting for treatment in a sex counselling program, claims that women are the cause of men's sexual problems. All of the women in his study were postmenopausal and none were taking HRT. Sarrel clearly blames the woman for her husband's sexual dysfunction as he writes, '... one guideline in sex therapy is that secondary erectile difficulty is often related to something that the female partner is doing which has a negative effect on the male'. He points out that thirty of the fifty wives experienced sexual problems. These problems include dyspareunia (n=19) and eleven women were 'non-orgasmic' (ibid, 234). Sarrel explains how 22 men felt angry and rejected as a result of their wives' lack of lubrication and the time it took for the wife to become sufficiently aroused in order for penetration to occur. Sarrel claims that the men tried harder to arouse their wives, became goal oriented and developed performance anxiety which led to erectile dysfunction. He writes

... in one extreme example a man who had been accustomed to the experience of simultaneous orgasm during intercourse with his wife found that he became so upset and exhausted while trying to stimulate her to a point of sexual excitement that in the interim he developed angina and eventually had a coronary thrombosis during one of their sessions (ibid, 235).

Sarrel makes the point that the woman's dyspareunia is extremely difficult for many men. He suggests that the women be prescribed HRT in order to treat the problem. I share the view of Linda Gannon who believes that prescribing potentially dangerous
drugs to women in order to treat their husband’s erectile problems is ‘a bit extreme, even for patriarchy!’ (1999, 114).

4.6 Lesbians and Sexuality at Menopause

Results discussed earlier in this section are in stark contrast to those found by Ellen Cole and Esther Rothblum (1991) in their unique study of lesbian sex at menopause. This study attracted 41 women with a mean age of 51.5 years from a non-clinical sample. All of the women indicated that they were lesbians, except for one who identified as bisexual and two who did not indicate their sexual orientation. Sixteen percent of women in this study had a hysterectomy and thirty-four percent were taking HRT (ibid., 185). Over half the lesbians in this sample (56 percent) were in a committed relationship with a partner. The average length of the relationships was 7.28 years. Most of the women’s partners were younger and still menstruating (idem).

Women were asked about changes in their level of sexual desire and frequency since menopause. Sixteen lesbians (39 percent) reported no change in sexual desire since the onset of menopause. Nine lesbians (22 percent) reported that their desire had decreased and eleven lesbians (27 percent) stated that their sexual desire had increased since menopause. Nineteen lesbians (46 percent) indicated that the frequency of sexual activity remained the same since the onset of menopause; six lesbians (15 percent) noted that sexual activity had increased and eleven lesbians (27 percent) stated that it had decreased since the onset of menopause (ibid., 188).

Thirty-one women (76 percent) surveyed stated they did not have a problem with sex. The ten women who indicated that they did have a sex problem cited vaginal dryness and longer time taken to reach orgasm post menopause. Many of these women commented that these were ‘differences’ rather than problems (ibid., 187). The authors note that in general the responses had a ‘celebratory quality’. Many of the respondents stated that the changes in their sex lives were not necessarily due to menopause, but rather related to other factors such as ‘the timely mellowing of our relationship’ (ibid., 186).

Twelve women (29 percent) mentioned an increase in the quality of sex since menopause and stated that sex was now better and more fulfilling. Generally the
responses were positive, reflective, insightful and honest. The following quotes illustrate the point well.

*Sex is evener since menopause; less emotional up and down. I experience sex more as a part of life now than as an altered state. It's definitely different, but not better or worse.*

*All of my sexual experiences with women, even prior to menopause have been quality – unlike the same with men, who I must admit that in my twenties and thirties I had more quantity ... meaning. I was much more promiscuous with men (quantity) versus the quality of sexual intimacy since 1977 exclusively with women. Since menopause, my orgasms happen more quickly and more multiple (ibid, 187).*

Women were also asked if their favourite way of having sex had changed since menopause and only one woman indicated that it had. The authors conclude that current favorite ways to have sex reflect the women's younger adulthood. Study participants were asked who generally initiates sex and whether this had changed since menopause. Three lesbians out of 37 who answered this question indicated that these patterns had changed. All of the lesbians in this study have had orgasms. Ninety-three percent of lesbians in the sample orgasm when they masturbate and ninety percent experienced orgasm with a partner. More than half of the women in this study reported no change in orgasms since menopause (56 percent), twenty percent had fewer orgasms and twenty-two percent stated that they experienced increased orgasms since menopause (ibid, 189).

Cole and Rothblum asked respondents to comment on positive changes in their lives, including sexual lives post menopause. These questions were included in an attempt to correct the 'usual research focus on pathology during menopause' (ibid, 190). Responses were interesting, original and varied. Women wrote about a myriad of things including the enjoyed absence of periods, increased sex and orgasms, being less driven, a greater sense of self-acceptance, coming out as a lesbian, feeling more free, financial and professional security, nothing to prove, kids leaving home and wonderful sex (idem). Only nine lesbians (22 percent) indicated that there had been no positive changes since menopause.

The authors acknowledge that just as clinical samples reflect a pathological bias, this volunteer sample may reflect a health bias. They warn the readers to be wary of making generalisations to a larger group and point out that perhaps only those
satisfied with their lives at midlife would take the trouble to respond and complete a questionnaire. Whilst this may well be the situation, the data obtained from this small sample are nevertheless important and add a new dimension to the existing data on heterosexual women's experiences of sex and sexuality at menopause. They guide my own research questions.

Heather Davis (1993) asked participants in her US study, *Coming of Age: The Experience of Menopause for Lesbian Women*, whether menopause had affected their experiences of sexuality. In her small qualitative study, Davis interviewed seven self-identified lesbians about their experiences of menopause. Lesbians in this study were English speaking, aged between 40 and 60 years, perimenopausal or no more than three years past their last menstrual period and naturally, rather than surgically menopausal. Women taking HRT were excluded from the study. Participants were recruited to the study through notices in bookstores, a women's center, a feminist newspaper and word of mouth (ibid, 13). The majority of lesbians in this study contradicted the commonly held belief that sexual activity and desire decrease during and after the menopause, and several of the lesbians reported an increased desire in sexual activity (ibid, 32).

Cole and Rothblum noted many differences in responses to their study with lesbians when compared with heterosexual women's answers. They observed that heterosexual women in past research were troubled by 'their deteriorating sexuality, performance pressure and fears of disappointing their partners' (1991, 192). Conversely, the lesbians who participated in their study emphasised the quality of their relationships rather than focusing on their sexual functioning. The authors suggest some possible explanation for the stark differences in the responses might relate to the ways in which lesbians deal with living in a patriarchal and homophobic world where youth and beauty are glorified. They suggest that lesbians '... who have had a great deal of practice living outside the mainstream, are less susceptible to the pitfalls of these values. Perhaps lesbians have an advantage when it comes to accepting the changes that the years bring' (idem). Cole and Rothblum (1991,193) conclude their report by saying:

*It is possible that if all women, lesbian and straight, could be free of heterosexist hangups about sexual functioning and the aging process, if all women were not handicapped by fears of aging, partner expectation and the extolling of youth, there would be many more reports of unchanged or better, more rewarding sex and deeper
relationships, in our fifties, sixties and beyond. It is certainly something to celebrate that many lesbians already experience menopause very positively indeed.

Summary

With the exception of the research by Ellen Cole and Esther Rothblum as well as Heather Davis, the studies reviewed in this chapter show that lesbians are seldom included in past and current research on women and menopause.

Older lesbians, it appears, are mostly invisible in research on menopause and other health-related issues. ‘Male dominated science has not taken women, including lesbians seriously enough to engage in the necessary research on which the helping professions could adequately base their theory and practice’ (Chafetz et al. 1974, 714). Sadly, it seems little has changed in the almost thirty years since this statement was made. Just as earlier studies and medical experiments were carried out on men and the results then applied to women, we are still repeating these errors by using results gained from heterosexual women’s experiences and applying them to all women. Such thinking, I believe, is heterosexist and homophobic and ensures that heterosexuality continues to be seen as the norm. Excluding lesbians’ experiences in research projects will also keep many lesbians in the closet. The negative effects of hiding one’s sexual preference and lifestyle have been well-documented elsewhere (Gentry 1992; Lynch and Woods 1996; Bradford and Ryan 1991; Copper 1988; Adelman 1986). In the following chapter I explore the issue of Hormone Replacement Therapy (HRT).
CHAPTER FIVE

Hormone Replacement Therapy (HRT)

Hormone replacement therapy (HRT) has become a hotly debated topic associated with menopause over the last two decades. At the beginning of the 21st century HRT remains a subject of great controversy, both within and outside medical discourse. Much of the current literature on menopause focuses on the issue of HRT. In this chapter I examine various aspects of HRT from a medical and sociological perspective. A brief historical overview of HRT will be given along with its delivery mechanisms. HRT, for the relief of menopausal symptoms as well as the risks and benefits associated with HRT, will be discussed. The question of women’s ‘choice’ will be presented as well as other issues, such as the prevalence of HRT usage today and the ‘big business’ side of HRT. Throughout the Literature Review I could locate only one study on HRT that mentioned lesbians. Once again lesbians at midlife remain invisible.

Many lesbians have been aware of the role that medicine plays in the perpetuation of compulsory heterosexuality for a long time and, perhaps for this reason, lesbians may be less likely to take HRT and other drugs reported to enhance sexual enjoyment and improve libido. However, as presently no data is available on lesbians’ usage of these medications, evidence for this claim is lacking. I hope that my research on lesbians’ usage of HRT will add some new knowledge on this topic and generate interest in conducting further larger studies in this area. I will conclude this chapter with a critique of female sexual dysfunction, which I argue is the next stage in the medicalisation of women’s sexuality.

5.1 From the 1940s to the 21st Century

Hormone Replacement Therapy for menopause has been around for more than half a century in the western world. The 1940s saw many different oestrogen preparations prescribed for a variety of ‘female ailments’ (Klein 1992). These early preparations contained oestrogen only and were referred to as Estrogen Replacement Therapy (ERT). In 1943 an oestrogen preparation was developed from the urine of pregnant mares. This was manufactured by Ayerst Laboratories and given the brand name of Premarin (Coney 1993, 154).

\[35\] In this thesis I use the Australian-English spelling of oestrogen. I use Australian-English spelling throughout the thesis unless quoted from US-English.
In 1966 Robert Wilson, a prominent Brooklyn gynaecologist, published *Feminine Forever*, a book that espoused his theories of oestrogen replacement therapy. Wilson regarded menopause as a 'deficiency disease' and considered it could be treated with female hormones (Rinzler 1993, 45). He believed that women ceased to be feminine after menopause and therefore became undesirable. He claimed that women who used oestrogen looked and felt better, and he began promoting hormone replacement therapy for women from the premenopausal years until the grave (Lewis 1993). *Feminine Forever* sold more than 100,000 copies in its first seven months having received much media hype in a diverse range of magazines, including *Time Magazine* and *Vogue* (Coney 1993).

Wilson conducted research and treated women at the Wilson Research Foundation. This organisation received funding from a range of drug companies, one being Ayerst Laboratories, the producer of the bestselling menopausal oestrogen product, Premarin. During this time there had been speculation about a possible higher incidence of endometrial cancer amongst women taking ERT. The first warnings about the risk of ERT and its adverse effects on the lining of the uterus, were sounded as early as the late 1940s. Despite these warnings ERT continued to be prescribed and administered to women during the 1950s and 1960s. By 1975 six million American women were regularly taking estrogen and similar trends were observed in other countries (Coney 1993, 157).

Earlier claims about the link between ERT and endometrial cancer were substantiated in 1975, with the publishing of two articles in the *New England Journal of Medicine* and *The Lancet*. Not surprisingly the sales of ERT fell drastically (Klein 1992, 26). An information leaflet was prepared by the Food and Drug Administration (FDA), which stated the dangers associated with ERT. This information had to be inserted in all ERT preparations. Although the manufacturers of ERT took legal action to ban the insertion of the information, eventually these package inserts became mandatory in the US (idem). By the late 1980s, progesterone was added to

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37 Feminists have long been aware of the problematic nature of the notion of femininity. 'Femininity' has often been used to keep women subservient and subordinate to men (Card 1995, 190). It is therefore important to ask if lesbians are likely to place as much importance on looking 'feminine' as do heterosexual women. If femininity is a concept deemed to be of greater importance and/or relevance to heterosexual women then it is possible to surmise that lesbians may be less likely to take HRT. As previous studies have not addressed the issue of lesbians and HRT use, no definitive data is available.
the oestrogen, thus a ‘new’ product was now promoted as ‘safe’ and ‘medically proven’ (Klein, 1992, 27).

Today, HRT is commonly administered as two hormones: oestrogen and progesterone. Progesterone is given in addition to oestrogen, as it is said to counteract the effect of oestrogen on the endometrium (lining of the uterus) by preventing its overgrowth. For this reason, progesterone is not required for women who do not have a uterus (Palmer 1998). Oestrogen only therapy is known to be associated with endometrial cancer (Dennerstein 1998). Studies have shown that oestrogen only therapy is also associated with an increased incidence of breast cancer and gall bladder disease (Ewertz 1996).

Lorraine Dennerstein (1998) acknowledges that to date, little research has been conducted on these drugs which makes it difficult to give an accurate analysis of the risks and benefits associated with HRT. She writes, ‘the incidence of heart disease is decreasing; that of breast cancer is increasing. This makes it difficult to assess whether HRT will have clear benefits in 15-20 years’ time’ (ibid, 27). Much of the HRT information is confusing and contradictory. Whilst many books have been written on HRT for women, authors either tend to embrace HRT entirely or reject it outright (Saltman 1994). It is thus not surprising that women are confused and concerned about HRT.

5.2 Managing Menopause

The biomedical model of health is the focus for much of the literature on menopause and HRT. The World Health Organisation (WHO) defines menopause as:

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

This approach defines menopause as an illness, an oestrogen deficiency disease. It promotes oestrogen replacement therapy as the cure (Kaufert and Gilbert 1986; Ussher 1992; Coney 1993). This point is illustrated well in the following quotation published in *Maturitas*, the European menopause journal:

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38 The biomedical model of health views health as a property of biological beings. It regards health as the absence of disease and illness and posits that medical treatment can restore the body to good health (Naidoo and Wills 2000). This model has been heavily criticised.
The gradual deterioration in ovarian function seen during the perimenopause results in a marked reduction in estrogen production and a significant decrease in levels of circulating estrogen. Estrogen replacement therapy (ERT) is designed to increase circulating estrogen levels by replacement hormones, prevent the consequences of long term estrogen deficiency, and treat symptoms associated with the menopause such as hot flushes, night sweats and vaginal atrophy which are a consequence of lower estrogen levels (Palacios 1999, S2).

A discussion of HRT would not be complete without a summary of the medical risks and benefits of such therapy. Kate Hunt (1994) explains that the debate within the medical literature on HRT has focused on the consequences of HRT usage in relation to specific diseases and indications for the use of HRT. The main diseases or medical conditions that have been examined are osteoporosis, endometrial cancer (cancer of the lining of the uterus), breast cancer and cardiovascular (heart) disease. A review of the literature about these interactions demonstrates conflicting viewpoints.

Santiago Palacios informs readers that ‘management of the menopause is becoming an increasingly important area of public health’ (Palacios 1999, S5). Hunt (1994) points out that when viewing HRT from a public health perspective, it is necessary to be aware of the frequent incidence of some of these diseases. In 2000 in Australia, for example, all diseases of the cardiovascular system accounted for 49,741 deaths; of these deaths 52 percent (25,967) occurred in women (Australian Institute of Health and Welfare 2000, 44). Twelve thousand and four hundred and sixty-nine Australian women died from coronary heart disease. That is almost five times as many deaths as from breast cancer (idem). Similarly figures for deaths attributed to breast, uterine and ovarian cancer in Australia in 1999 were 2,512, 262 and 731 respectively (Australian Institute of Health and Welfare 2002, 10).

5.3 HRT and Symptom Control

The most common reasons cited for prescribing HRT are the treatment of menopausal symptoms, protection against cardiovascular disease and the prevention of osteoporosis (Saltman 1994). Studies are also continuing to determine if HRT can prevent Alzheimer’s disease (Tang et al. 1996).

For some women, the onset of menopause does bring medical problems and HRT, in some cases, can alleviate or minimise the distress experienced. Barry Wren states that symptoms such as hot flushes, sweats, insomnia and a dry vagina are
experienced by 40 to 70 percent of postmenopausal women (Wren 1989, 35). Other studies claim that whilst women do experience these symptoms, the majority do not seek medical attention for them. Jeanne Daly (1997), in an Australian study, identified three categories of women experiencing menopause. She claimed a minority were ‘besieged with problems’, most ‘battled through problems’ and the third group ‘glided through mid-life’. These findings support the view that menopause is a complex individual and social experience, far more so than the biomedical model suggests (MacWhannell 1999). It must be noted that as a result of the emphasis given to the biomedical model, menopause has been entrenched in western(ised) popular discourse as a disease. Numerous studies have been conducted and reported that HRT is effective in relieving hot flushes, night sweats, vaginal dryness and urinary problems (e.g. Sturdee and Brincat 1988; Semmens and Wagner 1982; Belchetz et al. 1994).

HRT is also said to relieve the psychological symptoms of ‘anxiety, depression, irritability, forgetfulness and fatigue when they are directly related to the stress of symptoms and associated sleep disturbances’ (Palmer 1998, 45). The most common vasomotor symptoms associated with menopause are hot flushes and night sweats. These symptoms are reported to occur in approximately 85 percent of menopausal women (Rebar and Spitzer 1987; Hammond 1989). Whilst undoubtedly a common occurrence at the time of menopause, for most women, hot flushes are not overly troublesome. Women who seek medical attention for hot flushes usually present with multiple symptoms (Lock 1991). Susan Davis, Director of Research at the Jean Hailes Research Unit in Melbourne, writes of HRT that ‘... no other therapy has been shown to be as effective as oestrogen replacement in reducing hot flushes’ (Davis nd, 1). Complementary, or alternative therapists, however, dispute this claim.\(^ {39} \)

### 5.4 HRT and Cardiovascular Disease

The risk of death from heart disease increases as a woman ages. If women are non-smokers and do not have diabetes they rarely develop heart disease prior to menopause (Barrett-Connor, 1996 cited in Rousseau 1998). After menopause, however, coronary heart disease (CHD) is the leading cause of death for women...

\(^ {39} \) Complementary therapists are highly critical of the ‘disease’ model of menopause. A large amount of published literature is available on alternatives to hormone use. For example, see Love 1997; Greenwood 1989; Cabot, 1995; Voda 1997; National Women’s Health Network (2002).
(Grady et al. 1992). In 2000, CHD accounted for 12,398 deaths in Australian women over 45 years of age. This figure represents 22 percent of all deaths in women in this age group (Australian Institute of Health and Welfare nd).

Many observational studies have shown that the risk of coronary heart disease is 35 to 45 percent lower in postmenopausal women using HRT than in non-users (Henderson et al. 1991; Stampfer et al. 1991). These studies were based on women taking oestrogen replacement therapy only, usually in the form of conjugated equine oestrogen, i.e Premarin (National Health and Medical Research Council 1995, 5). According to Palacios (1999, S7) the level of risk reduction is dependent upon the regime chosen. However, results on the benefits of different regimes to date remain inconclusive.

Goldman and Tosteson (1991) noted that a link between CHD and HRT has been found in women taking oestrogen alone (cited in Wright 1998). It was suggested that the addition of progesterone may offset the potential benefits of oestrogen. However, this suggestion has been refuted by recent findings of the Nurses' Health Study40 (Grodstein et al. 1996) which state that the use of combined HRT does not appear to diminish the protective effects of oestrogen alone.

The authors of the Nurses' Health Study and other studies, have suggested that hormone therapy users may make healthier lifestyle choices than non-users. These healthier behaviours may include better diets and regular exercise thus it is possible that the favourable outcome in these women may not be due to the effect of hormones (Vandenbroucke 1995). Palacios supports this view and states that 'the degree of risk reduction gained by ERT or HRT is also linked to a woman's overall risk at the onset of treatment' (1999, S7).

Many studies suggest that the women most likely to gain the greatest benefit from HRT are those with existing cardiovascular risk factors (Davis nd). The American Heart and Estrogen/progestin Replacement Study (HERS) (Hulley et al. 1998), however, revealed contrary findings. Beverley Vollenhoven summarises the study as follows:

This study was a randomised, blinded placebo controlled secondary prevention trial undertaken in 2763 postmenopausal women with

40 The Nurses' Health Study is the largest women's health study in the US (National Women’s Health Network 2002, 28).
coronary disease. These women were administered continuous combined treatment or placebo. The results showed on an average follow up of 4.1 years treatment did not reduce the rate of overall cardiovascular events in these women and did increase the rate of thrombo-embolic events (first year) and gall bladder disease. The treated women had a significantly greater number of coronary event in the first year and fewer in years 4 and 5 (Vollenhoven, 2000, 9).

This study has received much criticism with HRT proponents criticising the fact that it did not continue until its planned period of observation (4.1 years versus 4.75 years). It has been suggested that if the study had continued, the results may have been different as there was a trend suggestive of a possible late benefit of treatment (Whitehead and Stampfer 1998). Clinical recommendations currently state that ‘in those with established vascular disease HRT cannot be recommended on the basis of existing data’ (Teede 2000, 8).

Elizabeth Barrett-Connor (1996), after summarising all the epidemiologic evidence about the link between HRT and cardiovascular disease, concluded that the majority of published reports suggest that the risk for CHD events is reduced as much as 50 percent in postmenopausal women who use oestrogen. Mary Ellen Rousseau (1998, 214) points out however, that most of these studies have been observational and appear to have ‘inherent biases, which might affect the interpretation of the results, either exaggerating or minimizing the effects of estrogen’. Studies are continuing in this area and the completion of the Women’s Health Initiative (WHI)\textsuperscript{41}, and other trials may provide more accurate estimates of the risks for cardiovascular disease (idem).

5.4.1 HRT and Osteoporosis

The risk of osteoporosis, like heart disease, is increased after menopause. Osteoporosis is characterised by a reduction in bone mass such that the bones become brittle and are more prone to breaking. Osteoporosis has become a major health issue for women in their later years and it is likely to increase in line with the aging population (Rousseau 1998). According to an Australian women’s health

\textsuperscript{41} The WHI is a major long-term American study designed to assess the risks and benefits of a number of primary prevention strategies, including the use of HRT in healthy postmenopausal women. This study involves 160,000 postmenopausal women aged between 50 and 79 years. On 31 May 2002, after a mean of 5.2 years of follow-up (planned duration 8.5 years), the trial evaluating oestrogen plus progesterin versus placebo was stopped because the test statistic for invasive breast cancer risk exceeded the stopping boundary for this adverse effect. Overall health risks exceeded benefits for use of combined HRT for an average 5.2 year follow-up among healthy postmenopausal US women.
physician, Sheila O’Neill (1995), for the average woman entering menopause, the lifelong risk of hip fracture is about fifteen percent. Within one year of fracture, the mortality rate is estimated to be between twelve and twenty percent (Wark 1996). It has been suggested that up to 50 percent of survivors of hip fracture experience severe incapacitation, often requiring assistance with activities of daily living for the remainder of their lives (Rousseau 1998).

Estrogen replacement therapy (ERT) reduces the risk of osteoporosis (Felson et al. 1993) and appears to increases bone density by approximately five percent (Eastell 1998). The incidence of hip fracture amongst women taking HRT is reported to be as much as up to 50 percent less than in women not taking HRT (Palmer 1998). The greatest benefit is seen amongst women who begin taking HRT close to the menopause (started within five years of the menopause) and current users (Hutchinson et al. 1979). When HRT is ceased, bone loss continues and at this stage convincing evidence that prior hormone use appreciably reduces hip fracture in women over 75 years, is not available (NHMRC 1996, 8). It has been suggested that a more effective means of preventing hip fractures is through ‘...lifelong hormone therapy commencing either at the menopause or at age 65 years’ (idem). This suggestion is another example of the increasing medicalisation of women’s lives.

The National Women’s Health Network42 (2002) explain that osteoporosis per se is not the problem; rather it is the fractures which might occur as a result, that lead to disability and death (ibid, 153). The authors point out that osteoporosis is not a disease, rather it is one risk factor for bone fractures. White women are more likely to develop osteoporosis than women from any other racial group. Similarly, women who are of a slight build are more likely to fracture their bones than heavier women (ibid, 154). Unfortunately, as acknowledged by these authors, women usually only hear that menopause causes osteoporosis and that HRT will prevent or treat this ‘disease’ (idem).

Sandra Coney asserts that it is wrong to simply blame loss of oestrogen for bone fractures experienced by postmenopausal women (1993). She contends that at menopause women tend to lose approximately two percent of bone loss annually, with the greatest reduction occurring in the first five or six years post menopause (ibid, 114). Coney argues that at the age of 65, women’s bone loss slows to the same
rate as men's, which is approximately 0.2 percent per year (idem). Coney suggests that an emphasis needs to be placed on factors which may decrease the risk of falls in old age. These factors, Coney suggests include attention to safer living environments and current drug use (ibid, 122).

5.4.2 HRT and Endometrial Cancer
Several studies have observed an increase in risk of endometrial cancer in women taking unopposed oestrogen with an intact uterus (Judd 1996; Writing Group for the Postmenopausal Estrogen/Progestin Intervention Trial 1995). This risk increases substantially with prolonged use (more than ten fold after more than ten years) and the risk persists for several years after discontinuation (Grady et al. 1995). The literature on the relationship between HRT and endometrial cancer is both confusing and controversial.

R. Don Gambrell (1982) noted a decrease of 50 percent in the risk of endometrial neoplasia compared with non-users. Another study, however, reported that women on HRT were at slightly increased risk of endometrial cancer with cyclic progestagen therapy even for more than ten days per month (Beresford et al. 1997). Beverley Vollenhoven (2000, 12) writes ‘... the shorter the duration of the cyclic progestagen therapy the higher the risk for cancer development and the longer the duration of use of HRT the greater the risk of cancer development.’ The confusion and conflicting information makes it extremely difficult for women to decide what to do at menopause. Not surprisingly, research in this area is continuing.

5.4.3 HRT and Breast Cancer
In the case of HRT and its links to breast cancer, we find once again that the literature is confusing and conflicting. Some studies show a relative increase in the risk of breast cancer among women using HRT whilst others show no increased risk (NHMRC 1996, 10).

Several studies have shown that the risk of developing breast cancer may be related to the duration of HRT use (Colditz et al. 1995; Bergkvist et al. 1989). Colditz et al. (1995) reported that the risk of breast cancer was significantly increased in women currently using HRT (Relative Risk RR 1.41) as opposed to postmenopausal women who had never used HRT. As the duration of use increased, so did the relative risk (RR 1.46 for ten or more years of use) (Vollenhoven 2000, 11). Conversely, another
published study showed contradictory data. Stanford et al. (1995) reported that the use of HRT for eight or more years was not associated with an increased risk of breast cancer but, in fact, led to a reduced risk (RR 0.4).

Susan Davis reassures women by stating, "a recent review of the world literature on 52,000 women with breast cancer and 108,000 controls found no significant increase in breast cancer in women using HRT for less than five years" (Davis nd). Davis writes that

... for women who had used oestrogen replacement therapy with or without progesterone for more than five years, a relative risk of 1.35 was reported. The use of HRT for more than five years had resulted in 2 extra breast cancers being diagnosed in every 1,000 users. The use of HRT for about 15 years had resulted in 1 extra cancer being diagnosed in every 100 users (ibid, 2).

Of the women who develop breast cancer whilst taking HRT, studies have reported that they have a better prognosis as their tumours are less advanced (Cobleigh et al. 1994) and that their mortality is decreased (Harding et al. 1996).

However, an Australian study by Anne Kavanagh, Heather Mitchell and Graham Giles (2000) found that HRT use reduces the sensitivity of mammographic screening. In this study, the investigators examined the sensitivity, specificity and small cancer detection rate amongst 103,770 women in Victoria who attended BreastScreen 43 for a first round screen in 1994 who did not have a history of breast cancer or breast symptoms at the time of screening (ibid, 270). Findings revealed that the sensitivity of screening mammography was lower in women using HRT than in non-users. The authors point out that of the women diagnosed with cancer during the two-year screening interval, women using HRT were more likely to have a false negative result than non-users of HRT. Similarly, of the women who were not diagnosed with cancer during the screening interval, women using HRT were more likely to have a false positive result (idem). The possibility of having a small cancer detected amongst all of the women screened was lower in the women using HRT.

The authors remark that 'an additional 23 cancers or 20 percent more cancers would have been detected by screening among HRT users if the sensitivity of

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43 BreastScreen Victoria is part of BreastScreen Australia and is jointly funded by the Victorian and Commonwealth Governments. It offers free mammography screening to women over 40 years of age every two years for the early detection of breast cancer.
mammography was the same as for non-users of HRT” (ibid, 272). In 2000, more than 177,000 women attended the BreastScreen Victoria program. Of those 1,077 screen detected breast cancers were diagnosed (BreastScreen Victoria 2000, 4). Over one-quarter of women attending BreastScreen Victoria in 2000 reported using HRT (25.5 percent) at the time of screening (idem). Given the above-mentioned findings, it could be suggested that women presently using HRT and attending BreastScreen every two years are receiving false reassurance. The fact that HRT reduces the sensitivity of mammographic screening may, according to Kavanagh et al. ‘... undermine the capacity of population based mammographic screening programs to reach their potential mortality benefit’ (2000, 270).

A recent controversy surrounding HRT was unleashed with the findings of the Women’s Health Initiative (WHI) in July 2002. The following section will detail the background and outcome of the WHI.

5.5 The Women’s Health Initiative (WHI) and WISDOM

The US-based Women’s Health Initiative (WHI) is the largest ever clinical trial and observational study designed to assess the risks and benefits of a number of primary prevention strategies for preventing cardiovascular disease, breast cancer, colorectal cancer and osteoporosis in healthy postmenopausal women. This fifteen year, multi-million dollar study is the largest prevention study of its kind (McGowan and Pottern 2000). The longitudinal study was launched in 1993 by the National Institutes of Health (NIH) and includes more than 161,000 healthy postmenopausal women aged 50 to 79 years.

Despite millions of women worldwide being prescribed HRT, the risks and benefits of postmenopausal hormone replacement therapy had not previously been tested in randomised controlled clinical trials\(^\text{44}\) in healthy postmenopausal women (McGowan and Pottern (2000, 110). In the US in 2000, 46 million prescriptions were written for Premarin (conjugated estrogens) and 22.3 million were written for Prempro (conjugated estrogens plus medroxyprogesterone acetate). Premarin is reported to be the second most commonly prescribed drug in the US (Fletcher and Colditz 2002).

\(^{44}\) Randomised controlled trials (RCT) are the ‘gold standard’ in medical research. As such, the RCT is recognised as the most persuasive study design (Webb 1999).
The WHI has three major components: a randomised clinical trial, an observational study and a community prevention study. The randomised controlled clinical trial has over 68,000 enrolled postmenopausal women between the ages of 50 and 79. The clinical trial has three study components. These are Hormone Replacement Therapy (HRT), dietary modification, and the role of calcium/vitamin D supplementation for the prevention of osteoporosis-related fractures and colorectal cancer (National Institutes of Health 2002). For the purpose of this thesis I will report only on the implications and findings from the HRT component of the clinical trial.

The main objective of this randomised clinical trial was to examine the effect of oestrogen plus progestin on the prevention of heart disease and hip fractures. A secondary objective was to assess any associated change in risk factors for breast and colon cancer. On May 31, 2002, the trial arm of the study which involved 16,608 women with an intact uterus who were taking either oestrogen plus progestin therapy or a placebo, was stopped prematurely after 5.2 years instead of the planned 8.5 years, because women receiving active therapy had an increased risk of invasive breast cancer and major cardiovascular events (Yusuf and Anand 2002, 357).

According to the Writing Group for the Women’s Health Initiative investigators, (2002, 6) the rates of cardiovascular disease events had increased to 29 percent relative to placebo for women taking oestrogen plus progestin (37 versus 30 per 10,000 person years). Similarly, rates of stroke (41% increase: 29 versus 21 per 10,000 person years) and venous thromboembolism (more than two fold higher rate: 34 versus 16 per 10,000 person years) were also higher in the women taking HRT. In terms of breast cancer, a 26 percent increase (38 versus 30 per 10,000 person years) was noted in women taking oestrogen plus progestin (idem).

Whilst some beneficial effects of HRT were reported, such as lowered incidence of hip fractures (10 versus 15 per 10,000 person years) and a 37 percent reduction in colorectal cancer rates (10 versus 16 per 10,000 person years), overall it was revealed that the active treatment was causing more harm than good and thus the trial arm of this study was stopped (Bhavnani 2002).

The media release of these findings caused mayhem amongst many thousands of women worldwide. The news of the discontinuation of the study was publicly released on July 10, 2002, one week prior to an article being published in the Journal of the American Medical Association (JAMA) on July 17, 2002. Women were urged
to see their doctors for information and advice one week before doctors had read the study findings. Newspaper articles, television reports and talk back radio were full of news about the WHI results. Leading health and medical experts were in demand to speak and provide some clear information to the many thousands of women taking HRT who, by now, were in a state of confusion, anxiety and fear. Conflicting public views about the relevance and significance of the findings were common and, unfortunately, increased women's confusion and anxiety. It has been reported that in the months following the release of the WHI findings, 25 percent of the estimated 600,000 Australian women using HRT, discontinued their combined HRT (Verghis 2003, 3). Similarly, Wyeth Australia, the company that makes Premaria (combination HRT) experienced a 30 percent decrease in sales (idem).

Scientists and medical experts were quick to point the finger at faults in the study design and methodology, once the adverse findings were released in JAMA. Criticisms of the study included: the study results were based on one only preparation (conjugated equine oestrogen 0.625 mg and MPA 2.5g), the increased risk for breast cancer did not appear in the first few years of the study, and the fact that the study did not examine the effects of oestrogen plus progestin for the treatment of menopausal symptoms, where the benefits are thought to outweigh the risks (Rossouw 2002).

Bhagu Bhavnani, Professor of Obstetrics and Gynaecology from the University of Toronto wrote in a letter to the editor of the Journal of Obstetrics and Gynaecology Canada "... the premature termination of the HRT trial was not due to a significant increase in breast cancer numbers, as the general public thinks, but because the number of breast cancer had reached a pre-specified number that crossed the designated safety boundary. This safety limit was, for obvious reasons, set low" (Bhavnani 2002, 690). Bhavnani points out that the average age of the 'healthy women' selected for the randomised control trial on HRT was 63.3 years and only 33 percent were between 50 and 59 years. This is, according to Bhavnani, 15 to 20 years older than the age at which most women commence HRT. Bhavnani informs readers that almost 70 percent of these women were overweight and of these, half were obese, over one-quarter were treated for hypertension and only half of the group had never smoked. Bhavnani writes, "... perhaps this is an acceptable definition of healthy women in the USA, but it may not be applicable to the rest of the world" (idem). Medical experts in Australia and other countries also emphasised these points
and shared similar concerns and criticisms about the clinical implications of the research findings.

In Australia, an expert panel was convened by the Therapeutic Goods Administration (TGA) to assess the findings on the safety of the WHI. The Committee comprised some of Australia’s leading epidemiologists, cardiologists, oncologists and gynaecologists. The Committee supported the conclusions of the authors of the WHI and reiterated that HRT should not be used for long-term disease prevention in postmenopausal women, as the benefits of such treatment do not outweigh the risks. The Committee reassured women that the use of HRT to manage short-term menopausal symptoms remains an appropriate treatment option, however, it was also suggested that women should discuss their particular needs and concerns with their doctor. It was recommended by the Committee that information about the risks of combined hormone replacement therapy be detailed on product and consumer information and a review be undertaken into the use in Australia of combination hormone replacement therapy in the long-term prevention of osteoporosis (Therapeutic Goods Administration 2002).

Further anger and confusion was caused on May 28, 2003 with a publication in the Journal of the American Medical Association concluding, ‘... estrogen plus progestin therapy increased the risk for probable dementia in postmenopausal women aged 65 years or older’ (Shumaker et al. 2003, 2651). The Women’s Health Initiative Memory Study (WHIMS) recruited participants from the WHI oestrogen plus progestin trial between May 1996 and December 1999. The objective of this part of the study was to determine the effect of these two hormones on the incidence of dementia and mild cognitive impairment compared with a placebo (idem). The premature discontinuation of the combined hormones, oestrogen plus progestin, in the WHI study caused an early and unplanned assessment of the same component in WHIMS.

The results showed that 61 women out of 4,532 in the study were diagnosed with probable dementia. Of these women 40 (66 percent) were receiving the oestrogen plus progestin, compared to 21 (34 percent) in the placebo group. Once again doctors are refuting the study results by questioning the study design and the age of the

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42 This is not the first time such action has been taken (See p. 64).
participants. The Jean Hailes Foundation website under a section entitled ‘Hot Topics’ informs women that:

These are important findings, but with an understanding of the results, they should not be a cause for panic. The second report was restricted to women over the age of 65 and showed an increased risk of dementia in the women receiving combined oral hormone therapy that translated to one extra case for every one hundred women being treated over 4 years. This research was in a specific group of women on a specific hormone therapy and cannot be extrapolated to the more conventional use of hormone therapy around the time of menopause for symptom relief (Jean Hailes Foundation 2003).

Another study, WISDOM (Women’s International Study on long Duration Oestrogen after Menopause), was put on hold in July 2002 as a result of the findings of the WHI. WISDOM was the world’s largest HRT study and was designed to examine the long-term effects of HRT. The study was planned to run over 22 years and involve 36,000 women internationally. The United Kingdom’s Medical Research Council granted $11.0 million to Adelaide University in 2001, to oversee the Australian arm of this study, under the direction of Professor Alistair MacLennan (Head, Department of Obstetrics and Gynaecology). Unlike the WHI study, women in the WISDOM trial would be aged between 50 to 69 years, receive ten years of HRT and then followed up for another ten years. On Thursday, October 24 2002, the funding for WISDOM was withdrawn and consequently the study ceased (The University of Adelaide, 2002).

Twelve months on from the publication of the WHI, many women remain confused and ambivalent about the risks and benefits of HRT. Anna Day, an Associate Professor in the Department of Medicine and Health Policy at the University of Toronto, explains how women are targeted to receive therapies and treatments to enhance or maintain their physical appearance, even in the absence of adequate studies of the risks and benefits of these treatments (2002, 362). Day cites examples of women being prescribed drugs that produce anorexia and are known to have a significant risk of pulmonary hypertension as an acceptable form of treatment, because obese women are at increased levels of risk of heart disease and diabetes (idem). Similarly, she cites the case of increasing numbers of women being prescribed antidepressants and anxiolytics with little knowledge of the long-term effects of such drugs. Day reminds readers that socio-cultural norms and values of a
society in which women and their health practitioner live, influence patient care. As she puts it

... on the basis of a belief that hormones are associated with youth and health, hormone replacement therapy for women was believed to be good. The WHI has clearly demonstrated that it is imperative that trials assessing the overall risk and benefit of primary prevention interventions for both men and women be conducted before such therapies are broadly instituted ... The WHI demonstrates the potential for doing harm ... we cannot continue to do so (idem).

Whilst many within the medical profession will continue to refute the results of the WHI, clearly the results have had an impact on both the treating doctors and the women who consult them for information, advice and treatment. It is currently accepted that HRT should not be used for preventative effects as the risks clearly outweigh the benefits. Attention might now be directed towards other non-pharmaceutical agents aimed at the prevention of heart disease and osteoporosis, such as smoking cessation programs, exercise regimes and healthy eating patterns (Yusuf and Anand 2002). As a result of the publication of the WHI results and the ensuing controversy, many more women are questioning if there is a place for HRT in ‘treating’ a natural stage of life. These questions and conversations between women and their doctors, I suggest, leads to a healthier professional relationship and indeed more informed and healthier women.

5.6 HRT and Women’s ‘Choice’

Women’s attitudes to, as well as, knowledge and experiences of HRT vary widely. There can be little doubt that women in western(ised) countries today are inundated with conflicting information about HRT. Women have to decide whether to use HRT or not and, in some cases, are made to feel that it is the responsible course of action to take. Christiane Northrup (1994) highlights how women are routinely warned by their doctors of the risks of not using ERT and thus they believe osteoporosis and heart disease are unavoidable without it. What ‘choice’ then does a woman have? As Northrup puts it:

The rare woman who wants to get through menopause without estrogen replacement now has to fear that she may not be making the right choice. She doesn’t get the cultural seal of approval that she would if she were on ERT. Women may feel better on ERT in part because they are doing the culturally approved ‘right thing.’ This can be comforting and health enhancing in and out of itself (Northrup 1994, 465).
In a qualitative study conducted by Hunter et al. (1997) women identified three main themes in relation to decisions about their own HRT use. Firstly, they were more likely to want HRT if they were experiencing problematic vasomotor symptoms. Secondly, the doctor’s opinion was an important factor in their decision-making process. The third theme identified by the authors related to views and opinions about hormonal medication. Women were concerned about side effects and possible health risks. Women questioned whether it was ‘natural’ to take medication for menopause and were concerned about distorting ‘... the natural rhythms of their cycles’ (ibid, 1545). These findings support the findings of another study conducted by Griffiths and Jones (1995) which revealed that women who disliked medication were prepared to use HRT because it relieved severe symptoms and was perceived as ‘... a real need to keep themselves well’ (Griffiths 1999, 473). In this study, the ‘choice’ to take or reject HRT was restricted by varying factors. Serious health problems and fear and social attitudes all contributed to a reduction of control over their ‘choice’ (idem).

It is often implied that with more information and education women will increase their uptake and compliance to HRT (Sinclair et al. 1993). Whilst there is some evidence to support this view, an explanation based on education alone is regarded as too simplistic in terms of understanding women’s views on HRT (Hunter et al. 1997). Griffiths (1999) notes that the sense of control a woman feels could in fact be both increased or decreased by information.

An Australian study challenged the notion that active information seekers have a better understanding of the menopause than the general population (Fox-Young et al. 1999). Two groups of midlife women, one a group of women who attended menopause seminars, and another chosen at random, were asked to select from a list of 39 changes those they believed to be directly caused by menopause.

The results found no significant differences in the commonly available knowledge and even level of biomedical knowledge, amongst the two different groups of women. The findings further indicated that women are rejecting a biomedical model of menopause and are using HRT for a multiplicity of reasons, not just oestrogen deficiency (Fox-Young et al. 1999).
5.7 Prevalence of HRT Use

It is difficult to determine with any degree of accuracy the exact number of women using HRT at any given time. It has been estimated that in the state of Victoria in the late 1990s, one in four menopausal women was taking HRT (Vollenhoven 1999). Dianne Palmer, head of the menopause clinic at the Royal Women’s Hospital Melbourne, estimates that HRT is used by 40 percent of Australian women aged between 45 to 64 years (2002). The ongoing Melbourne Women’s Midlife Health Study (Dennerstein et al. 1994) is a longitudinal study which has been following the lives and health of 357 women for more than nine years. Out of the 357 women participating in this research project, 42 percent had tried HRT and in 1994, 62 percent were taking HRT. This figure is very high compared with other countries (Guthrie 1999). Of the women who had stopped taking HRT, most gave it up after six months (idem). This concurs with other studies which show that HRT treatment is frequently abandoned during the first year (Ravnikar 1987). In Ravnikar’s study, the fear of breast cancer was found to be the most commonly cited reason for discontinuation of treatment (Ravnikar 1987). Reasons women commonly cited for discontinuation of HRT in other studies include increased risk of cancer, unwillingness to take ‘unnatural therapies’, side effects and the high cost of HRT.

Alistair MacLennan et al. (1995) reported the findings of a study to discover the prevalence of the use of oestrogen therapy in the South Australian community. One thousand and forty seven women over the age of forty were interviewed. The results indicated the then current users of oestrogen therapy to be 13.6 percent and ever users 24.3 percent. Many past users had stopped the therapy within six months, frequently because of side effects. The most common reasons cited for taking oestrogen therapy were to relieve menopausal symptoms, post hysterectomy adverse effects and to prevent osteoporosis. Reasons for not taking oestrogen therapy included women being pre-menopausal, asymptomatic, or being unaware of the therapy. The authors concluded that amongst current users there is a perception of only short-term benefits. They also believe that misinformation about the therapy exists amongst non-users.

These findings are consistent with another Australian study conducted by Shelley et al. (1995). As part of the Melbourne Women’s Midlife Health Project, in 1991 telephone interviews were completed with 1897 randomly chosen, Australian-born
women living in Melbourne aged 45 to 55 years\textsuperscript{46}. Twenty-one percent of the sample was using HRT and most women reported some benefit from their use. The most commonly reported benefit was the relief of hot flushes. As in other studies, prevalence of HRT use was higher in women over 50 years of age. Both Australian studies suggest higher HRT use here than in other countries.

Marie-Anne Schaad et al. (2000) acknowledge that HRT usage varies greatly from country to country and depends on many non-medical factors such as age, socio-economic status, social and cultural background and the availability of medical services. White, professional women who are highly educated were more likely to have used or be using HRT (MacLennan et al. 1995). A number of studies also report that HRT usage is high amongst the medical population and the spouses of medical practitioners (Schaad et al. 2000).

A study undertaken in Britain to determine female doctors’ uptake and experiences of HRT revealed that 55 percent of women doctors aged 45 to 65 years without regular menstruation were ever users of HRT. Of these, 70 percent were still taking HRT five years after starting therapy and 48 percent ten years after beginning therapy (Isaacs et al. 1997). The authors conclude the high usage of HRT by the women doctors reflects the fact that many started the therapy on their own initiative and with long term prevention in mind. Isaacs et al. acknowledge that HRT users may differ in their health-related behaviours from non-users, and that many women may never take up HRT until the benefit-risk ratio is more clearly established.

A Swedish study reported current HRT use to be 88 percent amongst postmenopausal gynaecologists and 72 percent of female general practitioners (Andersson et al. 1998). A US study was conducted to determine whether physicians’ beliefs about the risks and benefits of HRT differ depending on their gender or specialty in a managed care facility. The findings reported that gynaecologists were less concerned about the potential risk of HRT on breast cancer and thromboembolic events compared with family physicians and interns. Female providers from these three categories differed significantly from their male colleagues in their positive beliefs about the benefits of HRT in relation to the reduction in risk of heart disease, osteoporosis and Alzheimer’s disease. But female physicians were more

\textsuperscript{46} Sexual orientation was originally asked for, however the number of women who identified as lesbian was extremely small (Guthrie 1999). I have not seen sexual orientation discussed in any of the further publications arising from this study.
concerned about the risks of breast cancer than their male colleagues. The researchers concluded that this difference may affect provider-patient discussions about HRT (Exline et al. 1998).

5.8 HRT is Big Business

New Zealand feminist, health activist and author, Sandra Coney (1993) has comprehensively discussed how HRT has become a huge industry. Pharmaceutical companies are consistently bringing new products on the market for menopausal women (Berger 1999). Presently a wide variety of delivery systems are available for HRT. ‘The possible routes for HRT include slow-release oral tablets, transdermal, subcutaneous, intramuscular, transvaginal and intrauterine administration’ (Fraser and Wang cited in Wren 1997, 59). Fraser and Wang state that in order to increase the use of HRT it is essential to make it appealing and simple to use and ‘... a move towards increasing the availability and appeal of the newer developments in long-acting delivery seems to be one of the most promising avenues for further progress’ (idem).

Ever since the promise of a ‘youth pill’ through which, according to Robert Wilson (1966), menopause could be avoided and aging alleviated, women have turned to HRT in search of the promise of eternal youth. Sandra Coney claims that it is the preoccupation with the restoration of youth, beauty and (hetero) sexual prowess that is responsible for the success of the HRT awareness campaign (1993).

Gabriella Berger (1999) explains how it is advantageous for pharmaceutical companies to sell HRT ‘to an ever-expanding world market of female clientele.’ Women in western(ised) countries can now expect to live at least one-third of their life after menopause (Palacios 1999) and, as such, make up a large market of potential HRT consumers. Pharmaceutical companies therefore stand to gain massive financial benefits as a consequence of the aging female population (Berger 1999).

A recent French study conducted by Fauconnier et al. (2000) found that the amount of attention women pay to beauty care plays a role in determining HRT use. This study was a prospective survey, which consisted of three separate questionnaires administered in 1990, 1993 and 1996 (Fauconnier et al. 2000, 216). When the study began in 1990, 1,262 women completed questionnaires and the follow-up cohort

47 My emphasis.
consisted of 940 women who responded to the 1996 questionnaire. Six questions in the 1996 questionnaire explored representations of menopause, six questions explored beauty care practices and five questions from the 1990 survey explored women’s expectations of HRT use. As usual, sexual orientation was not noted and heterosexuality was assumed.

Results showed ‘... a positive linear relationship between the level of beauty care and HRT use, independent of other factors associated with HRT use’ (ibid, 224). Whilst the authors acknowledge that the small difference in users and non-users of HRT and beauty care practices may not represent an important difference in behaviour, they nonetheless suggest ‘... the relationship between beauty care and HRT use should be compared with that which is observed between HRT use and expectations of anti-aging effects’ (idem). This study suggests that some women are using HRT as a cosmetic agent to counteract the physical signs of aging. The authors point out that the cosmetic benefits of HRT are real, however, this effect is minor and physicians should not consider it in determining whether HRT should be prescribed. It is not known if beauty care practices are as important to lesbians as they appear to be to many heterosexual women. My study aims to shed some light on this issue.

5.9 Exit HRT: Enter Viagra

Despite a fall in the sales of HRT since the release of the WHI findings, the medicalisation of women’s sexuality continues. Viagra, the drug used to treat erectile difficulties in men, earned $US 1.5 billion in 2001 (Moynihan 2003, 45). In order to establish a need for similar markets in women, Roy Moynihan argues that a clearly defined medical condition is necessary (idem). Moynihan, an Australian US-based journalist, explained in an editorial cited in the British Medical Journal how drug companies have invented a new disease, female sexual dysfunction (FSD) in an attempt to create a market for the female version of the highly lucrative drug, Viagra (Sildenafil Citrate).

In his editorial, Moynihan details seven scientific meetings, dating from 1997. All but one were supported by a large number of pharmaceutical companies. Moynihan writes: ‘A cohort of researchers with close ties to drug companies are working with colleagues in the pharmaceutical industry to develop and define a new category of human illness at meetings heavily sponsored by companies racing to develop new drugs’ (2003, 45). He points out how specialists have been working to create a
definition of a condition in order for new drugs and clinical trials to be designed and implemented.

It has been suggested that the prevalence of sexual dysfunction amongst women aged 18 to 59 years is 43 percent (Laumann et al. 1999). Although this statistic is frequently cited, its accuracy is questionable. This figure arose from a survey conducted in 1992 in which 1500 women were asked questions such as whether they had experienced a lack of desire for sex, or anxiety related to sexual performance over the past twelve months. Women who indicated ‘yes’ to any of these questions were characterised as suffering from Female Sexual Dysfunction (FSD). It must be noted that the researchers exploring FSD were funded by Pfizer, the manufacturers of Viagra (Dow 2003).

Leonore Tiefer, a feminist psychiatrist at New York University, convened a group of clinicians and social scientists in 2000 to discuss the issue of the creation of FSD and to provide feminist responses to this emerging situation. A Working Group was formed that produced a document entitled, ‘A New View of Women’s Sexual Problems’ (2000). This document was to become the beginning of an educational campaign aimed at challenging the myths of female sexual dysfunction promoted by the pharmaceutical industry (Tiefer et al. 2002).

Tiefer and her colleagues critique the accepted American Psychiatric Association (APA) definition of sexual dysfunction which was created in 1980 for the Diagnostic and Statistical Manual of Mental Disorders (DSM). The Working Group highlight the problematic nature of the medical model in defining women’s sexual problems as it ‘... reduces sexual problems to universalized disorders of physiological function, comparable to breathing or digestive disorders’ (ibid., 226). They also emphasise the fact that women are seldom asked about their experiences from their own point of view and when they are consulted, their accounts differ vastly from men’s. The authors explain how the focus on genital and physiological similarities between men and women disregards the effects of personal sexual experiences and social inequalities relating to class, gender, sexual orientation and ethnicity (idem). Women’s social, political and economic situations all impact upon their ability to experience sexual health, pleasure and satisfaction. However, when using a biomedical framework to diagnose female sexual dysfunction, these issues are totally ignored. The reductionist, biomedical model does not acknowledge relationship and
the accompanying power issues between men and women which, as the working group note, are often the underlying reasons behind sexual dissatisfaction and/or displeasure (idem). Clearly, a new definition of women’s sexual ‘problems’ is needed. The Working Group defines women’s sexual problems as ‘discontent or dissatisfaction with any emotional, physical or relational aspect of sexual experience’ (ibid, 229).

Tiefer and colleagues’ critique of the condition FSD is not an isolated one. Shere Hite, long-time US feminist and researcher on female sexuality, argues that women do not need drugs in order to be sexually aroused. Hite suggests that a new approach to human intimacy is needed, one in which understandings of sexual expression extend beyond the limits of sexual intercourse. Hite’s research identifies a lack of orgasm during sex as the most common reason for women’s dissatisfaction and disenchantment with sex. To this end, she suggests that more attention needs to be paid to masturbation, rather than medication. As she puts it

... the overwhelming majority of women, according to my research, can have orgasms easily during masturbation so why not during coitus? The answer is that during masturbation women chose to stimulate the clitoral or pubic area. Only rarely - in 2 percent of cases - does it involve vaginal penetration. In other words, the stimulation women give themselves to reach orgasm is - unlike that used by men - radically different from the stimulation most women receive during coitus (Hite 2003, 11).

It might appear obvious from Hite’s research that another form of sexual expression is needed and indeed warranted. Hite concludes her article with the following comments:

Women know how to have orgasms but do not feel free to express this during sex with men. It's not arousal pills we need, but a whole new kind of physical relations with each other (idem).

Lesbian sexuality, I propose, is indeed an extremely valid and appropriate kind of physical relation. However, for reasons I will discuss in the Conclusion, lesbianism as a form of valid sexual expression is never encouraged, or even suggested in such articles, not even, unfortunately, in much feminist work.

**Summary**

In this chapter I discussed how the construction of menopause as ‘disease’ has created a market for HRT as the ‘cure’. Reasons women ‘choose’ or reject HRT are
many and varied. The benefits and risks of HRT are confusing and conflicting. Women are undoubtedly confused about the value of HRT and are often persuaded to commence HRT as a result of the media portrayal of its benefits and pressure placed on them by the medical profession. Women are made to feel that taking HRT is the responsible course of action with regards to managing their menopause and life thereafter. However, the release of the findings from the Women's Health Initiative (WHI) in July 2002 has had a significant impact on women taking and ceasing HRT. Interestingly, however, since the numbers of women taking HRT have begun to fall, more and more attention is devoted to a newly classified disorder, that of female sexual dysfunction. According to the drug companies, Viagra and similar drugs under development may offer a medical solution to this latest female 'disorder.'

Studies which have explored women's views and experiences of HRT have failed to acknowledge sexual orientation as a variable and have assumed heterosexuality. My research aims to explore the views, experiences and attitudes towards HRT from lesbians' perspectives. The idea of lesbianism as a valid and appropriate means of sexual expression has been highlighted in this chapter and will be discussed in further detail in the Conclusion. In the following chapter I will explore the topics of health services and homophobia in relation to menopause, as discussed in the literature.
CHAPTER SIX

Health Services and Homophobia

In this chapter I critically examine the literature on lesbians and their experiences of health services. Although a growing body of research is slowly emerging from Australia, the majority of studies to date are from overseas. I explore issues such as homophobia and heterosexism within health services, health seeking behaviour of lesbians, health practitioners’ knowledge and attitudes toward lesbian health, lesbians’ access to services and lesbian health issues. Evidence of homophobia and heterosexism within the health care industry is widespread (Peterson 1996, xvii). Very few health services provide lesbian-specific services/programs and when these are provided, most commonly they are aimed at younger lesbians. Menopausal lesbians, I contend, remain invisible within both mainstream and women’s health services.

The Australian ‘Lesbian Health Information Project’ (LHIP)\textsuperscript{48} collected data from interviews, focus groups and questionnaires between April and July 2000. Interviews and focus groups were conducted with 120 lesbian consumers, 80 hospital staff and 25 external health professionals (Brown 2000, 45). According to the data obtained, when accessing health care, lesbians commonly reported experiencing homophobia and heterosexism, combined with the assumption of heterosexuality. Lesbians consulted in the LHIP were concerned about the lack of knowledge regarding lesbian health issues and the lack of sensitivity displayed by health service providers. Similarly, lesbians stated that it was their responsibility to ‘come out’ to their health provider as the practitioner rarely asked. When they did ‘come out’, however, practitioners often responded in inappropriate ways (idem). Menopause and other specific health issues relating to midlife lesbians were not covered in this report.

6.1 Lesbians’ Dissatisfaction with the Health System

The vast majority of research on lesbian health has focused on the attitudes of health care providers and lesbians’ health seeking behaviours (Peterson and Bricker-Jenkins 1996, 35). Few studies reflect lesbians’ experiences of health care from their own perspective. The majority of lesbian-related research has been conducted by lesbians.

\textsuperscript{48} See footnote 26 on p. 27.
and for this reason it is often viewed as invalid and/or biased\textsuperscript{49} (Horsley and Tremellen 1996, 9).

US researchers Patricia Stevens and Joanne Hall (1988) assert that in order to provide quality nursing care to lesbians, ‘... nurses need an understanding of the cultural experience of being lesbian, a knowledge of what illness and wellness mean for them and a comprehension of their experience in health care interactions’ (1988, 69). Stevens and Hall designed and undertook a study to investigate these issues. Twenty-five self-identified lesbians were recruited through a snowballing technique from the lesbian community in Iowa. The participants were white, college educated, employed and ages ranged from 21 to 58 years. The authors acknowledge the potentially biased sample in that the majority of the women were, ‘... more vocal, who openly disclosed and accepted their lesbian identity’ (ibid, 70). Semi-structured interviews were conducted with the participants focusing on lesbians’ identifiability, health strengths and weaknesses, and interactions with health care providers. Findings revealed that 48 percent of participants believed they were clearly identifiable to everyone as lesbians, while 20 percent believed that no one could tell. The authors point out that as some of the participants believe that their lesbianism is obvious to others, these women develop ways to minimise the negative impact of the stigma (ibid, 71).

Participants viewed health as a holistic concept and regarded independence and self-reliance as key determinants of wellness. The topic of ageing was addressed in Steven’s and Hall’s survey. Women spoke of their distress about aging and regarded it as a time of loss of physical, economic and social independence – all of which were central to their definition of wellness. Most participants worried about becoming dependant on others as they aged and many anticipated alienation due to a lack of social support services for older lesbians. Interestingly, many feared an increased reliance on the mainstream allopathic health system because of a mistrust of the safety and appropriateness of its ability to care for lesbians (idem). The participants in this study did not address the issue of menopause. Stevens and Hall write:

\textsuperscript{49} It is interesting to note how this is often used to discredit the work conducted by lesbians. When research has been conducted on men by white male researchers, this is never seen as invalid or biased. On the contrary, this is often regarded as showing authority.
The means by which a lesbian believes her identity to be revealed may affect how she values such aspects of herself as body image, associations and personality characteristics. Her attitude toward the degree of identifiability she attributes to herself may be related to the degree of self-affirmation that she has as a lesbian. Her sense of control over the disclosure of her lesbian identity may be related to the level of stress that she experiences. For example, both the woman who believes that she can conceal her lesbian identity and the woman who behaves as though she is highly identifiable may experience a sense of control and thereby reduce stress (idem).

Participants’ responses to questions about communication with health care providers also related to stigmatised identity. Seventy-two percent of respondents described negative responses from their provider once their sexual orientation was known. These responses included shock, embarrassment, fear, pity, invasive personal questioning, unfriendliness, rough physical handling, partners being mistreated and breaches of confidentiality. Thirty-six percent of the respondents mentioned instances where they terminated the discussion and/or refused to return to that particular provider due to responses received after disclosure. The following quote illustrates the point well:

As soon as I said I was a lesbian, the nurses started giving me disgusted looks. They were nasty to my partner. They rough-housed me. They were not gentle like they would be to a straight woman. They treated me like I was ‘one of those,’ like they might catch something (ibid, 72).

As Stevens and Hall point out, there was an overwhelming assumption of heterosexuality and this was reflected in the health care providers’ questions. Participants expressed the view that there was ‘... no routine, comfortable way to let health care providers know that heterosexual assumptions were not applicable to them as lesbians’ (idem). In order to avoid being assumed to be heterosexual when they were not, many participants felt they were forced to come out to their provider. Ninety-six percent of participants mentioned situations in which it could be harmful to them if the provider knew of their lesbian identity. Lesbians spoke of having to assess each individual encounter with health care providers and having to make a decision as to whether to disclose or not (idem).

Not surprisingly, given these experiences, 84 percent of the study participants stated that they were reluctant to seek out health care (ibid, 73). This figure has been supported in more recent studies from the US and New Zealand (Brown 2000; Koh 2000; Saphira and Glover 1998/99; Bradford 1994; Stevens 1992). The reluctance to
seek care raises serious concerns re access of health care services to lesbians and requires urgent attention. According to Stevens and Hall (1988) the participants believe that

...dispelling heterosexual assumption and eliminating prejudicial attitude and action is the responsibility of health care providers so that health care can be made accessible to lesbians. With empathy and accurate information about lesbians, participants felt it would be possible for health care providers to overcome their negative responses. However, they wanted providers to have dealt with the issue before that moment when it comes to providing care to them (ibid, 73).

In a focus group I conducted in 2001 with lesbians from a rural area in Victoria, a significant finding was that 12 out of the 14 participants stated that they travel out of their immediate local area regularly to visit a general practitioner (GP). The women remarked that they had been dissatisfied with their interaction with the nearest GP and thus preferred to travel to find a GP they felt comfortable with. One woman travels more than 80 kilometres to the city to visit her GP.

6.2 Lesbians' Health Seeking Behaviours

US researchers Jocelyn White and Valerie Dull (1997) designed a study to investigate lesbians' health risk factors and health seeking behaviours. Respondents were recruited from a convenience sample from women attending a lesbian health conference in Oregon, US and the readership of a lesbian community newsletter. A total of 324 women responded to a four-part questionnaire. The women self-identified as lesbians (287), bisexual (15) and 'no identity' or 'other' (10). The first part of the questionnaire related to specific health issues such as cancers, substance abuse, weight, nutrition, coming out, violence, menopause, suicide, HIV, heart disease and others. The second part asked questions relating to the ease or difficulty in obtaining health care and health-seeking behaviours. The third section focused on levels of comfort or discomfort when discussing sensitive issues with their health care provider. The final section related to demographic information and provided space for additional comments (ibid, 104).

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30 I facilitated this group on behalf of the Victorian Department of Human Services (DHHS) for the Women's Health and Wellbeing Strategy 2001 which will provide a policy framework for planning, funding and delivery of services related to the health and well-being of Victorian women.

31 This figure does not add up to 324. The authors do not provide any explanation for this irregularity.
The mean age was 41 years and 84.6 percent of the lesbians were Caucasian. Participants were well educated with over 58 percent of respondents having more than a college level education. The majority of the women were employed in full time paid employment (70.1 percent) and 89.5 percent had health insurance. The authors acknowledge this bias in their sample and accept that this study group may not be typical of lesbians in the general population. As they explain, the respondents belonged to a community organisation that incorporated lesbian health into its mission statement. Consequently, the women’s health-related behaviours might differ from those of lesbians in the general community (ibid, 110).

The study found that the fewer male partners a lesbian had during her lifetime, the greater appeared her health risk. The authors suggest the reason for this is that heterosexual women (who are sexually active with men) go for regular medical consultations for issues such as birth control and Pap tests, and thus frequently receive health checks and other preventative health measures. White and Dull (1997, 109) state that lesbians who are having sex exclusively with women, ‘... may be forgoing primary care and other screening in the absence of a need for birth control’. This raises concerns regarding lesbians’ knowledge of the need for screening services and access to appropriate health care providers and, according to the authors, has negative effects on their general health. 

Younger lesbians were found to have a higher health risk than older lesbians and the authors hypothesise that this may be due to older women receiving regular health care for chronic conditions. Preventative measures such as mammography screening for older women heavily promoted through the media, has encouraged this group to attend for regular screening. Younger women, not yet in the target group for breast cancer screening, according to White and Dull, may be missing out on other preventative health checks.

Findings of the study suggest that a proportion of lesbians are relying on their partner for health information and that they may be replacing doctors and other health care professionals advice with advice from their partners. White and Dull acknowledge that partners offer much support to each other, but argue that they must not replace the care and information provided by health professionals. They suggest that lesbians

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52 White and Dull reflect a medical view of health screening and prevention. An opposing view may argue that fewer male partners would mean a lower rate of STDs and may avoid or minimise the damaging effects of contraceptives.
need to be encouraged to take their partners to their health care provider and they should be involved in the care. However, as already mentioned, other studies have reported the negative treatment received by lesbians when, indeed, they have followed this suggestion (Stevens and Hall 1988; Myers and Lavender 1997).

White and Dull’s findings also support those of previous studies that confirm that the interaction between the client and her provider is a major determinant in health seeking behaviour of lesbians. Lesbians are more likely to seek health care if they perceive the health care provider to be sensitive and competent (White and Dull 1997, 111). As Rhonda Brown discovered when interviewing lesbians for the LHIP in Victoria, Australia, lesbians, like all consumers, want ‘access to respectful, sensitive and informed practitioners’ (Brown 2000, 45).

A US study conducted by Allison Diamant and colleagues assessed and compared women of differing sexual orientations within a population based sample regarding their health risk behaviour, health status, access and barriers to health care and receipt of health care services (Diamant et al. 2000, 1044). The researchers used a public access data file compiled from the Los Angeles County Health Survey. The aim of the 1997 Health Survey had been to ‘examine key indicators of access to health care services and health status for adults and children living in Los Angeles County’ (idem).

The research sample consisted of 4697 women, of whom 51 self identified as lesbian, 36 bisexual and 4610 as heterosexual. The mean age of women in this sample was 42 years. The authors acknowledge the small number of lesbians in their sample, however, they cite a statistic that claims lesbians comprise 1.0 percent - 3.6 percent of the US female population and assert that if this finding is accurate, then their sample size of 51 lesbians and 36 bisexual women may, in fact, be, representative of Los Angeles County’s population (ibid, 1049).

Findings revealed that there were significant differences in the receipt of preventative health care services and that lesbians and bisexual women experience greater barriers to accessing medical care than their heterosexual counterparts. Lesbians and bisexual

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53 Due to the lack of accepted definition of lesbian and the effects of homophobia, which ‘force’ many lesbians to remain closeted, it is difficult to estimate with any degree of accuracy the number of lesbians. Ten percent is the most widely accepted figure (Zeidstein 1990).
women were less likely to have health insurance and this was a barrier to medical care. Similarly, lesbians and bisexual women were less likely to have a private physician as their regular health care provider. The authors argue that this may be related to the low numbers of lesbians and bisexual women with health insurance (ibid, 1048).

Another US study designed to determine whether lesbians and bisexual women are less likely than heterosexual women to use preventative health measures was conducted by Audrey Koh, a US obstetrician-gynaecologist. This study, the first to compare the health of lesbian, bisexual and heterosexual women in the same setting, and the first large study to describe the experiences of lesbian, bisexual and heterosexual women who use the healthcare system, yielded interesting results. Participants included 524 lesbians, 123 bisexual women and 637 heterosexual women. The settings were in 33 physicians' offices and community health clinics in urban areas of 13 states across the United States of America. The quantitative findings revealed that lesbians and bisexual women were less likely to use preventative health measures than heterosexual women. Koh (2000) suggests lesbians and bisexual women use the health care system less than heterosexual women, because they may have lower rates of income and lower rates of health insurance. However, they are also less likely to need antenatal and contraceptive care, and importantly, many of these women avoid contact with the system as they want to avoid discrimination due to their sexual orientation. Importantly, Koh also points out that other studies have shown that lesbians are likely to use complementary healthcare providers if they are seeking holistic and less discriminatory care \(^*\) (ibid, 379).

6.3 Health Practitioners’ Knowledge and Attitude Towards Lesbian Health

Patricia Stevens provides an overview of the existing research from 1970 to 1990 about healthcare professionals’ attitudes towards lesbians as well as lesbians’ experiences of the healthcare system (Stevens 1992). Stevens reviewed 19 published studies, which note care provider bias and ignorance as common themes throughout. Lesbians commonly reported health professionals to be rejecting, hostile and abusive.

\(^*\) It must be pointed out that alternative/complementary health care providers are not always non-discriminating in their approach (see Findings and Discussion).
In Australia, Ruth McNair and Sue Dyson (1999, 1) conducted a study in Victoria to ‘gather information about the prevailing attitudes and knowledge amongst primary health care providers regarding lesbian health’. Fifty-one practitioners participated in the study; the majority of participants were GPs\(^5\); however a small number of allied health professionals\(^6\) also participated.

McNair and Dyson conducted six focus groups over a range of geographic areas in order to involve a wide range of practitioners. A series of questions was designed to serve as discussion points within the focus groups. Participation in group discussions was voluntary and the sessions lasted between 60 to 90 minutes. Participants were male and female and ages ranged from 20 to 62 years.

The focus group questions were divided into four areas:

1. Assessing attitudes to lesbian patients and lesbian health;
2. Knowledge of lesbian health issues;
3. Strategies to increase awareness and knowledge;
4. Overcoming barriers within primary health care to lesbians.

I will discuss these four areas in the next section.

1. Assessing Attitudes to Lesbian Patients and Lesbian Health

The authors report ‘... that the level of comfort in treating lesbian patients was refreshingly high’ (1999, 3). Only two participants had not treated self-identified lesbians and others were aware that they saw lesbians who did not disclose their sexual orientation. Participants acknowledged some discomfort when lesbians asked questions about a topic of which they had little knowledge.

Some focus group participants spoke of witnessing examples of misogyny, yet very few had seen cases of clear discrimination towards lesbian patients. Other participants had witnessed cases of discrimination towards gay male patients in the hospital setting, however, as McNair and Dyson contend, ‘this points to invisibility of lesbian patients within the system rather than a lack of homophobia’ (idcm).

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\(^5\) The high number of general practitioners in the study is acknowledged. Ruth McNair is a Melbourne-based GP and is heavily involved in lesbian health provision, education and research, with consumers, medical students, GPs and other health professionals from a medical viewpoint.

\(^6\) This includes six nurses, one medical student, pharmacist, laboratory technician, psychologist and four administrative workers.
Jocelyn White and Wendy Levinson (1995, 463) argue that it is important for primary care physicians to know the sexual orientation of their clients in order to provide high quality primary care. The exact percentage of women who are lesbians is difficult to determine. Surveys estimate that between two percent to ten percent of the population are women sexually active with women (see Footnote 53, p.93). As White and Levinson point out any woman may be lesbian, bisexual or heterosexual, thus it is necessary for health care providers to use language that is free from heterosexual bias when working with women (idem).

The issue of disclosure of sexual preference in McNair and Dyson’s (1999) study provided interesting results. All participants believed it was important to know the sexual preference of the patient [sic] in certain situations (particularly in relation to sexual problems, sexually transmitted diseases and gynaecological problems), yet none of the participants routinely asked their female patients. (Two participants routinely asked male patients.) McNair and Dyson conclude that there is reluctance on the side of the practitioner to ask their female patients about their sexual preference. This reluctance, the authors suggest, is due to fear of offending heterosexual patients\(^{57}\) and, they surmise, due to a lack of skills in asking in a sensitive and non-judgemental way. Thus it is left to the patient to disclose. The authors contend that there is an expectation that lesbians will disclose their sexuality once they are comfortable with the provider, or if they believe it is relevant to the consultation. This view, McNair and Dyson claim, is in direct contrast to the expectations of many lesbians who wait for signs that it is safe to ‘come out’ to the provider before doing so, with the result that only between a third to half eventually disclose (1999, 4). The authors term this the ‘after you, no after you’ phenomenon which, they argue, perpetuates lesbian invisibility within medical consultations (idem). Participants identified a range of issues they considered to be lesbian health issues. However, menopause and other issues directly associated with older women were not identified. Health issues identified by the participants included Pap tests, mental health, fertility/parenting/STDs and safe sex, lesbian relationships, domestic violence, breast health, drug and alcohol abuse, sports injuries and access to services. These findings are supported by those of the previously discussed Victorian Lesbian Health Information Project (p.88) where the respondents stated that it was the responsibility of lesbians to ‘come out’ to their health provider as the practitioner.

\(^{57}\) The issue of offending heterosexual patients will be addressed in the Conclusion.
rarely asked. As pointed out earlier, when they did ‘come out,’ practitioners often responded in inappropriate ways (Brown 2000, 45).

As a result of their study, McNair and Dyson suggest to practice positive discrimination, which, they believe, is preferable to waiting for disclosure. Asking patients directly, they argue, should apply to research situations as well as in individual consultations. Unfortunately, the ongoing Women’s Health Australia Study (WHAS)\(^{58}\) does not differentiate data from the lesbians in the study, as there is no specific question addressing sexual preference\(^{59}\). The justification for this omission, according to McNair and Dyson (1999, 4) is that heterosexual women would be offended if asked\(^{60}\). In an attempt to correct this bias, a separate cohort of lesbian participants will be recruited, however, as McNair and Dyson state at the time of writing their report, this had not yet happened (ibid).

McNair and Dyson’s research demonstrates a marked lack of awareness by GPs and allied health professionals towards lesbian’s health needs. The authors state that the majority of participants were not aware of the differences between lesbian health and women’s health and most viewed lesbian health as a ‘subset of women’s health and that the differences were subtle or that there are really no specific issues’ (ibid, 5).

2. Knowledge of Lesbian Health Issues

Ruth McNair and Sue Dyson comment that many of the participants only became aware of lesbian health issues as a result of the focus group discussions. The lesbian health issues raised by the participants in the focus groups included Pap tests and lesbians’ perceived immunity from cervical cancer; mental health and ‘coming out’ issues; fertility and parenting issues; STDs\(^{61}\) and safe sex; lesbian relationships; domestic violence; breast health; drug and alcohol abuse; access to services and

\(^{58}\) The Women’s Health Australia Study is a study of 40,000 women in three different age cohorts and is designed to run for twenty years with surveys every three years. The study was designed to explore factors that promote or reduce health among women who are broadly representative of the entire Australian population (Lee 2001a, 1).

\(^{59}\) A question relating to sexual orientation was included in the second survey of the young women (18-23 years) for the first time in 2000. This question was asked of the middle-aged cohort in survey three in 2001. The older age cohort will not be asked this question.

\(^{60}\) This justification was supported by personal communication with Christina Lee (February 2001) chief investigator with the WHA research team.

\(^{61}\) STDs refers to sexually transmitted diseases.
Sports injuries. Many participants openly recognised their lack of knowledge on
lesbian health issues, with one GP expressing embarrassment about her own
ignorance of the issues and another expressing shock at her ignorance (ibid, 6).

Similarly, lesbians interviewed for the LHIP remarked that when they do seek
information from GPs, the experiences and responses are varied. Access to
appropriate health information and sensitive practitioners were themes commonly
mentioned throughout the consultations. As Rhonda Brown writes, ‘Lesbians are
constantly burdened with having to educate their health care providers who are often
unaware of issues affecting lesbians’ (2000, 46). McNair and Dyson conclude that
education and training is needed regarding consumer needs, the current invisibility of
lesbians and lesbian-specific health issues (1999, 6). Due to the double invisibility of
older lesbians, I suggest, this education is particularly important when working with
older, perimenopausal and postmenopausal women.

3. Strategies to Increase Awareness and Knowledge
Participants in McNair and Dyson’s study expressed the view that specific articles on
lesbian health would be competing with other issues that ‘were of more immediate
relevance’ (ibid, 9). Many participants stated they would read lesbian health articles if
they were seeing lesbians in their practices. As GPs have limited time and a vast
amount of training offered to them, such comments infer that they would need some
incentive to increase their likelihood of attending lesbian-specific health education
sessions. McNair and Dyson suggest that in order to reach doctors, ‘... there is a need
to overcome the invisibility of lesbian health as an issue and the invisibility of lesbian
patients within primary health care before practitioners will perceive a need to learn
more’ (ibid, 10). Printed information, the authors suggest, also needs to be made
available through a range of publications. The advantage of having a designated
lesbian health worker available for consultation, according to the authors, is that the
doctors then have a contact point for information and referral that otherwise would
not be readily available to them.62

62 The disadvantage of having a designated lesbian worker, I argue, is that all lesbian clients and
lesbian-related issues could be redirected to this worker; thus other members of the health team do not
have the need to increase their knowledge and awareness of lesbian health issues. Often the lesbian
health worker is isolated and unsupported in the workplace.
The focus groups demonstrated an overall lack of knowledge regarding the availability of resources available for lesbians and commented that most participants 'were struggling to know of any appropriate resources for referral or information' (idem). Some participants stated they would consult a sexual health service and others stated that they would ask lesbians known to them, either through work or social contact. Menopause and other age-related health issues were not commented on in the focus groups.

4 Overcoming Barriers Within Primary Health Care to Lesbians
Agreement that creating a lesbian friendly environment would assist lesbian patients was constant across all groups. However, some participants believed that displaying lesbian health material might offend or alienate heterosexual patients. Others had nevertheless already taken measures within their workplaces to create a lesbian-friendly environment. Other strategies suggested included training of reception staff to use gender-neutral language; placing a rainbow sticker on the entrance door; running a woman friendly practice with female GPs, and word of mouth. It was felt however, that in rural areas 'few rural GPs would go to the bother of making their practice lesbian friendly' (ibid, 12).

Communication skills, which included non-judgmental attitudes, an open and receptive manner, avoiding assumptions, good listening skills and the ability to ask probing questions with sensitivity, were viewed as skills GPs needed in order to work effectively with lesbians. Some participants, however, expressed concerns regarding the use of gender sensitive language as it was thought that this may offend heterosexual patients. They also expressed reservation about asking a lesbian about her sexual orientation as it was felt she, too, might find this offensive (idem).

Most of the participants agreed that they would record the patient’s sexual orientation in the patient’s medical history, as long as they had her permission to do so. When referring patients to another specialist/service, the majority of participants indicated they would write the patient’s sexual orientation on the referral form, if it were relevant to the referral. McNair and Dyson point out that this is problematic as many lesbians delay or avoid seeking medical treatment for fear of being 'outed' by their doctors and having their sexual orientation recorded on their patient history. The authors state that the participants discussed this issue sensitively; however, they were
unaware of the degree of anxiety it causes for many lesbians if this information is recorded (idem).

In an earlier Australian study on lesbian health with doctors, Philomena Horsley and Sonya Tremellen were frequently told, 'lesbians don't live in our local area so I never see any' (1996, 10). This highlights the issue of lesbian invisibility and raises the concern that lesbian health issues are not seen as legitimate concerns for heterosexual health care providers. Horsley and Tremellen contend that lesbian health must be legitimised and suggest two strategies to achieve this: recognition of the minority status of lesbians and recognition of lesbian-specific health needs (ibid, 11).

In 1986, a survey was undertaken in the US to determine doctors' attitudes towards homosexuality. The results confirmed that 60 percent of doctors were homophobic; 23 percent of doctors were severely homophobic; 40 percent were uncomfortable treating gays and lesbians; 30 percent were opposed to admitting gays and lesbians into medical schools; 40 percent would not refer clients to gay or lesbian colleagues (Matthews et al. 1986, 109-110).

A similar quantitative study was conducted in 1991, where 1121 US primary care doctors were surveyed to assess attitudes to gay and lesbian patients. Thirty-five percent of doctors surveyed stated they would feel nervous among a group of homosexuals (Harrison 1996, 12). Harrison found that in various studies

... between 31 percent - 89 percent of health care professionals had negative reactions to the revelation that their patients were gay or lesbian. These reactions included being embarrassed or anxious, responding in an inappropriate way, rejecting their patients directly, showing hostility and displaying excessive curiosity, pity and condescension (idem).

It is these same reactions that lesbian and gay patients repeatedly report in a number of international and Australian studies (see Stevens and Hall 1988; Myers and Lavender 1997; Diamant et al. 2000; Brown 2000). Such attitudes and behaviours reflect a deep-seated heterosexism and homophobia in society at large.

Carla Randall (1989) reviewed the responses of 100 US nurse educators on questions about lesbians and health care. Fifty-two percent of the sample believed that
lesbianism is ‘unnatural’, 34 percent ‘disgusting’, 17 percent viewed lesbianism as a disease and another 17 percent thought that lesbians molest children. More than one-quarter (28 percent) of faculty members stated that they would have some difficulty talking with a woman they knew to be a lesbian, and more than a quarter (26 percent) would not be comfortable mixing with lesbians (ibid, 304). Four percent of the nurses stated that they would refuse to care for a lesbian and 13 percent did not want a lesbian to care for them (idem). As these are nurse educators, it is to be feared that these attitudes might be conveyed to their nursing students.

Another US survey of attitudes of 120 female nursing students demonstrated feelings of disgust and revulsion regarding lesbians (Eliason and Randall 1991). Half of the nursing students indicated that lesbian life-styles were unacceptable, whilst 15 percent believed there should be laws against lesbian sexual behaviour. Twenty-six percent of respondents remarked that lesbians were, unacceptable, and that they would avoid all contact with a lesbian. Twenty-eight percent believed that lesbians were a high-risk group for AIDS (ibid, 369-370). The authors note that contact with lesbians and gay men is the most effective way of reducing homophobia and suggest that if lesbians remain ‘closeted,’ lesbian phobia will persist (ibid, 371).

Similarly, a survey of members of the American Gay and Lesbian Medical Association (AGLMA) in 1994, found that

... 52 percent of respondents had observed colleagues providing reduced care or denying care to patients because of their sexual orientation and 88 percent reported hearing colleagues make disparaging remarks about lesbian, gay and bisexual patients (Rankow 1995b, 487).

In a UK study, a quarter of the nurses interviewed had witnessed colleagues refusing to care for a homosexual patient (Rose 1993).

The US National Lesbian Health Care Survey was the first large-scale publication of national data about lesbian health and health care needs (Ryan and Bradford 1988). 1,925 lesbians from fifty US states completed and returned a 10-page questionnaire. The categories included demographic information, participation in community activities and social life, ‘outness’, current concerns and worries, depression, anxiety and general mental health, suicide, physical and sexual abuse, anti gay discrimination, impact of AIDS, substance use, eating disorders and counselling (Bradford et al.
Eighty-eight percent of the sample was white and the age range was between 17 to 80 years. Sixty-nine percent had college education yet 64 percent earned less than $20,000 per year. Compared with the US census data, the sample was younger, more educated and employed in more managerial and professional occupations than the general female population (idem). The authors note:

There was a distressingly high prevalence of life events and behaviors related to mental health problems. Thirty-seven per cent had been physically abused and 32 percent had been raped or sexually attacked. Nineteen percent had been involved in incestuous relationships while growing up. Almost one third used tobacco on a daily basis and about 30 percent drank alcohol more than once a week; 6 percent drank daily (ibid, 239).

Bradford, Ryan and Rothblum conclude

... in view of their low socio-economic status and experiences with discrimination and stigma, the capacity of lesbians in this survey to maintain interpersonal and primary relationships, educate themselves, hold responsible jobs and participate in the social, political and professional activities of their communities should be perceived as adaptive and resilient (ibid, 242).

6.4 Access to Services

Australian researchers and members of the Australian Coalition of Activist Lesbians (COAL), Helen Myers and Lavender (1997), contend that free access to health services should be promoted through policy and practice to ensure universal availability and provision for all. Lesbians are as diverse as women generally and belong to different racial, cultural, religious backgrounds, work settings, geographical locations and all age groups (ibid, 16).

Lesbians, as a group, do not have equal access to health services. Furthermore, Myers and Lavender assert that groups with special needs must be identified and accorded special treatment. They suggest that lesbians have not been given ‘baseline access – recognition of marginalisation and special needs’ (idem). When women from various ‘target groups’ are considered, Myers and Lavender state that they should not be assumed to be heterosexual and when attention is given to access to services, consideration needs to be given to all of their needs (ibid, 17). Myers and Lavender’s report identifies menopause as a health issue for lesbians and suggests that although a woman’s lesbianism is unlikely to affect her physiological changes, it will most likely affect the quality and delivery of her care. A participant explains:
At the community centre I went to a Changing Life discussion group, the youngest woman was 42 and so we decided to focus on menopause. There was another lesbian who was very shy and closeted and myself among a dozen or so other women. Usually when it's relevant I'll mention I'm lesbian but there it didn't feel safe so I left the group. Where can I go to talk about my body changes and my directions without having to feel different or misunderstood because of my sexuality and emotional commitment? (quoted in Myers and Lavender 1997, 12).

In the previously mentioned research in Victoria, Rhonda Brown (2000) found that few mainstream organisations were actually addressing the health needs and concerns of lesbians. In 1999, one regional women’s health service, two rural community health services and a private general practice did identify lesbians as a target group and provided health care to the lesbian community in Victoria. Whilst there are many community groups offering support and information to lesbians, their work remains largely unfunded and therefore invisible. Brown concludes that it is difficult to determine how many lesbians are accessing mainstream services, as these statistics are not routinely collected (Brown 2000, 46). Ruth McNair and Sue Dyson (1999) support this finding in their study, where 51 health practitioners reported that none of them routinely asked if their patients are lesbian (see p. 96).

It can be surmised from these studies that the health care system has traditionally based its model of care and treatment of women on heterosexual assumptions (Stevens and Hall 1988; Robertson 1992). Many health professionals’ attitudes are founded on the assumption that all people are heterosexual (Brogan 1997). Questions relating to marital status, sexual activity and contraception are evidence of assumed heterosexuality (Thompson 1998). If a lesbian answers 'yes' to being sexually active, she will then be asked about contraception, and will be in the unenviable situation of having to lie to the doctor or disclose her sexuality, and thus be forced to 'out herself'. As discussed earlier, studies have shown that when lesbians do 'out' themselves to their health practitioner, they are often met with homophobic hostility (Brown 2001; Harrison 1996; Stevens and Hall 1988). Thus it is up to the patient to disclose her sexual orientation or she will be assumed heterosexual and consequently remain invisible as a lesbian within the health care system (McNair and Dyson 1999,

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63 Despite sending questionnaires to health services for staff to display and/or hand out to lesbian clients, I did not receive any completed questionnaires from this method.
4. Older lesbians, due to the effects of ageism, misogyny as well as homophobia, remain triply invisible within health services and society at large (Kchoe 1989).

Patricia Stevens explains that access means more than affordable and available services and stresses that services need to be ‘… socially and culturally appropriate and geared toward effectively meeting the critical health needs of diverse communities’ (1993, 40). Stevens conducted a feminist narrative study of the health care experiences of 45 lesbians from different racial/ethnic groups and on low incomes in San Francisco (idem). Participants self-identified as lesbian, were aged between 21 and 56 years and all were English speaking. Over half of the participants were women of color (51 percent) and 69 percent of the participants had a college education. Despite their high education level, their income levels were below the average annual salary (ibid, 42).

Participants were recruited to the study through community-based purposive sampling, which included snowball techniques and informal referrals (ibid, 41). Thirty-two lesbians were interviewed individually and 13 participated in three focus groups. The findings of this study revealed that the presence and type of health care coverage determined the type of health care service available to them. Age was identified in this study as a barrier to quality health care. Sixty-four percent of the participants had health care coverage and 36 percent did not. According to the findings of this study, having no health care coverage was devastating. Participants without coverage spoke of health care that was ‘inadequate, dangerously inept, degrading and victimizing that they were driven away becoming literal refugees from health care’ (ibid, 53).

6.5 Lesbians and Illness

Information suggests that lesbians are not at an increased risk of illness or disease because they are lesbian. Rather, it is the social, political and/or lifestyle factors which may have an adverse effect upon their health status (Dean et al. 2000). Accurate and reliable evidence on lesbian health is extremely difficult to locate. Judith Bradford and Jocelyn White (2000, 68) indicate that as a result of lack of interest in lesbian health, inadequate support for lesbian health researchers and lack of funding, there is a lack of scientific knowledge from which to ‘develop clinical and programmatic interventions’. The authors further argue that existing studies have
often lacked sufficient rigour to determine if lesbians are at an increased risk of
certain health problems relevant for heterosexual women or women in general (idem).

6.5.1 Cancer Risk

The cause of many cancers is still largely unknown and therefore accurate risk
assessment has its limitations (Carroll 1999). Certain risk factors have been identified
which put women at greater risk for certain cancers. Risk for many cancers increase
with age or with a family history of that cancer (Solarz 1999). Similarly, certain
lifestyle and behavioural factors can increase the risk of cancer. National and
international surveys have found that lesbians often smoke and drink more alcohol,
have higher body mass index, have no, or fewer children and present for routine
health screening less than heterosexual women. Many of these factors place lesbians
in a higher risk group for certain cancers as well as cardiovascular disease and
diabetes (Carroll 1999). It has been suggested that lesbians may be at a higher risk for
breast, cervical, ovarian and endometrial cancers than other women (Dean et al. 2000;
Valanis et al. 2000). To date, however, large-scale epidemiological studies have not
included sexual orientation as a demographic factor to be explored and consequently
lesbians are, yet again, an invisible group of women within such studies (idem).

6.5.2 Breast Cancer

According to the Cancer Council of Victoria\(^{64}\), one in twelve Australian women will
develop breast cancer at some stage in their lives with most cases occurring after the
age of fifty years (Anti-Cancer Council of Victoria 2001). The risk of breast cancer in
lesbians is assumed by some researchers to be as high as one in three (Haynes 1994).
This is a US report and presently similar estimated figures are unavailable in
Australia. Lesbians are less likely to use oral contraceptives, more likely to smoke
cigarettes, be nulliparous and have a higher body mass index than heterosexual
women – all, except for avoidance of contraceptives, risk factors for breast and
cervical cancer (Rankow 1995). Studies suggest that lesbians may be less likely to
perform breast self-examinations, obtain mammograms and undergo clinical breast
examinations than heterosexual women (Carroll 1999, 612). Katherine O’Hanlan
(1995) claims that morbidity and mortality rates are reported to be much lower in
women who undergo regular mammograms (see also Chapter 5.4.3). However, given
the invisibility of lesbians in the health system as discussed earlier, it is important that

\(^{64}\) The Anti-Cancer Council of Victoria changed its name to the Cancer Council of Victoria in
February 2002, to bring it in line with the names of the other Australian state and territory Cancer
Councils.
appropriate epidemiological research be conducted to determine whether or not
lesbians are indeed at a greater risk for breast and/or other cancers.

6.5.3 Ovarian and Endometrial Cancer

Similarly, risk factors for ovarian and endometrial cancers may be more common in
lesbians than heterosexual women. Risk factors for endometrial cancer include:
nulliparity and obesity (Anti-Cancer Council of Victoria 2001). It has been suggested
that the oral contraceptive pill may provide some protection against ovarian and
endometrial cancers and the longer the use of the pill, the greater the protective
benefits. Although it is difficult to ascertain rates of contraceptive use among
lesbians, it is unlikely that large numbers of lesbians would have utilized any
contraceptive method extensively. Dysfunctional uterine bleeding (which may be a
sign of endometrial cancer), may be a concern for postmenopausal lesbians; however,
if they do not have a healthy therapeutic relationship with their doctor, they may not
communicate their concerns (O’Hanlan 1995).

6.5.4 Cervical Cancer

Few studies have been conducted regarding lesbians and cervical cancer and as a
result, the incidence of cervical cancer among lesbians is not known. Marion
Chinnock (1999) conducted a small qualitative study in Sydney, Australia, to identify
reasons why lesbians do or do not have Pap tests. The sample consisted of thirty
women, twenty-seven of whom identified as lesbian, aged between 20 and 49 years.
The major health concerns identified by the participants included breast cancer, drug
and alcohol issues, cervical cancer, reproductive issues and health service access and
doctor/patient relationship issues. Menopause as a specific health issue of concern
was not mentioned. Chinnock identified four categories involved in lesbians’ decision
to present for screening or to avoid screening. These are patient [sic] factors, doctor
factors, test factors and health care factors (1999, 3). Patient factors include previous
negative experiences with health professionals, fear of having to answer questions
concerning heterosexual sex, and a lack of awareness of cervical cancer. Doctor
factors include lack of knowledge regarding the need for lesbians to have Pap tests,
preference for a female doctor and a lack of lesbian-friendly doctors. Test factors
include the invasive nature of the procedure as well as the fear and embarrassment
associated with the test. The main deterrent in terms of health care factors was the
assumption of heterosexuality. A recent study undertaken by PapScreen Victoria at
The Cancer Council of Victoria, found that lesbians who were not out to their GPs
were 80 percent less likely to have Pap tests than women whose doctors knew they
were lesbians (PapScreen Victoria 2003). Issues women identified under this category reflect those of other larger lesbian health studies (see McNair and Dyson 1999; Brown 2000).

Chinnock concludes that due to the diversity of the lesbian community, targeted health promotion campaigns aimed at lesbians and Pap tests are problematic. She asserts that all women with a cervix need to be aware that they are at risk of cervical cancer, and thus need to be screened, regardless of whether or not they have had sex with men.

Findings from Chinnock’s study support those of an earlier quoted study conducted by the Australian Coalition of Activist Lesbians (Myers and Lavender 1997). Helen Myers and Lavender identified that a lack of knowledge by health practitioners towards lesbians and cervical cancer made cervical cancer a lesbian health issue. Physicians have often informed lesbian patients that they do not require Pap tests as it is assumed that they do not have, or had in the past, sex with men (Myers and Lavender 1997). Studies suggest, however, that between 77 and 91 percent of lesbians have had at least one prior sexual relationship with men (Byhee 1990 cited in O’Hanlan 1995; Bradford et al. 1994). This lack of knowledge by health professionals and the perception among some lesbians that they may be less susceptible to cervical cancer than heterosexual women, means lesbians are less likely to present for Pap tests (Myers and Lavender 1997).

A US study conducted by Allison Diamant et al. (2000) noted that there were differences in preventative health care services amongst lesbian and heterosexual women. As they comment, ‘lesbians were one-third less likely than heterosexual women to have received a Pap test or a clinical breast examination within the previous two years’ (ibid, 1049). As studies have shown that many lesbians have had sexual intercourse with male partners in the past, Diamant et al. conclude that this omission is problematic (see also Bradford and Ryan 1987; Rankow and Tessaro 1998; Chinnock 1999). Ruth Simkin (1991) suggests that if lesbians avoid regular routine care they may not receive early warning signs of abnormal Pap tests, endometrial cancer or breast cancer (ibid, 1621). Other authors suggest that as a consequence lesbians will be seeking care at a later stage when the treatment required is more invasive (Peterson and Bricker-Jenkins 1996, 37).
A medical record review of all colposcopies conducted at a Boston Community Health Centre from 1992 to 1994, showed that one-third were performed on self-identified lesbians who presented with genital warts or abnormal cytology (Carroll 1999, 612). Elizabeth Gruskin contends that the interval between Pap tests are nearly three times longer for lesbians than for heterosexual women (Gruskin 1999, 5). A range of five to ten percent of lesbians had not had a Pap test or clinical breast examination in the last ten years (O’Hanlan 1995). Nina Carroll suggests that not screening lesbians for cervical cancer or increasing the screening interval may lead to lost opportunities for health maintenance, or delayed diagnosis and treatment of high-grade cervical cell abnormalities and cervical cancer (Carroll 1999).

6.5.5 Mental and Emotional Health

The connection between lesbians and mental illness is complex and troublesome. As previously discussed, only in 1973 was homosexuality declassified as a mental illness from the Diagnostic and Statistical Manual of Mental Disorders 111 (American Psychiatric Association 1973), except for those who were in conflict with their sexual orientation (Dworkin and Gutierrez 1989). Since then homosexuality is no longer officially regarded as a mental illness, although, in the 1990s, 42 percent of the American Psychological Association membership still viewed it as a mental disorder (cited in Gruskin 1999). Despite this recent disassociation between homosexuality and mental illness, many lesbian clients have reported feeling that heterosexual psychologists and psychiatrists still view a homosexual life style as less than normal (Markowitz, 1991 in Gentry 1992, 84), with the result that they seek out gay and lesbian mental health professionals.

Presently, very little is known about the prevalence of anxiety disorders, depression, psychotic disorders and personality disorders in lesbians (Rothblum 1994; Trippet 1994). Issues related to ‘coming out’ experiences of homophobia and heterosexism, and combined with experiences of inadequate health care, all contribute to mental health problems for lesbians and gay men (Lock and Steiner 1999). An Australian study of 200 young lesbians reported that 60 percent of respondents experienced feelings of depression related to their sexual orientation, 63 percent contemplated suicide and 30 percent attempted suicide (Barbeler 1992). These figures are consistent with other larger Australian and international studies (Victorian Government Department of Human Services 1997; D’Augelli and Hershberger 1993; Welch et al. 2000).
The US National Lesbian Health Care Survey (Ryan and Bradford 1988) reported that lesbians experience a wide range of stress related illness and mental health concerns (see p. 102). This report was the first large-scale publication of national data about lesbian health (Denenberg 1995, 86). More than 50 percent of the sample had experienced suicidal thoughts at some time, and 18 percent had attempted suicide.

One-third of the women surveyed reported suffering from depression at some stage in their lives. Other findings included:

*Thirty-seven percent had been physically abused as a child or adult, 32 percent had been raped or sexually attacked and 19 percent had been involved in incestuous relationships while growing up. About three fourths had received counselling at some time and half had done so for reasons of sadness and depression. Level of openness about lesbianism was associated with less fear of exposure and more choices about mental health counselling (idem).*

In another US study, Paul Gibson estimated that gay and lesbian youths account for 30 per cent of completed suicides annually (Gibson 1994). He suggests that gay and lesbian youth are two to three times more likely to attempt suicide as heterosexual young people (ibid, 15). Gibson attributes the problem to living in a heterosexist society where homosexuality is stigmatised and lesbians and gays are not acknowledged (idem).

During consultations with Victorian lesbians, Rhonda Brown (2000) observed that the issue of mental and emotional health was raised consistently. The effects of societal homophobia and consequent discrimination have detrimental effects on one's self-esteem and mental health. Participants spoke of the significant stress associated with the transition from a previously heterosexual lifestyle to a lesbian lifestyle, and the difficulties associated with decisions around parenting. The fact that lesbians are constantly ‘coming out’ to others, including health providers with often less than positive responses, is an additional source of stress (ibid, 47). Lesbians consulted were concerned about the lack of access to mental health services and appropriate and affordable counselling (idem). In submissions to the Victorian Ministerial Advisory Committee on Gay and Lesbian Health (MACGLHi) from members of the GLBTI community and organisations, mental health issues ranked as the third most common issue raised (Brown et al. 2002, 33). Many of the submissions commented on their dissatisfaction with the quality of mental health

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*GLBTI refers to gay, lesbian, bisexual, transgendered and intersex.*
services in Victoria and the fear of discrimination by mental health professionals, with the result of reduced access to mental health services by many GLBTI people (ibid, 35). Midlife, as a life stage, was discussed in the report; however menopause was not mentioned.

The Victorian Suicide Prevention Task Force identified gay, lesbian and bisexual people as a high-risk group (Victorian Suicide Prevention Task Force 1997, 40). The report states, ‘... while comprehensive data on gay and lesbian suicide risk is limited, written and oral evidence provided to the Task Force suggests they are a particularly high-risk group, especially in rural areas’ (idem). Risk is believed to be particularly high for adolescent gays and lesbians when they acknowledge their sexual orientation and are consequently subjected to loss of friendships, community violence and/or family rejection (idem). The report acknowledges that ‘comprehensive data on gay and lesbian suicide risk is limited’ (idem). The majority of studies related to suicide amongst gays and lesbians have focused on young people. Once again, older lesbians remain invisible: a combination of ageism and homophobia.

6.5.6 Substance Use

Some studies suggest that lesbians have a high rate of drug and alcohol use (Moran 1996; Bradford et al. 1994; Myers and Lavender 1997). Sonya Tremellen (1997) found in an Australian community survey, that the percentage of lesbians smoking was 44 percent compared to 24.8 percent in the general female population. Sixty-six percent of this sample said they were unlikely to quit in the next three months compared with 50 percent of the general female population (ibid, 13). Lesbians have also been found to use higher amounts of alcohol for a longer period than heterosexual women (Myers and Lavender 1997, 7).

As part of the Women's Health Australia (WHA) study, Lynne Hillier et al. (2002) conducted a sub-study that compared the licit and illicit drug using patterns of young heterosexual and non-heterosexual women in Australia. The sample comprised 9260 women aged from 22 of 27 years of whom 8409 were heterosexual and 797 non-heterosexual. Findings reveal that non-heterosexual women report significantly

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66 The Women's Health Australia study included a question relating to sexual preference in the young cohort in 2000 and the middle-aged cohort in 2001.

67 Women were given five categories and asked which best described their current sexual identity. The categories are: ‘exclusively heterosexual’, ‘mainly heterosexual’, ‘bisexual’, ‘mainly homosexual’ (lesbian) or ‘exclusively homosexual’ (lesbian).
higher usage of all types of drugs compared to heterosexual women. The use of marijuana and other illicit drugs was higher amongst the non-heterosexual women and they were significantly more likely to have injected drugs. Forty-one percent of non-heterosexual women had used amphetamines, ecstasy and other designer drugs compared to ten percent of heterosexual women. In terms of heroin use, 7.2 percent of non-heterosexual women reported ‘lifetime experience’ compared to 0.7 percent of heterosexual women. The researchers note that young non-heterosexual women may be using drugs at higher rates than heterosexual women, as a response to the effects of living in a homophobic society. These disturbing recent results are similar to those found in other Australian and international studies.

A study by the Australian Drug Foundation reported on alcohol and other drug use among gay, lesbian, bisexual and queer communities (GLBQ) in Victoria. Results indicate that ‘... overall the alcohol and other drug use within the GLBQ sample was most commonly in the range of two – four fold higher than that found in the National Household Survey’ (Murnane et al. 2000, 57). Whilst the exact reasons for the high use requires further research, it has been suggested that experiences of stress, history of childhood abuse and effects of living in a homophobic world all contribute to high patterns of drug and alcohol use amongst lesbians and gay men (Myers and Lavender 1997, 7).

Summary

Whilst lesbians may not face specific health risks as a result of their sexual orientation, the evidence clearly suggests that the effects of heterosexism and homophobia have detrimental effects on lesbians’ health and wellbeing. Due to the lack of research and the problem of homophobia it is not known if certain conditions and diseases are more common in lesbians, as presently such information is not recorded. Lesbians utilise western medical health services less frequently than heterosexual women and, as a result, may be putting their health at risk. It is not known if they instead visit alternative health practitioners. Lesbian invisibility remains a big issue within the health care system. The lack of research on lesbian health, and the failure to acknowledge lesbians as a separate group with special needs, contributes to lesbian invisibility. Older lesbians remain even more under-researched. The fact that only one study could be located on lesbians and menopause is evidence of this invisibility (Davis 1993). Clearly, further empirical studies are needed. In the
following chapter I present the findings of my own study and a discussion of the issues in light of the existing literature.
CHAPTER SEVEN

Findings and Discussion

In this chapter I present the findings of my study and provide a discussion in light of the existing literature. The findings highlight both the general and unique issues lesbians frequently experience at the time of menopause. This chapter is divided into six sections which allows for a discussion of each theme identified in this study. The first section describes the study participants’ characteristics as determined from the questionnaire data. The following sections present the voices of the participants commenting on the identified themes.

7.1 Participants’ Profiles

This section presents a profile of the 116 lesbians who participated in this study, including the twenty lesbians whom I interviewed. I describe the sample’s demographics and introduce the study participants. 124 questionnaires were returned from all over Australia, which represents a high response rate of 62 percent. Eight women identified as ‘other’ than lesbian and thus were not considered. One woman identified as ‘homosexual’, two identified as ‘gay’ and five identified as ‘bisexual’. The final sample represents 116 self-identified lesbians from every Australian state and territory.

Lesbians who filled out the questionnaires ranged in age from 39 to 64 years. The mean age was 49.7 years. Interviewees were aged from 46 to 60 years. The mean age of the lesbians interviewed was 51.9 years. Fifty-eight women (50 percent of total participants) in my study were 50 years of age and over. Less than fifty-seven percent of participants described themselves as peri-menopausal (n=66), 38.8 percent as post-menopausal (n=45), and 4.3 percent indicated they were unsure (n=5).

The mean number of years the women in this study identified as lesbian was 20.7. Only 17 women out of 116 had been a lesbian for less than ten years. In response to the question, ‘how many years have you identified as lesbian’, four women did not answer and six women wrote ‘all my life’. One woman noted ‘forever’. Almost three-quarters (71 percent) of lesbians in this study were in lesbian relationships at the time of completing the questionnaire (n=82). The length of the time women had been in their present relationship ranged between two months and
30 years. Just under half of the lesbians with partners (n=38) stated that their partner was also experiencing menopausal-related changes (see page 154). Table 7.1 presents a breakdown of the participants’ ethnic backgrounds.

**Table 7.1: Participants by Ethnic Background**

<table>
<thead>
<tr>
<th>Ethnic Background</th>
<th>Number</th>
<th>% of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian</td>
<td>52</td>
<td>44.8</td>
</tr>
<tr>
<td>English</td>
<td>36</td>
<td>31</td>
</tr>
<tr>
<td>German</td>
<td>5</td>
<td>4.3</td>
</tr>
<tr>
<td>Irish</td>
<td>4</td>
<td>3.4</td>
</tr>
<tr>
<td>Welsh</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>N. Zealand</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Scottish</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Celtic</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>7.7</td>
</tr>
<tr>
<td>Unanswered</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>116</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The majority of participants identified as being from Anglo-Celtic backgrounds and were living in every Australian state and territory. It is of note that there were no women of Asian background in this study. Table 7.2 presents a breakdown of the participants’ state or territory of residence.

**Table 7.2 Participants by State/Territory of Residence**

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victoria</td>
<td>52</td>
<td>45</td>
</tr>
<tr>
<td>NSW</td>
<td>18</td>
<td>15.5</td>
</tr>
<tr>
<td>Queensland</td>
<td>13</td>
<td>11.2</td>
</tr>
<tr>
<td>West. Aust.</td>
<td>12</td>
<td>10.3</td>
</tr>
<tr>
<td>South Aust.</td>
<td>8</td>
<td>7.0</td>
</tr>
<tr>
<td>North. Territory</td>
<td>8</td>
<td>7.0</td>
</tr>
<tr>
<td>ACT</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>Tasmania</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>116</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Less than half (45 percent) of the participants were living in the state of Victoria at the time of completing the questionnaire (n=52). The remainder of participants resided in all states and territories of Australia. Whilst the percentages of lesbians from the Australian Capital Territory and Tasmania were small, it was pleasing that the sample included lesbians from every Australian state and territory thus ensuring the study is national, rather than solely Victorian. Lesbians in this study were living in rural areas as well as capital cities. Of the twenty lesbians interviewed, thirteen reside in cities and seven in rural communities. Interviewees live in Victoria (n=14), New South Wales (n=4), Australian Capital Territory (n=1) and Western Australia (n=1). The following table, 7.3 illustrates the participants' educational status.

Table 7.3 Participants' Educational Status

<table>
<thead>
<tr>
<th>Education Level</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary</td>
<td>88</td>
<td>75.8</td>
</tr>
<tr>
<td>Years 10 to 12</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td>Year 9 and below</td>
<td>6</td>
<td>5.2</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100</td>
</tr>
</tbody>
</table>

More than three-quarters of the participants in my study have tertiary education (n=88). Seventy-six percent of the participants were in paid employment (n=88). Of these, 60 percent were employed full-time, 28.4 percent part-time and 11.3 percent employed on a casual basis. Women were employed in a variety of occupations. Almost 40 percent of participants were employed in health-related fields and occupations (n=46)\(^{68}\). Women were asked to rate their income level as low, medium or high. Less than nine percent of participants nominated high (n=10), 56 percent indicated medium (n=65) and 35.3 percent low (n=41).

With regard to reproductive health, 47.4 percent of participants have their own biological children (n=55)\(^{69}\) whilst 52.5 percent of participants do not have children (n=61). Seventeen percent of participants have their children living with them at home (n=19) and 14 percent of participants co-parent a child and/or children (n=16). Eighty-six percent of participants had a natural menopause (n=100) and 13.8 percent had a surgical menopause (n=16). From the questionnaire responses, six of these

\(^{68}\) For selection 'bias' see Chapter 2.2.3

\(^{69}\) This number includes women who have experienced stillbirths and/or neonatal deaths.
women had their ovaries conserved, seven women had oophorectomies at the time of hysterectomy and three women did not respond to this question.

An overwhelming 87 percent of participants in this study self-identify as feminists (n=101) whilst 10.5 percent do not (n=12). Three women did not respond to this question. More than half (58 percent) of the lesbians in this study believe there are different issues for lesbians at menopause than for heterosexual women (n=67).

These specific issues will be discussed in detail in the following sections. Table 7.4 presents a breakdown of participants’ responses to the question that asked if there are different issues for lesbians at menopause than for heterosexual women.

**Table 7.4 Are There Different Issues for Lesbians at Menopause?**

<table>
<thead>
<tr>
<th>Response</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>67</td>
<td>58</td>
</tr>
<tr>
<td>No</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>Unsure</td>
<td>9</td>
<td>7.7</td>
</tr>
<tr>
<td>Not answered</td>
<td>5</td>
<td>4.3</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100</td>
</tr>
</tbody>
</table>

More than half (58 percent) of the lesbians in this study believe there are different issues for lesbians at menopause than for heterosexual women (n=67). These specific issues will be discussed in detail in the following sections.

### 7.2 ‘There is Less Pressure to Maintain That Youthful Look’: Lesbians and Body Image

Much of the mainstream literature on menopause focuses on body image. In Chapter Three I discussed how women in western (ised) societies are vulnerable to the ‘culture of thinness’ (Gilbert and Thompson 1996). Whilst some studies have suggested that lesbians may have a better body image than their heterosexual counterparts (e.g. Gettelman and Thompson 1993), my findings neither totally confirmed nor rejected this notion. Women in this study were asked if they believed a lesbian identity protected them from the desire to be thin. Responses to this question were varied. Over one-quarter of participants (n=31) agreed that a lesbian identity might protect lesbians from the desire to be thin, while 46 percent (n=53) disagreed with this suggestion. Another 26 percent (n=30) were unsure and two
participants did not respond to this question. Questionnaire data which support the view that a lesbian identity may protect lesbians from the desire to be thin, include:

*I don’t desire to be thin - just comfortable and healthy with my body. I stopped worrying about thin/fat as an image long ago. This is partly due to a feminist view and lesbian influences.* [25]

Many study participants wrote of the enormous societal pressures placed upon women in terms of looking, acting and ‘being’ in this hetero-patriarchal culture

*It could be all the media hype of exploiting women’s bodies/image for male satisfaction that would impact on lesbians in that way.* [28]

Other women explained:

*Women who accept themselves as they are don’t have to prove anything about their appearance. Lesbians are less tied into the social pressure, i.e. thin bodies.* [34]

*Being a lesbian seems to free most women from many of the pressures that want women to conform to stereotypes of shape, beauty, fashion, etc.* [67]

Similarly, another woman wrote:

*I still like my body regardless of the sagging breasts, varicose veins and age spots on the back of my hands. Some lesbians I know are very weight conscious, diet, display anxiety about their weight and openly criticise others they consider fat. I believe they have been socialised into accepting that thin is beautiful in the same way that heterosexual women have.* [1]

It appears that lesbians, like heterosexual women, are exposed to society’s negative messages; however, in some cases, lesbians seem to be protected from these views in some specific areas. Despite these comments which indicate a positive approach towards body image, other responses reflected a common dissatisfaction with one’s body. Clearly many lesbians in this sample are vulnerable to the ‘culture of thinness’.

The following quotations are evidence of this:

*I don’t like fat arms, no waist, cellulite on my legs. I have drawn and painted women’s bodies all of my life and I enjoy the sexiness of youth. I resent that this [menopause] has happened about 10 years before it should have. At 50 I could cope but in my early 40s I feel cheated and unable to start again.* [125]

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70 In order to differentiate between questionnaire responses and interviewees, I have included a code number to indicate questionnaire responses and a pseudonym accompanied by a code number to indicate interviewee responses.
I am afraid at looking old and [having] grey hair and I do not want
to be an old bitter person and all alone. I think young and try hard to
hang on to my youth. I need it now. My son keeps me young inside.
[137]

Another woman when asked about her level of satisfaction with her present body
shape, size and weight commented:

I am not entirely satisfied. I feel that my weight gain is a sign that I
have let myself go. At a time in my life when I have the time and
finances to indulge in fine food, the universe has conspired to slow my
metabolic rate and not allow me to indulge as frequently as I would
like. [198]

It is interesting to note that many of the women who have a negative body image
indicated that they had been in previous long-term heterosexual relationships. As I
did not specifically ask all of the study participants whether they had been in
previous long-term heterosexual relationships, I cannot make any representational
claims. However, whilst this is a small sample and not representative of the
population of lesbians generally, it could be surmised that some of the lesbians who
had been previously married and led ‘conventional’ heterosexual lives, may be more
likely to be affected by the negative effects of a patriarchal society which pressures
women to conform and therefore, to be thin. From self-disclosure of issues in their
previous married lives, some women’s responses and attitudes towards their bodies
appear to be framed through a heterosexual lens.

A disturbing element revealed during the interviews was that some lesbians
displayed extreme homophobic attitudes and reinforced many of mainstream
societies’ negative views of lesbians. These views are to some extent understandable,
as any lesbian or gay man knows that it is virtually impossible not to have, to some
degree, internalised some of society’s negative messages about their sexual
orientation. This internalisation of negative attitudes about one’s lesbian or gay
sexual orientation has been termed ‘internalized homophobia’ (Malyon 1982). Celia
Kitzinger and Rachel Perkins (1993) are highly critical of this terminology as they
argue it pathologizes [sic] lesbian oppression (ibid, 101). ‘Therapists tell us that as a
direct consequence of our oppression in an anti-lesbian world, we are sick and in
need of cure’ (idem). These authors assert that when lesbians refuse to be defined
and controlled by men, lesbians are a real threat to heteropatriarchy and consequently
‘... we experience hatred, fear, aggression, derision, rejection, marginalisation, as a
direct consequence of being lesbian. Is it any wonder that at times we don’t like being lesbian very much?” (ibid, 103). Kitzinger and Perkins contend that the result of using this terminology is to depoliticise lesbian’s oppression and instead, reduce it to an individual, psychological problem, which requires individual, rather than social change (ibid, 104). Whilst I do not wish to depoliticise lesbians’ oppression and blame the individual lesbian for her internalised negative views, it is obvious that some of the lesbians in this study held extremely negative and homophobic views.

In the follow-up interview to filling in the questionnaire, Janet asserted:

*Some lesbians go out of their way to make themselves unattractive and they hide behind a victim façade. A lot of women aren’t completely OK within themselves or have low self-esteem. They kind of band together in a tribal sort of group, while I’m not criticising them, it’s just not how I work myself. Some lesbians like to look alike which I don’t actually find attractive myself. To me they just don’t seem to want to make themselves look attractive. People should make an effort to look their best. I think it is a sign of self-esteem and self-awareness.* [170]

Although disturbing and reflective of the view that being ‘attractive’ meant attractiveness as defined within the dominant hetero-patriarchal culture, this negative attitude was clearly a minority view. Nevertheless, Jess relayed similar views

... *some lesbians are under pressure not to look straight, e.g. you are not a ‘real’ lesbian if you wear makeup or carry a handbag. I don’t go around looking like a fityz straight person. I never wear a dress but I don’t believe in a uniform for anybody. You can still run around looking like Margaret Thatcher, she’s someone who just popped into mind, because she used to wear pearls. It is easier for identification purposes, if you have a dress code rather than trying to suzz people out all of the time. But I don’t believe in putting people under pressure to all have short haircuts, carry a wallet in your back pocket, but if you want to be like that... it’s just not me.* [180]

As noted earlier, an interesting observation is that both these women disclosed that they had previously been in long-term heterosexual marriages. As this issue is beyond the scope of this study, these matters were not investigated in any further detail. Many of the lesbians interviewed held opposing viewpoints and drew a strong connection between their feminist identity and healthy body image. In my study an overwhelming majority of participants identified as feminists (87 percent; see Chapter 2.2 for comments on feminist ‘bias’). Only twelve out of 116 women stated that they were not feminists. Although 87 percent of lesbians identify as feminists, their attitudes towards their bodies were not, in all cases, always positive. Thus my
findings support those of Dionne et al. (1995), which did not confirm the notion that a feminist ideology necessarily leads to a more positive body image.

Several of the lesbians interviewed shared Esther Rothblum's views on the importance of physical attractiveness for women in sexual relationships with men (Rothblum 1994) and explained how, for women who do not relate sexually to men, physical attractiveness is not such an issue. In response to a question which asked if there are any differences for lesbians at menopause compared with the experiences of heterosexual women, Sulo wrote that there is less pressure to maintain that youthful look. In an interview she elaborated:

This is very subjective but it seems to me, and I don't want to idealise it, that lesbians are more interested in the sort of friendship and spiritual quality of the relationship than in a heterosexual relationship where your looks and sex appeal is more important to men than it is to women. That is my own feeling towards my partner. I want to maintain my health and fitness and it may be because of that we are concerned about how much weight we are gaining rather than just about the way we look. [26]

Anne wrote that 'a strong feminist look is more important than physical attractiveness.' Anne explains:

Age in itself is attractive. I find it attractive, as it is a history of where they are at this time. So a youthful look is just that but an old woman has the road maps of where she's been as well as in her whole being. In particular on her face as well. I think we as lesbians don't have this stereotype that the blonde bimbo is the person that is necessarily the one we find attractive. So an older woman, because of who she is rather than having a Barbie doll figure is what we are more likely to be attracted to and the whole person. It's not just the physical part, it's the attractiveness of the whole personality too. I think this isn't the case for men picking partners. They still have to be leering over another person and porn stuff. I think we have the capacity to get beyond that. So as an older person, I don't think you feel as though you are on the shelf as such because it's from that point of view. [81]

Joy continued this theme and spoke of the ways many heterosexual women consider themselves less sexual, less useful and less attractive to men at menopause. During an interview, Joy expanded on this theme:

My heterosexual friends who are getting to menopause are quite unhappy about it because it signifies the end of something for them. I don't know whether them being childbearing makes them more attractive to men. I don't know exactly about that because I haven't done it. These are very close friends, women I have known all my life. Well they talk now like it is normal. I mean when I told them I was in
menopause they did a ‘feeling sorry for me’ lot of sounds rather than, ‘oh great’. And I said, ‘Oh no, this is really good’. But for them it is a sign of ageing. Being older as a heterosexual isn’t very attractive, if you are a woman. For them, they are apparently not sought after. The heterosexual culture goes for the young look, as we all know. And in lesbian culture, I haven’t found that. Quite a few of us are looking forward to not bleeding; quite a few of us are making jokes about ‘royal flushes’ and things like that. Two of my heterosexual friends were quite negative about it without actually articulating why they were negative. It was almost as if it were a normalised internal negativity. [68]

Chrisler and Ghiz (1993, 70) suggest that regardless of whether menopause is viewed as a positive or negative event, it certainly changes how women perceive their bodies. In response to the question, ‘Has your experience of menopause changed the way you view yourself’, almost 58 percent of participants indicated yes (n=67). Similarly, 85 percent of participants had noticed their body shape changing (n=99). Of these, 64 percent (n=63) were concerned about these changes, whilst 36 (n=35) percent were not. Responses from the questionnaire data reflect both negative and positive body image issues.

I suggest that my results support the conclusion drawn by Sherry Bergeron and Charlene Senn (1998). Bergeron and Senn compared the attitudes of lesbians and heterosexual women towards their bodies and investigated the relationship between body dissatisfaction and the internalisation of socio-cultural norms. The authors concluded that lesbians are generally less dissatisfied with their bodies than their heterosexual counterparts. Bergeron and Senn’s study found that the lesbians felt stronger and fitter than the heterosexual women in their sample. Participants in my study were asked about their level of satisfaction with their present body shape, size and weight. Fitness was an attribute many women remarked upon. Fitness appeared to be much more important than physical attractiveness as is illustrated in the following quotations:

*I am more concerned about my physical fitness than attractiveness as I believe one leads to the other. [199]*

*I don’t crave the perfect body – never have. I carry a few extra kilos but I am physically fit and don’t see this as a problem. I like my body and what it does. I enjoy an active life and fitness is important. [101]*
Similarly, another woman wrote,

*I don’t think thin is important but I think fit is. I need to shape up for the Gay Games in 2002.* [134]

Another woman commented,

*I have always set out to maintain a fairly physically fit body. I see physical fitness as a strength.* [8]

This focus on fitness was a common recurring theme throughout both the questionnaires and interview responses.

As discussed in Chapter Three, a study by Gettelman and Thompson (1993) found that when compared with heterosexual women, lesbians were less concerned with weight, dieting and issues of body image71. Heterosexual women and gay men showed the greatest level of body dissatisfaction. Heterosexual women showed the greatest level of anxiety about being overweight and had the highest level of eating disorders amongst the groups. Whilst the authors are careful to avoid drawing any definitive conclusions from these results, they do suggest that lesbians and heterosexual women may have different physical ideals that they strive to maintain. Whilst my study is not a comparative analysis between heterosexual women and lesbians, the findings do yield interesting results regarding body image and support Gettelman’s and Thompson’s hypothesis. As acknowledged by Brand, Rothblum and Soloman (1992), although all women experience societal pressure to be thin, this effect appears more pronounced amongst heterosexual women than lesbians. The emphasis placed on fitness, and the fact that over a quarter of the lesbians in my sample had noticed their body shape changing and yet were not concerned about these changes, tends to support this view.

In summary, both the questionnaire and interview data indicate that within this group of lesbians, there exists a wide range of views and experiences relating to lesbians’ satisfaction levels with their body image. Clearly, a feminist and/or lesbian identity does not provide automatic immunity to the ‘culture of thinness.’ However, as acknowledged by Bergeron and Senn (1998, 398), it may, in some instances, act as a buffer to the internalisation of these socio-cultural mores. Some lesbians who disclosed that they had lived in long-term heterosexual relationships expressed views

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71 The participants in this study were university students.
that may be regarded as homophobic and anti-lesbian. These results tend to support some of the findings from other published studies, whilst also adding new information and providing ideas for further research (see Chapter 3.4).

7.3 ‘I Genuinely Feel More Sexually Alive’: Lesbian Sex at Midlife

As already discussed in Chapter Four, much of the focus of the mainstream menopause literature centres on the issue of heterosex and heterosexuality. A large portion of the discussion on sex and sexuality in the mainstream literature is concerned with sexual dysfunction in ‘menopausal women’ (see Chapter 4.1). The information gained from the questionnaire and interview responses in my study sheds further light on the heterosexist and medicalised approach to sex and sexuality at the time of menopause. 72

Seventy-one percent (n=82) of lesbians in my sample were in lesbian relationships at the time of completing the questionnaire. One participant indicated that she was in two sexual relationships. The length of time women had been in their present relationship varied between two months and thirty years. Of these women, 84.1 percent (n=69) were sexually active with their partners. Nett Hart (1996, 69) explains how women loving women threatens and weakens the hegemony of male bias. Consequently, lesbian sexuality is inconceivable under heteropatriarchy. She writes:

Our desire is boundless. Our Lesbian love does not occur inside boundaries from violation, but within the realm of safety created by connection ... There are no sexual acts. This desire, this opening between partners is not defined by whose what is rubbing whose whatever when. Any focus on sexual acts or techniques limits our ability to be present to one another. Sex is always relational even when it is solo. There is an infinity of ways Lesbians make love (1996, 77).

In my study, lesbians who were not sexually active, in a heterosexually defined way with their partners, wrote of the love and intimacy that they shared and explained this in ways that reflect Nett Hart’s contention. For example,

... it is difficult when talking about lesbian sex to define it only as vaginal sex similar to hetero-sex. My intimacy is just as intense and important to me in my relating. [72]

72 In accordance with ethical clearance, I did not ask women about their sex lives in the interviews, unless participants raised the issue themselves. Much of the information in this section draws upon the questionnaire responses and those in interviews in which the women volunteered to discuss the issues of sex and sexuality.
Genital sex is infrequent, however. I continue to be sensual and intimate with my partner. [73]

When we met we were bonding beautifully – energetic, orgasmic days and nights. We would hold each other, rock each other and when we are sad kiss each other, massage, care for and remind each other of our love and sometimes we fuck. Basically fucking is not a priority, however, our love for one another is. [204]

However, some study participants maintain that ‘real’ sex equals genital sex as is evidenced by the following questionnaire responses.

We stopped being sexually active four months ago. It just seems to have happened – a different sort of intimacy has developed. I haven’t ruled out sexual activity in the future; just at the moment it feels right. [6]

Similarly another woman remarked,

... we have less genital sex now and more moments of quiet, sensual/sexual intimacy. We’ve probably toned it down some. [28]

And another participant explained:

We never started a sexual relationship. We decided that we would rather have a sensual intimate relationship that focussed on caring and nurturing each other rather than engage in a sexual relationship that might inhibit our creative ways of experiencing sensual intimacy/pleasure. Initially we had both been in heterosexual relationships and needed to overcome social conditioning. This is by far the most connecting and intimate relationship I have had. [142]

These words support Nett Hart’s critique of hetero-patriarchal definitions of sex and illustrate how powerful and pervasive such views are. As Hart asserts:

There is no way the programming we received about sex can be translated into a woman-loving context. We have to invent it, discover it, do it. We only know what we are discovering stroke by stroke, lip to lip, Lesbian to Lesbian (1996, 77).

Clearly, many lesbians in my study were inventing and discovering lesbian sexuality.

In my questionnaire I asked lesbians if their interest in and/or desire for sex had changed since the onset of their peri-menopause. Almost fifty-three (52.5) percent of participants indicated that their interest/desire had changed (n=61). Forty-three percent of lesbians in this study reported no change in their level of sexual interest and/or desire (n=50) and 4.3 percent of participants did not answer this question
(n=5). Following from this question, participants were also asked if the frequency of sexual activity had changed since the beginning of their peri/menopause. The results obtained are similar to those found in Cole and Rothblum’s (1991) unique study of lesbian sex at menopause (see Chapter 4.6).

Forty-eight percent of lesbians in my study reported a decrease in frequency of sexual activity (compared with 27 percent in Cole and Rothblum’s study), and 9.4 percent indicated an increase (compared with 15 percent). Thirty-five percent indicated that the frequency of sexual activity remained the same (compared with 46 percent) whilst less than two percent reported fluctuations in the frequency of sexual activity. More than five percent of respondents did not answer this question. The biggest variation between Cole and Rothblum’s study of lesbian sex at menopause and my study, relates to the decrease in sexual frequency.

Some lesbians in my study had only recently begun to identify as lesbians whilst others had identified as lesbian all of their lives. As in Cole and Rothblum’s study, my sample also included lesbians who were surgically, as well as naturally, menopausal and lesbians who were using Hormone Replacement Therapy. Both studies highlight that it may not be menopause that is responsible for the changes in frequency of sexual activity, but other ‘external’ influences. Much of the mainstream (heterosexual) literature identifies partner problems as one of the key determinants in women’s decreased interest in sex at this stage of their lives (Gelfand 2000; Hawton 1994; Sarrel 1982). Findings from my study do not reflect this notion. Women who indicated that their interest/desire in sex had changed since the start of their menopause (52.5 percent) did not suggest the change was due to partner problems. Partners were identified as a problem only in terms of lesbians who did not have a partner, rather than as sexual difficulties in a partner. Reasons lesbians cited for the decrease in sexual interest and/or frequency related to external or situational factors rather than reflecting a biological or hormonal basis. These factors included tiredness, lack of energy, stress, tension, length of the relationship, daily stress of managing work and family life and geographical constraints, such as partners living in different states and, in some cases, different countries.

Participants were asked to complete the following sentence, ‘the main factor affecting my sex life at this time of my life is …’ and responses revealed a myriad of factors impacting on this change, very few of which related directly to the
menopausal experience. For example, the main factor affecting this study participant's sex life at this time of her life is ... the fact that we have a six-year old son and we are both exhausted by bedtime. [33]

Or, as another participant put it:

I'd be hard pressed to say that my lack of interest in sex is due to menopause. More likely it is a weighing up of priorities. Do I want to expend energy fucking then sleeping, like knocking out half a day in a weekend or do I want to study and work towards making a significant change in making our schools safe places for GLBT kids and teachers? I choose study: I'm just not focussed on sex. [204]

Nevertheless, whilst it was not a common view, some lesbians did see their declining sexual interest directly related to the menopausal process. In response to the question asking lesbians to identify the main factor affecting their sex lives, one woman wrote

... all due to loss of hormones HRT does not fully restore sexual function and in my case has caused weight gain that I have gradually adjusted to. I feel very sad for my loss of full sexual enjoyment and function. The desire, sensation and lubrication is 'just' adequate. [35]

Similarly, another woman drew a connection between the role of hormones and sexual interest/activity. She explained

... the higher the dose of HRT, the greater the desire for sex hence the more frequent. I try to take the least amount of HRT to alleviate symptoms. I have a greater desire for sex when I put on a new patch. By the end of the week, just prior to patch changing time, my desire wanes. Without HRT I would prefer to go to bed with a good book. My sex life on HRT would only be limited by a lack of a lover! [12]

HRT obviously played a pivotal role in both these women's sexual lives, however, the other participants on HRT did not confirm these experiences.

Participants were also asked if the type of sex they enjoy had changed and 29 percent indicated that it had. These responses were similar to those reported in Cole and Rothblum's study (1991).

Questionnaire responses included:

I had a lesbian relationship for four years in my early 20s but still identified as bisexual at that stage. I then had a twenty year heterosexual relationship, marriage and raised two magnificent daughters but always thought and hoped that one day I would be with a woman again. I became steadily unhappier in my marriage in the
second ten years and gradually lost all desire for sex with my ex-husband and eventually couldn’t handle it at all. I continued to do it for the peace and security of the family until I was going crazy and had to summon the courage to end the relationship. During my perimenopause I became a lesbian again – oh joy of joys! I suddenly discovered that I can still feel very strong sexual desire. I thought I may never get wet again ... so wrong. This is much better sex than has occurred at any stage of my life. My lover is so understanding and cares so much. [194]

Another woman commented:

I think I am more interested in sex not less. This might be because I am no longer living with a man. On the other hand, I genuinely feel more sexually alive. Hot flushes seem to bring other 'heat' with them which is very nice actually. [217]

Lesbians in this study were clearly discovering their own sexuality and the type of sex enjoyed was personal and varied. Whilst some lesbians were enjoying less genital sex, others were ecstatic about the increased focus on vaginal sex, as evidenced by the following comment

... yes [the type of sexual activity I enjoy has changed] there is an increased focus on vaginal sex as I now ejaculate large volumes of fluid at orgasm, increased masturbation and otherwise less sensitive clitoris and more G spot sensitivity. Multiple orgasms and longer sessions of sexual activity. [141]

Contrary to this experience, another participant wrote

... it is worth pointing out that sex, especially penetrative sex is not as frequent. The style of sex has shifted to a more vanilla level. [125]

Other women wrote how the type of sex they enjoy has changed as a result of becoming more familiar with a new partner and sexual inhibitions disappearing [8]. These responses illustrate how the narrow notions of sex, as defined under heteropatriarchy, are frequently foreign and irrelevant to many lesbians in this study. Annie indicated that her experience of menopause had been affected by being a lesbian, and commented that being in a new sexual relationship with another woman helped her enormously during this time. In an interview, Annie expanded on her comments and asserted:

I just think I was doing menopause big time when I was in a new sexual relationship and it was incredibly exciting and so I was just so turned on and so sexual, as you are in a new relationship, but I just walked around saying, ‘what are all the people talking about? You know I have absolutely no problems’. And all the stuff about dry vaginas and you know, low libido, it was so foreign to me. I had absolutely no problem with a dry vagina. If I did have a relationship
that was a bit flagging sexually I think it would be very easy to blame menopause. So much of this stuff is in our heads and I think if somebody's got a flagging sexual relationship and you suggest to them that it could be about their hormones, you cling onto that as being a reason. [131]

Andic also explained how she believes the emphasis on dry vaginas is totally inaccurate:

Our sex life has been determined by how available we are to males and how they feel about us. Now when I was a younger dyke, say in my 40s and 50s, when all the old dykes would say how terrific their lives were, and how much freer they felt, and how much fun they were having, and especially when I would hear them say, how great sex was, I simply didn't believe them. I thought they were lying to try and give us some hope, a reason to stay alive, or that they were trying to make themselves feel better by exaggerating their joys and their accomplishments. Or that they were trying to stave off some pain by making it seem not so bad to get old, but I thought they were at best, misguided, and possibly lying. So here I am, at age 61 in two or three days, and I know that they weren't lying. Yes, it's like an apple, you know even if an apple does get dried up, all you have to do is put it in water, and it will be hydrated. The same with our sex. At one point in menopause, due to a combination of physical menopause and having another round of incest memories, I did dry up, metaphorically, just like a dried up apple, but then when I came to a different part of my life and was rehydrated by the love and nurture of others, especially a wonderful partner, and my own willingness to open to that, I'm all juicy again. And I mean literally juicy...you know Jill and I make love and there is plenty of vaginal fluid. Now there can be some physiological reasons, including ageing, that we might have a little less fluid but it is absolutely simply not true that we dry up, simply not true. Our eyes don't dry up, our saliva doesn't dry up, and our cunts don't dry up ... it is all part of the same fluid system. [7]

Elizabeth also spoke of the misdirected focus on dry vaginas and the lubrication 'problem'.

Because I've had sexual experiences as both heterosexual and as a lesbian, I guess sex is different. Because I know my readings indicate that lubrication is an issue. I think it may be more so with penetration than it is with a lesbian relationship. My experiences of a lesbian sexual relationship is much, much, more than penetration. Whereas, that has something to do with it as well that sexually there hasn't been any issues; whereas perhaps in heterosexual relationships if lubrication does become an issue and sex does become painful or their libidos drop then there's a lot more issues. But again it is about what your attitude is and that type of thing as well. I do think my experience is as a person in a lesbian relationship, as opposed to a heterosexual relationship, intimacy is quite different. Even in my early times in a relationship other than heterosexual relationship, intimacy is quite different. Now whether that's a maturity thing or
being much more aware of who I am sexually I'm not sure but certainly, I'm ... it's a difficult one. If something was to change we'd have to look at it and work it out as well. It's always under the shower [laughter] that's why we have a double shower I'm sure. [168]

The topic of sex was not discussed in all interviews and thus there is limited data on this topic in my study. Participants who did discuss sex were often critical of the ways sexual activity is promoted and encouraged in the mainstream. Anne shared with me her views on sex since menopause. She explained how since menopause she feels a more mellow and contented person and 'hankering after sex' is not part of her reality. Anne remarked:

... we have this pressure that we have to be sexually active and you have to be 'doing it' all the time and we tend to be given, what I see as the end of the spectrum, which is the abnormal behaviour so if you go off to 'Sexpo' they presume that what is advertised is what we all should be doing. If you see that viewpoint as what sex is all about and sexual interaction, then I see that as one end of the spectrum and quite bizarre. We don't tend to be given, what I'd like, I mean if you sat people down and asked, found out what is going on, I think you'd find a great range of things that are happening. There are personal differences just like there are, you know, hair colour, eye colour or whatever. We all feel differently and respond differently so I think that the pressure that you have to keep going and doing this serves men's purposes rather than women's. Also you do find lesbians who pick up on these things and start emulating this strange behavior and being cool and trendy. I think that's a bit disturbing. Since menopause, sexual activity isn't really something that's in my focus. It's just ... I do tend to feel more self-contented anyway and I don't really feel that I have to keep up with anybody in that way. It's just that I'm doing what I feel I'm comfortable with and racing off to a bar to chat somebody up to go and have sex isn't part of it. [81]

Ellen Cole and Esther Rothblum's study (1991) was the first to dispel many of the myths associated with lesbians and sex, and included 41 lesbians with a mean age of 51.5 years from a non-clinical sample. By deliberately asking many of the same questions in my study, I was able to obtain responses from a larger sample of lesbians at midlife and from lesbians living in a different country. As in Cole and Rothblum's study of lesbian sex at menopause, I asked questionnaire participants to explain what lesbian sex was like for them at menopause by completing the

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'Sexpo' is a four-day annual event held in four major Australian cities. It is promoted by the organisers as a 'health, sexuality and lifestyle exhibition.' In Melbourne 'Sexpo' is sponsored by Club X - a large chain of sex shops. In Melbourne in 2001, 68,123 adults visited 'Sexpo'. The organisers claim the event is gaining more popularity each year. Women's groups such as the Coalition Against Trafficking in Women (CATW) are regularly picketing Sexpo.
following question, 'Based on my experience, lesbian sex at menopause is...'. The vast majority of participants reported positive and healthy responses. Examples of questionnaire responses include the following:

Based on my experience lesbian sex at menopause is...

- beautiful, soft, gentle and loving [3]
- is just as good, no probably better as I am evolving [8]
- satisfying and changing in its expression. It requires a sense of respect and mutuality given that partners are at distinct phases in their own physical process [28]
- fulfilling and loving [30]
- with a long-term partner in a relationship based on mutual respect increasing in intimacy as any other time, where intimacy is physical, mental, emotional and spiritual [59]
- as good as its always been. I feel awful writing this because I feel I should be more sensitive to changes and that perhaps I ought to have attended to menopause more closely! [210]

These responses were similar to those reported in Colc and Rothblum's study. I believe that findings from lesbian participants present another, alternative view to the dominant discourse of sex and sexuality as constructed under heteropatriarchy. Questionnaire responses support my basic contention that the focus on hetero sex (painful sexual intercourse, dry vaginas, etc) in the health, and specifically menopause literature, does not apply to many lesbians (also see Conclusion). Many lesbians in this study have clearly defined sex in ways that as Nett Hart has argued, are not conceptualised within a heteropatriarchal perspective (1996). These issues raise the question as to why lesbians' alternative views on sex and sexuality are not commonly known in mainstream society. This question will be discussed in further detail in the Conclusion.
7.4 'I Try to Stay on the Lowest Dose Possible to Prevent Breast Cancer': Lesbians and Hormone Replacement Therapy

The issue of Hormone Replacement Therapy (HRT) and its use is an important theme in this study. With the research findings released from the Women’s Health Initiative (WHI) in July 2002, and further negative findings in May 2003 (see pp. 73-77) much controversy continues to abound regarding its risks and benefits for the users.

Sixteen percent of lesbians in this study were taking HRT at the time of completing the questionnaire in 2001 (n=19). This number appears to be less than the figures cited in other, larger studies (see Chapter Five). It has been estimated that in the state of Victoria in the late 1990s, one in four menopausal women was taking HRT (Vollenhoven 1999). The Women’s Health Australia study data for Phase 2 survey of the mid-age cohort (47-52 years) found that 23.2 percent of women were currently taking HRT and 76.8 percent were not (Women’s Health Australia 2002, 9).

Similarly the Melbourne Women’s Midlife Health Study (Dennerstein et al. 1994) reported that out of the 357 women participating in the study, 42 percent had tried HRT and 62 percent were currently taking HRT in 1994. The lower numbers of women taking HRT in my study requires exploration and discussion. Whilst I realise that mine is not a representative sample of lesbians living in Australia, therefore absolute conclusions cannot be drawn, I believe it is an interesting finding that the number of lesbians taking HRT is considerably lower than in other studies with predominantly heterosexual women.

Some of my study participants suggested that HRT may be more popular with heterosexual women and several spoke of the role HRT plays in perpetuating the role of ‘compulsory heterosexuality’. These comments were reported in both the questionnaires as well as interviews. Questionnaire responses included:

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74 It must be noted that in my study the vast majority of questionnaires were completed and returned prior to the WHI research findings being released in 2002. One participant has since contacted me to inform me that she has stopped taking HRT since this information was made public.

75 Refer to footnote 59, p. 97 (see Conclusion for further comments).
I suspect that HRT would be more popular with heterosexual women, maybe because of pressure from their male partner to 'get better quickly' but that is just a thought without any basis in reality. [113]

Although this participant stated that this was 'just a thought without any basis in reality,' it appears that for some women the connection between HRT and heterosexuality is very real. For example, Merle wrote that if she were still married she would most likely be taking HRT. Merle is fifty years of age, identifies herself as postmenopausal and had been in a heterosexual marriage for twenty years. She has two adult children and has recently 'come out' as a lesbian.

In the follow-up interview Merle explained:

Yes I suppose it is my own personal experience but when you are with a man you sort of have to come up to a certain standard and the thing is he would probably encourage me to do something about it [menopause]. Because if I'm uncomfortable then of course I didn't want sex and that was a big thing. So he'd be encouraging me to take something to lessen the symptoms to make me more comfortable so I'd be happier sort of ... to go along with whatever he wanted and yet with another woman I don't feel that at all. It's sort of like it's normal life, if you're a married woman and your kids are growing up, you're going through menopause, you take HRT. Life is different now and I just don't want to go down that track. [212]

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

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

In a similar vein, Sandra Coney in The Menopause Industry claims that it is the
preoccupation with eternal youth, beauty and sexual prowess that is responsible for
the success of the HRT campaigns. As Coney writes (1993,163):

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

Could it be that these messages are internalised to a greater degree by heterosexual
women than lesbians? As suggested by Gettelman and Thompson (1993; see
Chapter 3.4) lesbians may have different physical ideals than heterosexual women
and consequently lesbians may 'refuse to accept this culturally prescribed mold for
themselves, which many believe to be indicative of male oppression, and instead
accept a wider range of personal appearance styles and tastes' (1993, 552). To some
degree, my data confirms this notion. Another lesbian interviewed spoke of similar
issues. Andie asks:

_We don't give adolescents something to prevent puberty so why would
we give something at the other end to prevent that? What it prevents
is what the patriarchal society says we are supposed to continue in.
We are supposed to stay sexually available to men, our breasts are
supposed to stay firm. We are supposed to be available for servicing
men at any moment and menopause takes us out of that realm. So if
they delay or prevent menopause, it keeps us our creatures longer. I
don’t know, what is HRT supposed to do? Supposed to keep us
youthful and appealing, with firm breasts and non-ageing skin? HRT
is designed to continue the availability of women to men as men
define it and our own natural bodies have times when we are not
suited for sexual activity with men, if that’s our choice. The
availability to men is no longer an issue, because we are now the
crones. Now we are menopausal and now is the time when we are
available to ourselves. And HRT and all of this patriarchal 'when you
are an old lady you are useless,' are designed to deny us time for
ourselves and each other. Still we manage._ [7]

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[7] As discussed in the Introduction, feminists such as Germaine Greer and Sandra Coney regrettably
also do not mention lesbians as possibly experiencing menopause - and HRT - differently.
Many interview participants repeated the theme of HRT and the role they believe it plays in keeping women sexually available to men. Questionnaire data, too, confirmed similar views on this topic as is evidenced in the following comments:

*HRT provides artificial oestrogen to keep the body younger and sexually available to men. Add progesterone to the recipe to reduce dangerous ‘side effects’ such as cancer – breast in particular. [59]*

*HRT may offset symptoms of menopause but I believe menopause is simply delayed. There does seem to be a suggestion in advertising that ageing is delayed, therefore women will be more attractive to men. Taking HRT may turn out to be one of the biggest social drug experiments against women. [72]*

Knowledge of HRT was high in my study. All of the participants had heard of HRT and most described it as a combination of two hormones: oestrogen and progesterone. Questionnaire data revealed that women learnt of HRT from a variety of sources including lesbian conferences, gatherings and festivals, women’s health services, books, printed information, lesbian and women’s magazines as well as through more conventional means, e.g. medical services and health professionals. Sinclair et al. (1993) have suggested that women will increase their uptake of HRT in line with increased information and education. The results of this study do not support this view. Of the nineteen lesbians who were using HRT, reasons they cited for its use were in line with those published in larger studies. Women who were taking HRT explained it in terms that were echoed in other studies, and frequently stated that it helped with ‘troublesome symptoms’ and several indicated that they were advised to do so by their GPs. Other women taking HRT indicated that it helped the discomfort they experienced as well as providing some protection against heart disease and/or osteoporosis. One participant has contacted me since the release of the WHI findings and reported that she has discontinued HRT as a result of these findings (pers.comm.). As previously stated, it must be noted that the questionnaires, and majority of interviews, were completed prior to the publication of the WHI results. Consequently, I do not know if study participants have continued or discontinued HRT. When asked, ‘what is HRT?’ women who were using it, often described it in very ‘medical’ language. This medicalised definition reflects the medical model of menopause which dominates public discussion in western(ised) countries. The following quote from a participant who is not a health professional, but who works in a medical environment and has been taking HRT since 1990, illustrates this point well:
HRT substitutes equine hormones as oestrogen replacement and combined with progesterone protects against osteoporosis and possibly heart disease and ovarian cancer. It aids in protection of bone density when combined with dietary and physical exercise. [105]

Other quotes from HRT users defined HRT in medical language. This is not surprising, given the high number of health professionals in my study, and the fact that popular knowledge of HRT is high amongst women in the general community. Every woman in my study had heard of HRT and similarly all were able to explain HRT in their own words. Popular knowledge of HRT reflects a medical understanding of the drug, as is evident from a diverse range of sources including women’s magazines, talk back radio, television programs and newspaper articles. Three of the six participants quoted below are (or were) Registered Nurses [35, 134, 202]. The following quotes illustrate the medicalised language:

HRT replaces diminished or ceased supply of oestrogen and testosterone. [202]

HRT replaces oestrogens and progesterones that are no longer produced by the ovaries. It also aids with treatment of osteoporosis. [164]

Replaces ovarian hormones at a level sufficient to maintain premenopausal hormonal influence on total body systems and functions. It may cause some women to menstruate again. [134]

Gets rid of hot flushes and stands a chance of kick starting my menstrual cycle. [125]

Relieves the symptoms of menopause - hot flushes etc. It also helps protects against osteoporosis and heart disease. It replaces lost hormones. [57]

HRT decreases calcium loss, prevents hot flushes, slows skin aging, preserves perineal muscle tone, prevents complete loss of libido, causes weight gain. [35]

In addition to commenting on HRT as alleviating the physical ‘symptoms’ of menopause, other participants wrote and spoke of emotional and psychological distress experienced at this time. For some women, these feelings were far more distressing than any of the physical ‘ailments’ often highlighted in discussions of

77 It is an interesting finding that although a high number of my study participants are employed in health-related occupations (almost 40 percent), the overall number of women using HRT in this study is lower than in other studies.
menopause. Pat explained how suddenly she found herself crying and becoming upset at trivial things. This caused her an enormous degree of distress:

*Being out of control with my emotions really upset my work. So off I went to the doctor which I'd been to many times but just decided to do nothing and I said, 'look all the other things I can handle, but I can't handle this. I need some help here' and to my surprise this doctor had said to me there is something we can do about it. These are your options; one of them was HRT. She gave me a video and said go home and watch the video and see what you think. I feel that it will help level out those things and get you back on the right track but that is my opinion. I don't want you doing something that is against what you think, go home, read up about what different options I've given you and some of them were natural things, although there wasn't a great deal on that then, because it was an up and ... umm ... new thing even in the shops, you know, health food shops and that, they didn't have as many things as they do now. So I went home, watched the video, talked about it with my partner who I was not...(laugh) she was, you know, my 'best' friend then, right? So I talked with her about it and ... um ..., eventually decided, well I couldn't handle these outbursts of being out of control because that wasn't me. So I went back and said 'I'd like to give it a go' and she said to me 'well you can stop it anytime'. She did also explain to me, as did the video, that there were other things which at that point in time they thought were really good like, um, the reduced risk of osteoporosis and heart disease but you had to keep an eye on things like breast cancer and you know, so I think she informed me really well and I made my decision on that and decided to try it. Yes it has helped, absolutely.* [174]

Pat is 53 years old, post-menopausal and at the time of the interview (26 April 2002) had been taking HRT for eight years. Pat told me she was not concerned about side effects such as breast cancer, because she has had both her breasts removed for ‘precancerous cysts’. Pat says that as long as she has her Pap tests regularly, she believes ‘the benefits [of HRT] outweighed the risks’.

Other women too described ‘mood swings’ as one of the most difficult and unexpected aspects of menopause. As one study participant put it rather dramatically:

*HRT stops me wanting to cry and/or the almost irresistible urge to kill people!* [202]

Another woman commented:

*I was diagnosed with depression during this time and now on reflection I think it was a menopausal symptom but the link wasn’t*

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78 This is an erroneous view as breast cancer can also occur outside of the breast tissue.
made at the time [6].

The combined number of years that lesbians in my sample had been taking HRT was 89.5. (One participant did not answer this part of the question.) The mean number of years a woman had been taking HRT in this sample was 4.97. Eight out of eighteen participants had been taking HRT for five years or longer (two women took it for more than ten years). Given the 2002 WHI findings, this has serious health implications. Clearly, the nineteen lesbians taking HRT in my sample were well aware of the controversial nature of this medication and yet, they stated they believed that they were making informed choices to take HRT.

In contrast to these findings, the majority of participants, however, expressed views that were antithetical to the medical model view of HRT. This is evident in the following questionnaire responses:

- **HRT keeps drug companies in business, causes breast cancer, causes diabetes and relieves some symptoms in some women at an unknown long-term cost.** [43]

- **HRT enriches the drug companies and medical doctors.** [66]

- **HRT suspends menopause until such time as HRT stops so it becomes a lifetime prescription unless a woman decides to proceed with her menopause.** [73]

- **HRT enables doctors to give something to older women, whatever the health complaint may be.** [154]

- **HRT puts unacceptable artificial hormones into the body and provides dollars for the industry aiming to medicalise all natural bodily functions. It increases the risk of further illness and cancer but is promoted as preventing heart disease, osteoporosis and symptoms of menopause. It turns women into guinea pigs.** [81]

One of the study participants, who is also a medical practitioner wrote:

> As a medical practitioner I do feel it [menopause] has been overly medicalised as a really lucrative business. I do believe HRT and alternative therapies have a significant role to play. As my hot flushes became more severe despite Black Cohosh and soymilk I am increasingly tempted. [141]

Other lesbians appeared to reflect a more philosophical view of menopause and the role of HRT. For example, Elizabeth, a 47-year-old lesbian explained:
I've always seen it [menopause] as just another life stage and because I see it as a life stage it's just well, that's just what happens and there will be some inconvenient times and there may be times when you're not feeling very well but you just get on with it. Lots of women I know have gone and sought medical treatment and some are using HRT but they are still experiencing what I would have called 'indicators' of menopause. I played sport for a lot of years and you just play with injuries so things that are inconvenient, like you still swim if you've got your period, 'coz you can't allow, or for me, I can't allow issues around menopause or anything like that get in the way of my life. So I guess it's an attitude towards it that I guess it's like when people have chemotherapy. They either make a decision that it is going to be horrible, horrible, horrible and they put themselves to bed or they say, 'I have to have this treatment but then I come out and I go back to work and get on with it.' [168]

Almost 14 percent of lesbians in this sample had previously tried HRT for various durations. Many of these women discontinued its use after a short time. This concurs with the findings of Ravnikar (1987), which show that HRT treatment is frequently abandoned during the first year. Reasons cited for its discontinuation in my study were similar to those cited in other studies and included increased risk of cancer, unwillingness to take 'unnatural therapeutics', unknown long term side effects, and the fact that for some women, the menopause 'symptoms' persisted despite HRT.

7.5 'Acknowledge Our Existence': Health Services and Homophobia

The topics of homophobia and lesbians' experiences of the health system were crucial to this study. Questionnaire and interview responses revealed that for over half of the lesbians in my study (52.6 percent) to encounter homophobia within health services was a common experience. Many lesbians wrote and spoke freely about their negative experiences with the health system and many suggested strategies for improvement. In this section I discuss the main findings from the questionnaire and interview data relating to lesbians' experiences with the health system. I also explain how these findings relate to, and indeed often support, findings from other larger Australian and international studies.

Questionnaire responses reveal that women in my study were relying on a variety of health providers and diverse sources for information related to menopause. Seventy-seven percent of lesbians in this study had consulted a health professional about their menopause (n=90) whilst 21.5 percent of lesbians had not (n=25). One woman did
not answer this question. In the following quote, a participant explains why she did not consult a health professional about her menopause:

There seems to be an assumption that a change means a problem. I haven't consulted health providers and have discovered that for me, the changes were a stage on the way to menopause. I believe they would've been 'treated' had I seen a health provider and I'm glad that I did not. But I have found very little useful information when I just want information about how common each change is. What I've found when I looked was that the change would be under a heading such as 'problem' and then of course a 'solution'. I didn't want a solution because I didn't think I had a problem but I would have liked to assure myself that it was NOT a problem [9].

Some of the health professionals participants consulted in this study include, general practitioners (GPs) naturopaths, Chinese herbalists, acupuncturists, nurses, homeopaths, a masseuse, chiropractors and staff at menopause clinics. Other ways in which lesbians in this study sought information about menopause-related issues were by means of talking circles at lesbian gatherings and conferences, women's health centres, partners, friends, their mothers, books, websites, ABC radio, Radio National, lesbian and general women's magazines, and journals.

In the questionnaire, I asked lesbians to nominate their primary health provider and the responses listed a wide range of health providers. As other studies have reported, lesbians in western(ised) countries are likely to use a range of health providers in their search for more holistic and less discriminatory care (Brown 2000; Koh 2000). Results from my study support these findings. Almost one-quarter of participants (24.1 percent) rely on a combination of health care providers rather than one primary care provider. Seventy-nine percent of lesbians in my study see a regular General Practitioner (GP) (n=92). Over sixty percent (60.3) of participants nominated a GP as their primary health provider. Naturopaths were identified as the primary health provider by 6 percent of lesbians in the sample (n=7) and 4.3 percent nominated a chiropractor as their primary provider (n=5). Five percent (5.1%) of respondents stated 'other' as their primary provider. Lesbians were asked their reasons for using a range of 'alternative' providers and responses mirrored those of other studies. From the questionnaire data, it appears that some lesbians in this study view the medical model as narrow and 'symptom orientated', rather than reflecting a holistic approach. For example, study participants said:

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79 This quote highlights the medicalisation of women's lives - including at the time of menopause - which I discuss in more detail in the Introduction.
I think that western medicine treats the result not the cause. It treats ageing and death as the enemy, not natural progressions and it is very out of touch with the human state and interferes too much. I try to stay away. [3]

Alternative medicine works on the causes whereas western medicine works to alleviate the symptoms regardless of what other body damage occurs. [43]

A major problem with traditional western medicine is compartmentalisation, i.e. will only look at one bit of the body at a time (the offending bit) doesn't look for relationships between bits. [190]

Other women wrote:

Western medicine has a good place for acute needs. For whole body considerations we need access to broader understandings. Our bodies are complex and limited outlooks are not helpful. [72]

Western medicine is good for accidents, setting broken bones and diagnosis, not much else. [16]

Similarly, another woman remarked:

Sometimes doctors have too narrow a view of the body – I don't agree that the medical model is the only one that works. [130]

Other women explained how they consult different health providers for different health conditions and related issues. For example:

I tend to seek different health providers for different health problems. I choose naturopathy first but sometimes I need a doctor or chiropractor. [128]

Acupuncturist is best for tissue injuries, naturopath and homeopath best for hormone balance and general metabolism. The GP is for Pap Smears, blood tests, vaccinations and medical certificates. [133]

I have over my life used natural therapy but usually when I see someone it's for a medical certificate rather than treatment. [148]

Homeopathy is the most effective modality for me. I also use a GP for prescriptions and standard health information. [187]

Acupuncture is wonderful, I believe in its fundamentals of energy flows, and energy blocks, which result in ill being. My GP is for quick fix issues, i.e. infection, aches and pains. [27]
Some women mentioned the mind/body/spiritual balance and indicated that they use a range of providers and treatments in an attempt to regain balance and alignment.

One woman wrote:

*I believe that when things are not working properly (illness or disease) then I need to realign my bodies (spiritual, mental, emotional, physical) with natural remedies and lots of rest/sleep, meditation and being in nature.* [68]

And similarly another stated:

*Doctor is for prescriptions and monitoring of my osteoporosis; naturopath is my 'witch-sister' who discusses more spiritual aspects of healing and gives me rescue remedy.* [197]

One woman commented:

*Allopathic medicine seems to me to be fundamentally corrupted by the investments in profit (pharmaceutical companies and multinationals).* [38]

Nathalia was explicit in her judgement:

*Mainstream medicine is fucked and only good for emergencies.* [163]

These questionnaire responses illustrate a general dissatisfaction with the medical model. Mostly, medical practitioners are sought out for ‘quick fix’ approaches and/or compulsory medical certificates; whilst a range of alternative practitioners are consulted for realigning mind and body. I also wanted to know about the extent of homophobia lesbians participating in this study experienced in contacts with their health practitioners. Homophobic attitudes and behaviours appear to be widespread throughout the health system and not related to one occupational group, although study participants frequently singled out medical practitioners. This information came from both the questionnaire and follow-up interview data. Many lesbians conveyed personal anecdotes of discrimination and homophobic behaviour on the part of health professionals. Few of the lesbians who experienced homophobia felt able to challenge these behaviours and instead chose not to return to that particular health professional. Homophobic themes were reported in both the questionnaire and interview data. Of all sections in the questionnaire, health services and homophobia received the most additional comments. Some examples of experienced homophobia reported on the questionnaire data include:

*Once during an internal examination I jumped when the male doctor literally stuck the speculum into me – his sneering voice said, 'most women like it'. Even the nurse was shocked.* [125]
One GP I went to (I think for a Pap Smear) said how much he preferred treating lesbians as we were so 'clean', meaning I presume, that we were unsullied by penis penetration or sperm. I never went back to him. [156]

In A & E [Accident and Emergency] after an accident, the nurse presumed my straight girlfriend and I were lovers. She treated the scrubbing of my deeply grazed back overzealously until my friend left the room to phone her husband! The nurse was apologetic UNTIL I explained that only my friend was hetero and not me! [118]

I had an STD from a female partner and the doctor asked me to give this medication to my male partner. I said to the doctor I don't have a male partner. I have this problem from a woman and he looked at me with utter complete disgust and said to me, 'I would like you to leave my surgery and I'd prefer it if you found another doctor to treat you, don't come back to this clinic again'. [179]

Other comments, whilst perhaps not seen as extreme, nonetheless, clearly mirror homophobic views and attitudes.

When I asked about safe sex practices for lesbians I was given a list of venereal diseases. [48]

An assumption of stereotypes - nymphomania, wanting to seduce all women, must be a 'man-hater' etc. There was embarrassment at my disclosure resulting in defensive behaviour, telling me my lesbianism made no difference when I believed it did. [59]

As previously stated, over half the participants in my sample (52.6 percent) reported experiencing homophobia and/or heterosexism in their interactions with health professionals. It must be noted that of the 47.4 percent who had not experienced such interactions, almost 30 percent of these women were not out to their health providers (n=16). I asked women about their reasons for not disclosing their sexual identity to their health providers and responses included: ‘fear of the response I may receive’, ‘I may then suffer discrimination’, and ‘I may not receive good care if she/he knows I am a lesbian, ‘she/he will think differently of me’ as well as ‘it is not relevant’. These responses confirm those of other national and international studies. 

Not being out, however, does not ensure a discrimination and homophobic free consultation. If a lesbian is not out, she will be assumed heterosexual and

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80 The issue of invisibility will be discussed in further detail in the Conclusion.
consequently remain invisible as a lesbian within the health system. Seventy-one percent of lesbians in my sample \( n = 82 \) believe that lesbians are invisible within the western(ised) medical model, whilst 40.5 percent \( n = 47 \) suggest that lesbians are also invisible within the ‘alternative/complementary’ health system. The issue of invisibility was one of the most commonly mentioned themes throughout my study. Many lesbians spoke of the need to discuss relationship/sexual issues with medical practitioners yet felt that because of fear of discrimination it was not safe for them to do so. The following questionnaire responses highlight these points:

_The doctor never asked me how menopause was affecting my sexual relationship but I bet she would’ve asked a married heterosexual woman._ \[69\]

And another woman wrote:

_Doctors are willing to discuss sexual issues relating to menopause if you have a husband but if you don’t have a husband you can’t have a sex life so there’s nothing to discuss._ \[136\]

From the responses received, the majority of lesbians who wrote about this issue felt strongly that health professionals needed to be more aware of the language used and the need to be inclusive, as is evidenced in Alison’s remarks:

_From my experience with the medical system, all women are generally viewed as straight by doctors unless you set yourself to them. It would be better if the issue of partners was a first line, routine question for GPs as this would set a more accepting parameter for the usual following routine questions. I feel as if I need to be on guard when I see a health practitioner to out myself or wait for an assumption to be made and then I have to correct it. I also feel that often I have to look after the GP if her/his reaction is one of shock. Unfortunately we have a limited choice of health practitioners available here in the country._ \[27\]

An opposing view suggested that lesbians’ invisibility within the health service is due to a woman’s lack of openness and honesty with her health provider. Whilst this view may be interpreted by some as ‘blaming the victim’, some lesbians interviewed believed strongly that if change is to occur, then it will only come from lesbians themselves. Elizabeth told me:

_We make ourselves invisible I think. Like there are plenty of women’s clinics and gay and lesbian friendly clinics for example and there are opportunities for people to receive good medical care either through_

\[81\] McNair and Dyson (1999) found a reluctance of the GP to ask female patients about their sexual orientation due to fear of offending heterosexual patients as well as lacking skills in asking questions in sensitive and non-judgmental ways. See Chapter Three as well as the Conclusion for further explanation.
their local clinics or through specialist clinics. I just... you would hope that they would recall your case history and realise that you're a lesbian and not talk to you about birth control during this time. So as a lesbian, I guess if you want to receive good medical treatment you need to be out in a sense that you need to have explained your situation to the doctor because I think if you hadn't and the doctor asked about birth control, because this is a time when you can be falling pregnant, and you got really upset about that because you're not having sex with a male, then to a certain extent it is your own fault for not explaining to the doctor that you're in fact a lesbian. It's like that we're a patriarchal society even though we're working hard all the time. Like I just feel that I have a responsibility to educate, as a confident lesbian I have a responsibility to educate. [168]

Elizabeth is a well-educated, assertive, professional woman who has a background in nursing. She acknowledges that she is confident and realises that this impacts on the communication she has with her health providers. She further explained:

I've been to a gynaecologist and he said what are you using for birth control and I said I'm not using anything I'm a lesbian and he just didn't blink. It was no big deal. He obviously treats lots of lesbians. **** is a major town. It has a population of 20,000. He'd come across lots of people from lots of diverse backgrounds so there's no problem and I don't get asked those questions from either my GP or a specialist. So there's no issue there for me but I'm confident too. I haven't got a sense of fear that he'll go and tell everyone or he'll treat me differently because I guess, I feel that if he tried to treat me differently I would do something about it. [168]

Jill shared Elizabeth's views and spoke of the roles assertiveness and self-knowledge play in getting what is needed in terms of good health care. Jill wrote on the questionnaire:

Assertiveness is an absolute prerequisite to getting health advice/care, so is self-knowledge about our own bodies/health. Otherwise we can be so badly advised/diagnosed/treated we can die. As an ex-nurse, that is, someone with an 'insider' view of the health system, I am appalled by the western medical approach to our health overall and avoid it like the plague. [58]

Other questionnaire respondents who shared this view include the following comments by two participants:

Medical/nursing people could provide more lesbian targeted services/information if we would identify ourselves. We need to be out to make our needs known. Society/attitudes could change more so that it is OK to have targeted services. [67]

By stating my sexuality at the outset everyone is aware of my individual needs and no assumptions are made. Being out with
medical practitioners and services I believe improves awareness and improves service delivery. [176]

And another woman stated:

I have experienced the constant assumption of heterosexuality until I have declared my lesbianism at which point people attempt to be 'understanding'. I feel I am a privileged, articulate, high-income lesbian with a voice. I think I've been pretty lucky. I've been upfront and bold about my lesbianism and have 'demanded' respect for that position although I do have to continually educate people about their heterosexism. [210]

Some lesbians in my study did not regard disclosure of their sexual identity to their health provider an option. This appeared to be particularly so for lesbians living in rural and remote communities. The following quotes from the questionnaire data illustrate this point:

Every local medical service I have had dealings with assumes I am heterosexual and married. They call me 'Mrs' despite being told several times 'Ms'. I cannot trust a positive reaction to my disclosure of my sexuality so I choose not to in this town. [35]

A nurse who lives in a small town and is not out to her primary health provider, explained, 'It is a very small town and the receptionist has a big mouth.' [167]

More than half of the study participants reported that their health provider identifies as gay and lesbian friendly (59.4 percent), whilst over one-quarter indicated that their provider did not identify in this way (28.4 percent). Twelve percent of respondents were unsure. Many lesbians living in cities commented how they prefer to use the services of a known gay and lesbian friendly health clinic. These services, however, are not commonly found outside major cities. Lesbians who live in rural and remote locations rarely have this option. In many smaller communities the option of a female doctor is often not a possibility.

Many lesbians in this study were travelling vast distances to see the doctor of their choice. Of the 92 lesbians who had a regular GP, 51 percent (n=47) indicated they travel a distance to see their preferred doctor rather than consulting the nearest available. Distances women travelled ranged from 5 kilometres to 1200 kilometres.

One woman commented:

If possible I travel from Brisbane to Sydney [approximately 1200 kilometres] to see my GP although that is not always possible. [125]
I travel from X to Melbourne [approximately 100 kilometres] as the local GPs seem narrow, suburban and limited. [21]

And another woman wrote:

She was my local doctor and I have kept seeing her when I moved away. I now live 150 kilometres away and I will be moving to a local doctor soon. The problem is that the local lesbian doctor’s books are closed and that is why I keep going back to my old doctor. [34]

Not all respondents indicated the distances travelled to see their preferred doctor; however most cited reasons for their choices. Some of the other reasons given were:

I travel because she is comfortable with my sexuality and the choices I have made such as having a child via self-insemination. She is also very competent in the clinical stuff as well as an excellent communicator. I have worked hard to find practitioners I feel will accept my lesbianism. We pay the price by having to be ever vigilant. As a lesbian and a single mother it is very hard to find bulk billing GPs in our community and alternative health is very expensive. [172]

I travel 10 kilometres because she is a lesbian. [3]

My GP is a lesbian and the distance is 15 kilometres from home. [1]

Up to 10 kms because it is gay and lesbian friendly and there is a sense of community. [45]

Only about 3 or 4 kms as it is lesbian/gay staffed. [9]

Thirty kms for suitable female doctor who is lesbian friendly and understanding of my history and medical conditions. [30]

Thirty minutes because recommended as gay friendly and female focussed and good care. Also is a naturopath. [60]

I travel for privacy. I live in a very conservative community and do not wish to battle homophobia every day especially not during health issues and stressful moments. [129]

I go where I find a doctor I trust. I build a relationship with the GP over years and will follow where she goes. I do not know how far she would have to go before I would change GPs. [109]

Thirty-nine percent of lesbians in this study work in health related fields and occupations. For many of these participants, being a lesbian health worker poses additional issues related to discrimination in the workplace. Kate is employed in a rural community health centre and shared with me some of her experiences of being an ‘out’ lesbian in such a workplace. I asked Kate for her thoughts on the view that it is up to lesbians to out themselves in order for positive change to occur:
I’ve found myself more and more outing myself in the last probably four or five years. Because I felt that stopped discrimination at work and just sort of ‘... well now you know you can stop gossiping about me, putting me down and making homophobic jokes and if you continue to be homophobic coz you know directly now because I’ve told you I’m a lesbian, you’re in big trouble mate, do you know what I mean?’ Because while they don’t, there could always be that thing ‘well we didn’t really know’ and it’s interesting in the workplace that I was at recently. I mean it’s really big on embracing diversity and doing all this diversity training and I found it to be one of the most homophobic places I have ever worked in. ‘Oh God, she’s a lesbian, oh really, but she’s really nice’. I hate that comment. I’ve experienced some pretty nasty discriminative practices in work places over the years. At the end of the day, I guess I’ve started to think, what could be worse than allowing that behaviour to go on? It’s so subtle isn’t it? It’s like work place bullying and stuff like that too. If you feel that something is happening people can say it’s very subjective to you and yet other people might have a feeling about it. It’s exclusion, not including you in conversation and can happen in very subtle ways. [44]

Many lesbians wrote and spoke of the homophobia and discrimination they, as well as clients, experience in their workplaces. Leah is employed as a medical receptionist in a busy medical practice in Sydney. In an interview, Leah shared some of her professional experiences of homophobia with me. She told me how many of the sales representatives would pass homophobic comments on a variety of gay issues, for example, the Gay Games, Mardi Gras etc. Similarly she remarked:

*Doctors would commonly pass derogatory comments about patients that were openly gay and lesbian; quit demeaning remarks on their physical appearances and clothing.* [218]

Leah continued to explain how her employer is of Irish catholic descent and extremely homophobic. She has, at various times, confronted him about his attitudes; however, due to the power imbalance this is extremely difficult. Leah stated:

*I had an employer tell me that all gays and lesbians should be shot in the kneecaps. When this remark was passed I told him to start with me if he felt so strongly. Needless to say the issue of sexuality was never brought up again.* [218]

Helen, a Registered Nurse employed at a local community hospital, explained how she has been ‘quite fortunate’ with the health professionals she has dealt with. She believes this is due to the fact that she is honest and up front with her health providers:

*I guess I have always been honest with my GP, for example, and I chose a woman GP and it turned out that she was gay. I didn’t know at the time but that was OK. I guess I just be honest and people well,
you know, you just tell people how things are and it's up to them. I
don't do that in a confrontational way and if they have a problem
with that, ten ... I guess I'm rather diplomatic. If I perceive there is a
problem with that I let the matter rest. [1]

Although Helen has not experienced homophobia at a personal level, she is well
aware of others who have been discriminated against on the basis of their sexual
orientation. Helen explained about the double standard that exists, yet seems to have
a philosophical approach to the issue. She commented:

There is a double standard too I suppose because sometimes people
are different towards you because you are a friend. I'm aware that
some of my colleagues are still of the view that if you are a lesbian
you have missed out on something in your life or you're a lesbian
because of some very negative unfortunate experience with men and
it's not something they would like their daughter to be. I mean I think
prejudices and things like that just get eventually worn away like the
old dripping tap analogy. You just keep on being confident and if
people are going to change their view then they will. Sometimes this
process happens like osmosis, you know. They suddenly realise that
they don't feel quite the same that they are more accepting than they
have been in the past. I've found sometimes the attitudes of my
colleagues towards lesbians who are patients has been a bit
discriminatory. They've made some rather crude jokes about them but
that would have to be in the minority and on those occasions when its
happened, I've made some comment, from a professional point of
view that its inappropriate in the first place and secondly if they feel
that way, perhaps they shouldn't be there providing care for that
person. [1]

A lesbian nurse told me how at the women’s health service where she was employed,
a colleague sent all workers an electronic Christmas card of a naked male. As this
nurse was an ‘out’ lesbian, the colleague realised that this would not be appreciated
and instead sent her an e-card of a woman flashing her bare breasts. When the
lesbian spoke to her colleague about the inappropriateness of this gesture, she was
accused of not having a sense of humour and not receiving the greeting card in the
kind manner in which it was intentioned (pers.comm.). Thus the stereotypes of the
angry, bitter, humourless lesbian prevail and dominant heterosexual patriarchal
culture is reaffirmed (Hawthorne 2002).

Often it is assumed that women’s health services will be less homophobic than
mainstream services. Sadly, my study suggests that this is not necessarily the case.
During the recruitment stage of this research (discussed in Chapter Two), I contacted
all women’s health services in the state of Victoria to ask for their assistance with
recruitment. Initially I sent an email which I followed up with a letter and then if no response eventuated, I made a telephone call to the Director of the service in an attempt to enlist their co-operation. Despite all these measures and three phone calls to one particular women's health service, my calls were not returned. Responses such as these suggest that homophobia may be just as prevalent in women's health services as in mainstream services.\(^2\)

Other participants who identified themselves as nurses and allied health professionals wrote of the insights of 'insider' information. In response to the question asking about personal experiences of the health system, a family and child health nurse remarked:

*Because I have insider knowledge I fear it [the health system] is becoming a band-aid and less time/finance is available for health promotion. I believe you need to know what questions to ask to get the information you need. Staff are not giving the 'extra' information to make the difference in people's lives because they are overworked and there is reduced value on preventative health care.* \(^{117}\)

Another Registered Nurse shared with me how she acts as a client advocate and challenges homophobic attitudes in her workplace.

*Health care practitioners pay lip service to holistic care but they are influenced by societal pressures and socialisation. They are homophobic and let it affect their care. As a health professional I act as an advocate where I can. In 'standing up' for guys I have been ostracised but will continue to do so.* \(^{101}\)

Clearly many lesbians in this study are experiencing and challenging homophobia within the health system at both a personal and professional level.

An overwhelming 82.7 percent of lesbians in this study believe that the western(ised) medical model could be improved to cater for the needs of lesbians (n=96). Another 15 percent of participants were unsure (n=17) and 1.7 percent indicated that no improvements were necessary (n=2). One woman did not answer this question. Lesbians in this study suggested a variety of strategies for eliminating homophobia and creating safer health environments for lesbian consumers. Many of these

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\(^2\) It may be argued that not responding to my email, letter and phone call reflects too much work at the health service. However, when contextualized by the comments of my study participants about their experiences at women's health services, I believe my use of the term homophobia is, unfortunately, justified.
strategies were original and innovative. Other ideas were straightforward and could be implemented with very few, if any additional financial resources (see Conclusion).

The most commonly cited suggestion for improvement within the western model was the avoidance of the assumptions of heterosexuality. As previously discussed in Chapter Six, many health professionals assume that all people are heterosexual. Some typical questionnaire responses included:

_Acknowledgement that not everyone is heterosexual would be a good start._ [113]

_My biggest concern with the health system is the assumption of 'heteronormativity', which assumes I'm heterosexual until I have to indicate I'm lesbian – normally in response to questions such as, 'what contraception do you use?'_ [210]

_By not assuming heterosexuality and by understanding our different social health issues (e.g relationships)._ [30]

_More awareness of assumptions made in relation to the need for contraception (most assume all women need it), sensitivity about the variety of needs that lesbians have in relation to IVF, childbirth etc._ [46]

_Studies like this are a good start! It would be nice to not be presumed heterosexual. I wouldn't then be told, 'only people with HIV get oral thrush.'_ [118]

_Yes – acknowledge our existence!_ [69]

_Don’t assume a woman is not sexually active just because she doesn’t have a male partner._ [136]

Other participants wrote of the education and training needs of health providers in order to create more appropriate and acceptable health care to lesbians. A Registered Nurse suggested:

_Provide more education to health professionals about our lifestyle and urge them to be more accepting of us. Dr Phelps may be a new beginning._ [1]

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83 Dr Kerryn Phelps was the president of the Australian Medical Association (AMA) from 2000 to 2003. She is Australia’s highest profile medical doctor and is an ‘out’ lesbian (see Mitchell 2002).
Others remarked:

It is a matter of education of these needs by consulting with lesbians. [31]
Ensure training and professional development includes values and attitudes re difference and diversity. [133]

Policy needs to be inclusive in its language. Practitioners need to be offered awareness training. More lesbian-focused resources. [6]

Another woman suggested:

There needs to be more education of doctors, nurses, allied health professionals about the special needs and voices of lesbian women (who may be concerned about their sexual orientation and fear discrimination for good reason). [210]

Many suggestions demonstrated that a great deal of thought and personal experience had gone into the response. For example:

By normalising us for a start to the rest of the communities and by aiming information at lesbians, educating the old brigade of AMA members that we are not going to disappear. Spending more money on educational material aimed at young/teenagers to stem homophobia, offering more support to ‘out’ doctors. [105]

Maybe gay women need a little affirmative action. There’s a certain appeal/ease in dealing with people of like persuasion (so to speak) so maybe some dissemination of networks and information made more accessible. [165]

Every medical person must accept that gay isn’t a disease. [19]
Look at the language on health leaflets, etc. Remove all references to husband/wife. Look at images of couples; some could be same sex. Forms for completion should be reviewed to ensure questions, options and language used is inclusive. Doctors and other health professionals training should include how to ask open or inclusive questions rather than heterosexually based. [25]

Change the language they use; don’t make assumptions. Make it socially and emotionally safe. [73]

Partner issues in critical care situations are often ignored, e.g inclusion of partner in health decision-making. [134]

A previously heterosexual woman who has recently come ‘out’ as a lesbian commented:

The health workers have little to no understanding about married women who change to lesbians in later life. I wish more research on this issue could be done so women like me could be better understood
and respected for our choices. I prefer not to out myself unless I am sure that I will be accepted and treated with respect. [129]

And similarly:

More research – perhaps there are many areas in which we have different needs and research might assist in this. [125]

A minority of lesbians in this study held vastly different views and did not believe that homophobia was a big issue. These responses, although small in number, present an interesting and opposing view. They include:

Yes there is always room for improvement. I do believe that it’s better to be seen by your own gender rather than by [sexual] preference – who cares who I sleep with? [142]

And another woman explained:

Homophobia is alive and well but I also said and think that health services are equally discriminating against men and women. I’m not sure that they target or deliberately discriminate against homosexuals because that’s what they are. I believe the health services discriminate across the board – both men and women. [170]

It must be pointed out that both these lesbians were previously heterosexual and were not ‘out’ to their health providers. As a result of not disclosing their sexual orientation they are likely to be assumed heterosexual and therefore unlikely to experience homophobia. Both participants did not see any need to disclose their sexual orientation to their health professional. In an interview, Janet explained:

I go to my health provider with medical issues that are not exclusive to my sexuality. Women’s health issues are women’s health issues irrespective of [sexual] orientation. Lesbians are women first and lesbians second. Any improvement in women’s health is always good news. [170]

Janet wrote on the questionnaire that she has identified as a lesbian ‘all of my life but out to myself and some people for 17 years.’ [170]

Similarly, the other woman wrote:

I don’t see a doctor very often and it’s for this reason that I am not ‘out’. I see the doctor as a woman not as a lesbian. [142]

These responses may either indicate the presence of a degree of internalised homophobia or the fact that these women are not aware of these issues. I also asked my study participants about preventative health behaviours. As other studies have
demonstrated, lesbians are less likely than heterosexual women to seek routine preventative health care\(^{84}\) (Stevens 1992; Bradford et al. 1994; O’Hanlan 1995; Diamant et al. 2000; Koh 2000). Questions relating to preventative health behaviours in this study were restricted to Pap tests and BreastScreen\(^{85}\). Results from my questionnaire provide new information regarding an Australian sample of lesbians and their health seeking behaviours.

Fifty-eight women (50 percent of total participants) in this study were fifty years of age and over at the time of completing the questionnaire, and therefore eligible to attend the National Program for the Early Detection of Breast Cancer (BreastScreen). Out of an eligible population for BreastScreen, almost one-third of lesbians were not accessing this service (32.7 percent). These results are similar to those published in larger, international studies. As lesbians are considered a possible higher risk for breast cancer, this finding may have significant implications (see Chapter 6.5.2).

In relation to cervical cancer, studies have shown that the interval between Pap tests is nearly three times longer for lesbians than for heterosexual women (O’Hanlan 1995; Gruskin 1999). In my study, however, an unusually high number of lesbians were having regular two yearly Pap tests. Seventy point six percent of women (n=82) reported having two yearly Pap tests, whilst 29.3 percent (n=34)\(^{86}\) reported not having Pap tests at all. This inconsistency with the international data may reflect the higher educational level and/or the fact that many women in my sample are employed in the health care industry (75.4 percent tertiary educated and 39.4 percent health workers).\(^{87}\)

I also asked participants to rate their overall experiences of the health system and gave them the options of: good, average, fair, excellent, less than satisfactory, poor, or other. The following Table 7.5 presents their responses.

\(^{84}\) The issue of women’s health screening and the increasing medicalisation of women’s lives requires much further discussion and exploration. However, this is beyond the scope of this thesis and a different topic. For further information see Batt 1994; Klein 1989; Klein and Dumble 1994; Greer 1999; McKee 1995; Oakley 1998; Worcester and Whately 2002.

\(^{85}\) See Footnote 43, p. 72.

\(^{86}\) Sixteen of these women had hysterectomies.

\(^{87}\) I did not follow up why lesbians in this study are more likely to have Pap tests than mammograms as it is outside the topic of this thesis. It is, however, an intriguing finding and it would be interesting to find out if these tendencies/discrepancies could be verified in a larger study of lesbians.
Table 7.5: Participants’ Experiences of the Health System

<table>
<thead>
<tr>
<th>Rating</th>
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<tr>
<td>Good</td>
<td>52</td>
<td>45</td>
</tr>
<tr>
<td>Average</td>
<td>26</td>
<td>22.4</td>
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<tr>
<td>Fair</td>
<td>11</td>
<td>9.4</td>
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<tr>
<td>Excellent</td>
<td>9</td>
<td>7.7</td>
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<tr>
<td>Less than satisfactory</td>
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<td>5.1</td>
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<tr>
<td>Poor</td>
<td>5</td>
<td>4.3</td>
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<tr>
<td>Other</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>116</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

As illustrated, less than half of the participants in this study indicated that their experiences had been ‘good’ (45 percent). Almost one-quarter replied ‘average’ (22.4 percent) whilst only 7.7 percent said their experiences had been ‘excellent’ (n=9). Less than ten percent (9.4) of the participants ticked ‘fair’ (n=11) whilst 4.3 percent indicated their experiences had been ‘poor’ (n=5). Five percent of lesbians in this sample remarked that their experiences of the health system had been less than satisfactory (n=6) and 6 percent ticked ‘other’. Although this is a subjective rating of personal experiences of the health system, the findings have implications for health providers and health services generally (see Conclusion).

Women were given the opportunity of writing additional comments on the questionnaire about their experiences with the health system and many took up this option. These added notes were mixed in terms of negative and positive remarks. A Registered Nurse who indicated that her experiences of the health system had been ‘poor’, wrote:

*Despite above [poor experiences] there have been some wonderful health professionals who have challenged their internalised homophobia since I have known them and with whom I have experienced healthy professional relationships – not all women I must say.* [1]

Other women wrote and spoke of the sense of surprise and shock experienced when a health professional appeared to be working outside of the ‘usual’ heterosexist framework.

*I was shocked once when a doctor asked me if I had ever been heterosexual! I later found she was a lesbian but this is the only*
example [her emphasis] in all my experience when such a question was included at an initial consultation. [72]

Kate, in her interview, shared a similar experience. Kate lives in a rural community where there is a shortage of GPs generally and a shortage of female GPs, in particular. She explained how the medical practice she visits has ‘closed its books’ to new patients and will only see people who reside in the immediate area. Kate told me how her friend who lives in a nearby town wanted to see the local female doctor but did not have a local address. Kate explains:

A woman that I recently met who is straight and lives down the road wanted to come up to that surgery because she wanted a female doctor. All the female doctors in *** had closed their books because they all work part-time but you had to have a local address. I said she could use mine and anyway she got in. I saw her and she goes, ‘oh I saw this doctor’ and I go, ‘yeah I heard she’s really good’. ‘Oh she actually asked me a very strange question’. The two of us were just sitting there and we go why? She said, ‘oh she asked me was I heterosexual or homosexual? Why would she ask me that’? And we went, ‘that’s fantastic’ and she just didn’t get it. She was really offended. So the other woman that was with me was straight and her and I both went on about why she would’ve asked that. We talked about lesbian health and Pap Smears and Breastscreening and blah blah blah and she had no awareness whatsoever what it was like for lesbians. [44]

Such open-minded health professionals unfortunately appear to be the exception rather than the rule. This female doctor was a locum filling in for a short time from the city. Attitudes and questions such as these asked by doctors, will contribute towards eliminating homophobia and may lead to a better quality of health service for all.

A woman who indicated that her experiences with the health system had been ‘down right disgusting’ wrote:

Misdiagnosed and under-serviced due to being fat. Fobbed off as a depressed neurotic for being assertive and not accepting their word as law. Fat, female, lesbian and over fifty all affect my experiences. I have a lot of anger about how I have been treated over the years. I’m still sorting through it all. [43]

Another woman remarked:

Generally I’m a confident, assertive, informed user of health systems and been well responded to across several interactions with western medicine. If my lesbian identity has been known, it has not in my eyes,
impinged on how I've been treated. My experience has generally been
good but I've had good control over how I interact with it, never
having been seriously ill or reliant on health providers for big stuff.
I'm not as sure about safety as a lesbian if I were seriously ill. [5]

In summary, many lesbians in this study commonly experience homophobia in their
interactions with health professionals. Lesbians frequently consult a range of health
professionals according to their specific preferences and health conditions. The data
indicates a range of views and experiences; however, there exists a general level of
dissatisfaction with the health system. The only way to not experience homophobia is
to remain in the closet and therefore, invisible. Many lesbians in this study are
frequently challenging homophobia, at both a personal and professional level in their
working as well as their private lives. Clearly, the information generated in this thesis
has implications for health service providers in order to improve the quality of health
care that is presently delivered to many Australian lesbians. The following section
will present some other issues that lesbians in my study identified that have not been
documented elsewhere in this thesis.

7.6 ‘There are Always Different Issues’: Lesbians’ Unique
Experiences of Menopause

In this research project I was keen to discover if there were any issues that were
unique to lesbians at the time of menopause. I also wanted to know if lesbians in this
study believed their experience of menopause had been affected by being a lesbian.
Fifty-eight percent of participants agreed that there were different issues for lesbians
at this stage of life than for heterosexual women (n= 67). Forty-seven percent of
participants indicated that being a lesbian had affected their experience of menopause
(n=55), whilst forty-six percent (n=54) believed that their sexual orientation had not
affected their experience. Six percent of participants were unsure or did not answer
this question (n=7).

Despite the fact that over half of the participants believe there are different issues for
lesbians at menopause, these issues are not acknowledged nor understood in
Australian society. In this section I will discuss some of the issues identified by many
of the lesbians in my study that have not been addressed elsewhere. The
questionnaire and interview responses have been grouped under the following
headings and will be discussed accordingly. The differences lesbians identified in
this study relate to:
Emotional support and understanding
Reproductive issues – loss of fertility
Sex and sexuality (see Chapter Four)
Health services and treatment

Emotional Support and Understanding

In this study, 46.3 percent of lesbians with partners indicated that their partners were also experiencing menopausal related changes (n=38). This shared menopausal experience between partners is a phenomenon unique to lesbians. Many women commented on this aspect and wrote of the level of understanding and support that this shared experience brings. Questionnaire responses include the following comments:

I think that the lesbian community would provide the atmosphere for sharing about menopause that heterosexual women may not have. Having a woman partner and lesbian friends makes it so normal to talk about it and not only talk about it but understand from a woman's point of view. I can't imagine a heterosexual woman in menopause would get the same support and understanding from a male partner. [28]

More understanding from partners and friends. No ridicule or jokes by men. [16]

My cycle coincides with my partner's cycle and there is greater understanding from my partner who has experienced her own symptoms. [172]

I imagine it could be different in that two lesbians in a relationship going through menopause together could discuss their 'symptoms' or what they've personally noticed in more immediately empathic ways. [210]

There are two of us in the same household going through the same symptoms. It has affected our relationship. [33]

During the interviews, many participants mentioned the level of support they experience from their partner and/or lesbian friends. Anne explains:

I think we are more sensitive to each other because we go through the same process as our partner so we’re more understanding of what’s going on and I think we certainly discuss issues much more. I think we’re certainly more alert to ourselves and we talk about it to our partners and lesbian friends. I don’t think this happens to the same degree with heterosexual women, let alone with their partner and if
anything, it seems like among some of my heterosexual friends that they've been really timid in wanting to even discuss it. [81]

Jill also talked about the shared experience and level of support she and her partner receive:

Well I think that one of the major things is that we both understand what the other is going through, that there is a similarity of experience that neither is going to be surprised or shocked or bothered or worried about the symptoms that the other one is experiencing. My partner and I are both menopausal; in fact we were in menopause when we met. Now the main symptoms are just the hot flushes, primarily, which in the night the two of us will be hot flushing simultaneously or at different times. Both of us, I mean, we are in the middle of a hot flush ... it is quite an obvious thing and we can be flinging off bedclothes completely. It can be quite amusing really. [58]

Whilst many of the questionnaire responses were positive and mentioned the benefits of having a supportive female partner, other participants wrote of the loneliness and sense of isolation they experience at this time in their lives.

A woman wrote:

Very little support is available to women who are openly lesbian. [164]

Similarly:

Some lesbians may not have family support during menopause particularly those living alone. [129]

Since I've come out I'd had no contact with my biological family so I don't know what happened in my mother's menopause. Having lesbian friends to support me and talk about the issues is a help. [45]

Another woman explained:

Being a lesbian is actually a lifelong predicament in a heterosexual patriarchal society. However, as a single, childless, middle-aged woman, I believe I face the same issues of isolation and hormonal discomfort as heterosexual, childless etc women. [21]

Other women wrote and spoke about the degree to which menopause is discussed amongst partners and lesbians friends and, as already mentioned above, some suggested that this may not be the case for some heterosexual women. Sulo [26] explained how she and her friends talk candidly about menopause, yet notices that in her work place and amongst her heterosexual women friends, there is more of a
reluctance to discuss these issues openly and informally. In an interview, Annie commented:

*When friends come around for a meal or whatever, menopause will certainly come into the conversation on a regular basis along with retirement and lifestyle choices. It wouldn’t be something that in my community of friends that we’d shy away from or feel as embarrassing or something not to be nutted out. I think we are very open with each other about these things. For myself it started back in consciousness raising groups where we talked a lot about sexuality and sex and part of the buzz of the CR era was the openness and bravery to talk about things that had never been talked about before. Certainly we had been conditioned not to talk about it. [131]*

Leah shared with me how having a lesbian lover enables her to talk through issues that are often considered too intimate to discuss with friends or family.

*I have always been able to discuss all intimate things and shadow stuff as well. I thought this was the norm until I started to discuss some of these things with my heterosexual friends and sisters. They were shocked and envious that I have been able to talk about so many things to my partner. [218]*

Pat also described the level of understanding and empathy that she and her partner experience in relation to menopause. During an interview she told me:

*My partner and I were talking about this the other day. She’s going through hers now, she’s behind me because she’s younger than me and she was saying she felt good and I felt good because I knew exactly where she was at. Even though I know everyone is an individual and they have their different experiences, she felt that I knew what, and I felt that I understood, as much as possible, without actually being her, but that doesn’t happen with a man because they can’t. No matter how much you talk, how open you are, how comfortable you feel, it isn’t the same because they can’t. It is just not part of their thing at all. [174]*

For many lesbians in this study, the level of support and understanding gained from their partners and lesbian friends was a feature they identified as being a different issue for lesbians at the time of menopause.

➢ **Reproductive Issues - Loss of Fertility**

The issue of loss of fertility was a common theme raised throughout many of the questionnaire and interview responses. Less than half (47.4 percent) of the participants in this study have their own biological children (n=55), whilst 52.5 percent do not have their own biological children (n=61). Almost 15 percent of women in this study indicated that they co-parent a child and/or children (n=17). I
did not ask if the children were the result of previous heterosexual relationships or not.

Although more than half of the participants in this study (52.5 percent) did not have their own biological children, there was a clearly expressed view that loss of fertility was not an important issue for the majority of participants. Many lesbians explained how they rejected the notion of being past their reproductive ‘use-by’ date and did not view menopause as a time of loss. Several women in this study identified fertility issues as one of the major differences between lesbians and heterosexual women. If the topic of fertility was mentioned on the questionnaire, I followed it up in the interview. Some typical questionnaire comments include:

*I think lesbians have a more positive attitude in that they don’t see it [menopause] as an end to fertile life so much as a new stage in life.* [14]

*For lesbians who are childless, being past childbearing is of no consequence. Losing your attractiveness to males isn’t within our reality and menopause, a sign of getting older, does not bring the same fear as hets would feel. As a feminist lesbian the experience is a positive one.* [81]

*Lesbians are not a homogenous group, nor are heterosexual women, but most lesbians won’t have issues with changes in fertility. We could expect to have greater opportunity to discuss any issue with our partner and other women in our community.* [67]

The interviews enabled participants to expand upon their thoughts and explain their views in further detail. For Joy, ‘bleeding and periods is about having babies’. In an interview, Joy spoke about this connection and how it did not apply to her:

*From my way of thinking, bleeding and periods is about having babies and once that whole phase of life has passed (I didn’t give birth, I fostered a child) it was such a long haul basically thirty years of bleeding. I was so glad when I stopped because I wasn’t going to have a child so I would have liked the periods to stop earlier. Yes so I thought it is something to celebrate and I would have liked, you know how when you get the period it is a sort of celebration, so I would have liked the same sort of feeling around it, that we could have a bit of a party because I had stopped bleeding. It was so fantastic! Yes I was a little bit excited because I had stopped. All that stuff between your legs, it was like wearing nappies once a month for thirty years!* [68]
Nathalia remarked:

*I'm not at all worried about being infertile. I've never had the impulse to have children at all, even though it's true that some lesbians seem to have that impulse*. There is a lot of pressure on heterosexual women to have children and I've heard them talking about the fact that time is running out but I've never actually had the desire to have children. It's absolutely a non-issue for me that I am becoming infertile. I don't see menopause as a transition into some negative stage of being. I guess that's partly connected to the fact that I didn't want to have children and so I see the menstrual cycle as a bit of a waste of time and energy because why bother if you're not going to have children? [163]

Leah had a similar opinion and explained:

*For me, every single book I've picked up dealing with the change of life was obviously written by a heterosexual woman, maybe not obviously, but appeared to be a heterosexual woman writing about what would happen for heterosexuality and a lot of emphasis was put on the fact that a lot of women would start grieving because they were no longer fertile, the end of their childbearing years. Now I find that quite interesting because I chose not to be a mother and the emphasis for me was never on child bearing. It just really has surprised me how for many heterosexual women so much emphasis was put on the end of childbearing and fertility.* [218]

Anne shared these views and stated:

*I know that lesbians do have children, but for a lot of us, that isn't part of what we see. Certainly for heterosexual women, childbearing is a key factor and I know many who have been distressed by getting to menopause for exactly that reason. They feel that their capacity to have children is no longer there and even some situations where I've seen women who function in relation to their male partner and losing their glamour looks is part of it too. So you become at menopause, this non-childbearing and also this thought that you're going to become a wizened up old prune and disintegrate physiologically at the same time and you mightn't be available so turned on for sex either so all of these things are fairly worrying. For lesbians, the pressure isn't quite the same I don't think. We see how we relate to our partners in a different way and it's not as a function of childbearing for the other partner as if we were in a relationship with a man, so it doesn't have the same pressure for the lesbian as it does for the heterosexual woman. It's really quite threatening for heterosexual women to be thinking that they are getting to this stage and they don't even... it seems a very frightening thing for them, to discuss it with their partner or friends as well.* [81]

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88 Many lesbians in Australia are presently attempting to conceive by In-Vitro-Fertilisation (IVF) and Artificial Insemination. When presenting preliminary findings of my research at an international conference (Kelly 2002) a delegate suggested that in twenty years as many more lesbians will have babies or had babies; hence lesbians' views of loss of fertility through menopause might be different.
Andie expanded upon this viewpoint with a feminist analysis of this issue:

Because we are all girls born into patriarchy and young women being raised in patriarchy, we are loaded with the expectation that we will bear children and that we will bear them for the sake of their fathers and for their inclusion in patriarchy. So having a child, or children, is considered natural and inevitable for women, the word ‘instinctual’ is sometimes used. And that is simply not true, because if it were true, if it were instinctual, every woman would be completely biologically driven to have a child, and not every-one of us is, so it is not instinctual. We are not far enough along, in the women’s revolution, or in having separatism for women, to have any idea at all which of us would have children and which of us wouldn’t, and how many we’d have or anything else, because we never yet have had a time when it has been truly a free choice. I would imagine that in a time of real true choice that some of us would and some of us wouldn’t. And that some of us might give birth but not raise a child, because her biology insisted that she do that but she wasn’t, let’s say, socially equipped to raise a child. Others might want to participate in raising a child, or having a child around for a period of its life, or a period of our life, but not actually birth one. And that if we were left completely to our own devices we’d probably work that out. And some of us might raise children in groups, and some of us might pair off with one, the same way we do our sex, or our work, or anything else. Also now especially, since it’s a little safer in at least western, white countries to come out as a lesbian earlier, we are able to make a little more choice as to whether to have children or not. So when it comes to menopause, the key factor for us as women is not whether we continue to have children or not. The key factor for us is, given these changes in my body, how do I function, grow, develop? Women are hurled into despair because they can’t have children anymore. That is entirely a male concept of our value; it is not our idea of what makes us valuable. So menopause is supposed to be this horrible time when you lose your entire reason for being and the entire rest of your life, you’re a drag on society because you are no longer childbearing. I think that lesbians can get this perspective a little quicker, because in whatever measure it is, by the very fact of being a lesbian we have removed ourselves that much from patriarchy, and that much from male domination. [7]

Whilst Andie’s articulate point of view clearly reflected the majority of lesbians’ views in this study, approximately ten percent of lesbians in this study held opposing viewpoints. One woman commented in the questionnaire, ‘often there is grief over no children.’ [221]

And two other women wrote:

Because of our ‘psychological infertility’ to use a current phase, I do not feel we are able to mourn the cessation of our periods. I also do not think issues surrounding decreased libido are taken seriously. [128]
Possibly less lesbians have had children and now at menopause may be a crisis of baroness [sic]. [118]

Karla was still grieving for her child that died more than thirty years ago. During an interview, Karla shared her pain and sadness with me. She had a child at 19 years of age who died and a total hysterectomy at age 34. Karla described how difficult it was for her to have a hysterectomy at 34 and ‘close the door on not being able to have children forever.’ She told me how at menopause many women are losing their own mothers, but she believes having your own children and possibly grandchildren, allows ‘this sense of having something to continue with.’ Karla pointed out:

To have ... I hate to say it, but I say it in inverted commas, sort of ‘fulfilment’ you know, if you haven’t got the wherewithal to have children, at least you’ve had them and your kids have got kids and it carries on you know, this sort of continuity story. Somehow that makes up for it. So being childless is very, very difficult. [156]

Sadly, Karla did not find any solace from organisations that provide support to lesbians who have experienced stillbirths or neonatal deaths. According to Karla, most of the women attending these groups have other children and even if they don’t, they are definitely not lesbians. She concluded this discussion with the following statements:

I’ve never actually met, and I’ve met a lot of lesbians, any lesbians in my position at all and that’s very sad. That would be really good. I’m always looking for a lesbian who has lost a child and doesn’t have any other children. Perhaps I should advertise in LOTL89 [laughter]. It’s all very complex and complicated for me. [156]

At the time of interview, Karla stated that she is enjoying the company and love of her partner’s adult children.

➤ Health Services and Treatment

In response to the question ‘are there different issues for lesbians at menopause’ one of the most commonly cited difference related to health services (see Chapter Six). Many lesbians wrote in the questionnaire about difficulties they encounter when seeking medical assistance/information such as:

I think the difference would have to do with medical assistance where the assumptions would be that the lesbian is heterosexual and she would be questioned on these assumptions. [28]

Yes [there are differences] only about the sex and how we deal with our pride and tell our doctor about our lifestyle is then a problem

89 Lesbians on the Loose (LOTL) is a monthly lesbian magazine published in Sydney, New South Wales, Australia. It publishes 20,000 copies monthly and has a readership of 54,000.
being gay. I feel pushed aside, left out, being gay is bad to some doctors. [157]

Yes these different issues relate to discussions between doctor/patient [about] libido problems, dry vagina etc. and the implications for sexual relationships. Lesbians have the added pressure/discomfort of correcting assumptions of heterosexuality and that they are probably in a heterosexual relationship. [192]

We invariably need to talk about our partner or the doctor asks about type of relationship, mood swings, painful intercourse etc. [12]

Yes there is a different kind if communication with a woman partner and different discussions with health professionals. [25]

Another theme that emerged during the course of the interviews was that of repressed memories surfacing at the time of menopause. One participant shared with me her 'theory' of lowered sexual desire at the time of menopause. Andie explained how she believes that many women often experience flashbacks and vivid recollections of repressed, painful memories at the time of menopause:

When we start menopause our system begins in effect to gear down. So here we are in pre-puberty and our hormones went like this ↑ and then they went like this → and now [at menopause] they are going like this ↓. At some point we reach the pre-hormonal upsurge so in effect our endocrine system goes back to a pre-pubescent stage. We have biologically, chemical, electrical access to a state of being that we haven’t had in the interim. I think that’s one reason that menopausal women especially at the very beginning of menopause experience an increase in flashback and childhood memories. Not only memories of incest and brutalisation, but memories of what it was like to be with your own gender. [7]

Although only one participant mentioned this issue, I decided to explore the matter in greater detail. I conducted web searches for further information on this topic but did not find any supporting data. I consulted a counsellor/advocate from a Centre Against Sexual Assault (CASA House)90 who urged and encouraged me to ask this question to every woman I interviewed. Annie’s response to the question of repressed memories was similar to Andie’s:

Any changes in your body can bring stuff up. I think menopause makes you think about puberty, famously enough. I was reading the book, Woman by Natalie Angier and she was talking about how at menopause your genitals start to shrink back and I suddenly thought,

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90 CASA House is a centrally located Centre Against Sexual Assault in Melbourne. It provides services to victim/survivors of sexual assault, support and consultation for friends, non-offending family members and other professionals.
‘gosh maybe my genitals have shrunk back’ and they had and I hadn’t noticed. She gives a very graphic description of how they’ve changed shape and go back to a kind of pre-pubescent shape. I’m talking about the labia particularly. I just hadn’t kind of checked, you know it just happened and then I thought about all the stuff around when I was pubescent and you know how extraordinary and shocking it was that my genitals changed shape and suddenly I had these labia and like a lot of young girls I was really worried about them, really, really worried about their size and shape and were they normal? Suddenly they’re not there anymore and I had a huge panic that they’d slipped away without me noticing so that bought up lots of memories about body changes and in the same way that at puberty things suddenly happen and you know you don’t kind of notice them happening. And then I felt a bit sad ... it was like I’d lost something. [131]

The majority of lesbians interviewed told me how menopause/midlife was a time of reflection; reflecting upon past decisions, actions and behaviours, however, most women did not report a direct link between menopause and memories of earlier abuse and/or incest. Several women told me that they had dealt with matters of incest and other forms of abuse earlier in their lives. I asked Leah if she thought menopause was a time when repressed memories surfaced and she responded:

*It most certainly does and I have wondered if it’s because you start looking at life in a bigger sense. The complexities, the simplicities all of these things you suddenly realise there are massive contradictions and things are not as straightforward as you thought they were. I have found that I have been remembering incidents that were from my very early childhood and thankfully having my mother here at Christmas, I was able to have a reference base to go back to. Sometimes she was quite shocked at what memories were coming up for me, especially as they were from a very young age. I am not sure why this is happening, maybe it is part of the mellowing process where the intensity of having to be so perfect, so good etc are being removed from us that we now have time to recall things pleasant and unpleasant. Maybe as one gets older you relax more.* [218]

Elizabeth informed me that she had done a lot of self-reflection at the age of 38 when two people close to her died suddenly:

*Maybe when you have a life stage change that can happen as well but it hasn’t been the case for me. Some people feel it as a sense of loss of their reproductive years but I really do see it as a life stage and this cycle of life that you go through.* [168]

Kate explained it in the following way:

*I wonder if it’s just a combination of growing older and being deeply reflective knowing that it’s passed and also too often it’s not unusual for a lot of women during that age period to also experience big changes in their life. Like relationship break-ups or loss of job or*
status or whatever it may be, which I think makes you deeply
reflective because a period of your life has passed and you can never
again have it back ... I don’t know if it’s repressed memory or just
allowing life experiences to come into the foreground of our lives.
[44]

Merle thought that perhaps menopause/midlife might be a time where women now
have time to be reflective. She remarked:

I think that perhaps it is a time when you actually do look back and
maybe think about things that you haven’t had time to think about
before perhaps. I think you do start to cast back and you do start to
think about your origins, maybe your family and maybe your
childhood. [212]

Only one participant spoke of a direct relationship between recalling her memories of
incest at the time of menopause; I believe this is an issue that requires further
investigation (see Recommendations in Conclusion).

Another unexpected theme that emerged throughout the data collection phase was
that many women appeared to ‘come out’ as lesbians around the time of menopause.
Although I did not ask women if they had been in long-term heterosexual
relationships prior to coming out, several participants readily shared this information
with me by writing on the questionnaire, or discussing this issue in the face-to-face
interviews. As this was not a standard question, I do not know exactly how many
women were previously married and therefore cannot draw any conclusions as to
how previous heterosexuality may have impacted on their sense of self and
wellbeing. The responses, however, do reveal common themes amongst women who
were previously married and have ‘come out’ in midlife. Many women spoke of the
feeling of having been controlled and not wanting to be controlled any longer. For
some of the participants, it appears that menopause - or middle age - gave them
permission to at last do things for themselves. Merle saw it as if she were now
grown-up and no longer had to toe the line. I include Merle’s comments in full as she
articulates a general feeling about the possibilities of midlife/menopause expressed
by many other study participants:

I think I just started feeling that this wasn’t what life was all about
and there was something missing. I didn’t want to be straight
jacketed. I didn’t want to feel what’s the word, not oppressed but
controlled. So I started feeling that I actually wanted to take more
control over my own life and that’s when I started to do things. I
started to do more things on my own even though my husband really
disapproved and he didn’t like my friends. I didn’t really have any
friends, most of my friends were our friends so and if I did make a friend, he really didn’t like it and I started to think well this is ridiculous, I’m a grown up woman. I’m not a kid anymore. I don’t have to be controlled by my parents or, ‘coz my parents were quite strict so I had a very strict upbringing. I’ve always felt that I sort of toed the line and I got to the point where I felt I didn’t want to toe the line anymore and that happened way before I realised I was gay. I did have close friendships with a couple of women and he really objected to that. It was actually when my daughter was a baby that I started not wanting to be, physically not wanting to be close with him anymore which I found really strange and I couldn’t understand why actually but it was very soon after Belinda was born, she’s the younger one and ... err... it’s taken a long time I got to the point where I really and truly just wanted to be on my own and be able to control my life myself and I think possibly the menopause just going through that time when I ... I guess I get frustrated really easily clearly in this hot cold hot cold thing you can’t tolerate much and I think my tolerance level was really low and we just came to the point where we thought, right well look we’d better split up right now rather than hang on until the kids finish year 12, so we actually split up while my son was in year 12 which was hard on him but he still did very well. It was very difficult but it really was the best time and I really think if I hadn’t been going through that menopausal stage, I probably would’ve put up with it until later and then done something but I just got to the point where I really had to change my life and then I discovered after that, it was about two years after we actually split up that ... um ... I ... I sort of fell into this relationship with a woman and sort of discovered, goodness gracious that’s why I didn’t want to be with him! I think in as much as it’s a change and it’s a change of life and I really wanted to get away from being controlled. I just didn’t want to be controlled any more in any shape or form and I ... I sort of felt really guilty because I thought this is very selfish of me, ... um, ...and ... um ... I’m disrupting ... I’m destroying the whole family because of my selfishness but I couldn’t help it ... it was something that I had to do. As far as the menopause and the lesbianism is concerned, there sort of isn’t really a direct relationship but, um, there certainly is one. It’s just this whole complete change of life and really wanting to really find out I guess what I was all about ‘coz I’ve always gone through life thinking I don’t really know what I want, I don’t really know what I am, you know I’m an off shoot of my parents. I’ve sort of gone along with my husband ever since we’ve been together and that sort of thing. I never really found myself. I still haven’t but I’m getting there, yeah it takes a long time. [212]

Participants frequently shared with me how menopause or midlife was a time where they reviewed and reflected on the ‘choices’ they had made in the earlier part of their lives and told me how they were now able to make different decisions. For some of the women in my study, this meant coming out as a lesbian. As Pat explained it:

So you are doing what other people expect of you and then there comes a time when you think, ‘hey who am I really because I can’t be
all things to all people that they expect me to be now who really am I?' I'd always been to everyone else and never been to me, you know as the song says. I think there comes a time when most people do that. I think probably particularly women, and I think because things happen in people's lives that make them do that. I chose to work out who I am and sort it all out and I think that you don't do that personal growth work because it's really difficult, it's hard, challenging but it's also life changing and it's the most fantastic thing. But people don't usually do it unless something comes along in their life that makes them do it. Sometimes that's having babies, sometimes it's having a marriage breakdown, some usual thing that makes you think I really have to do something because I can't stand it how it is the way I am. Menopause might be one of those things for some women. This is just my belief and I think with me it started happening when my marriage was breaking down and I couldn't do anything about it. Because I believed that marriage was forever whether, whoever you are, whatever you are, but I also believe that you have to be true to yourself and ... arr ... do what, you know.... So I was having a bit of a fight in there about knowing... yeah, so it created me to do a lot of work. And so there I said, 'I don't like this about me because and I'm going to do something about changing it' and that's where that started from which happened, sort of in the middle of the time that I was having early menopause. It came by outside, something stuck up in my life where I thought I had to do something about it. From that I learnt other things so then I thought that once the learning starts you can't ever go back. And it's a very freeing experience so from there I sort of did other things and yeah... here I am ... now a lesbian. [174]

Both these quotes illustrate that lesbianism, like heterosexuality, is not biological, but rather that it is socially constructed (see Introduction). And perhaps, more importantly, both quotes explain the liberating effect of menopause - and of becoming a lesbian.

Summary

Within this chapter I have discussed the findings from my study. They include the general, as well as, unique issues that lesbians frequently experience at menopause. More than half of the study participants believe there are different issues for lesbians at the time of menopause than for heterosexual women (58 percent). These lesbian-specific issues focus on emotional support and understanding, issues relating to reproductive factors and loss of fertility, sexual issues and the experiences of homophobia and heterosexism with health services. Many of these findings have implications for health policy makers, health professionals and mainstream society. Clearly, most lesbians in this study do not experience menopause as a negative life
stage and several view it with optimism and excitement. In the final chapter I present concluding comments about my research and propose recommendations for further research.
CHAPTER EIGHT

Conclusion and Recommendations

The findings of this study challenge the ways in which menopausal women are currently viewed in society at large, as well as in the medical literature and by many health providers. Through recording the views from a sample of midlife lesbians’ living in Australia - and discussing their experiences of menopause - I have exposed, and analysed the implications and consequences of ongoing heterosexual assumptions in research, medicine, the provision of health care services and mainstream Australian society. As pointed out earlier, this study is the first in Australia to examine lesbians’ experiences of menopause. Moreover, I was able to find only two other published studies on similar topics – both from the US. This shocking paucity of research highlights the fact that lesbians are invisibilised within the existing literature and research on menopause and, on a practical level, are not acknowledged as a separate group of women by health care providers.

Both the literature reviewed and the women’s views in my research show that most women, lesbian and heterosexual, experience some physical changes in their bodies at this stage of life. However, it is crucial to note that over half of the participants in this study (57.7 percent) believe that there are different issues for lesbians at menopause from those of heterosexual women. So far these issues have not been acknowledged in society at large, or health care systems specifically. I believe that the study participants’ views and experiences as presented in this thesis contribute significantly to filling the gap in knowledge about lesbians at midlife. I sincerely hope that the knowledge I have generated from this study will contribute in one way or another, to better health care for lesbians.

Importantly, the findings in this thesis also illustrate how for many lesbians, the frequently held negative views of menopause are not true. This is an exciting outcome and one I hope will be confirmed in further research on lesbians and menopause, as it has the potential to contribute to de-stigmatisation and de-medicalisation of this natural transition in lesbian’s lives.

Several of the issues that are widely acknowledged in the mainstream literature as important concerns for heterosexual women at midlife, were seen by many of my
study participants to be irrelevant. These issues include feelings of grief and loss around fertility (pp. 161-162), issues around decreasing libido and the focus on vaginal dryness and subsequent painful sexual intercourse (see pp. 126-127). Instead, many women in this study view menopause as a time of reflection, a rite of passage and a ‘growing up’ time. A percentage of the lesbians stated that they looked forward to the end of their periods favourably, and many greeted their menopause with much optimism and enthusiasm. The medicalisation of menopause (as discussed in the Introduction), so pervasive in the medical and mainstream discourse, was seen as odd at best, and annoying at worst, by the many of the study participants.

8.1 Summary of Findings

8.1.1 Body Image Issues

In terms of body image, the findings clearly indicate that for many participants in my study, perceptions of their aging bodies do not match those commonly held by heterosexual women at midlife as emanating from the literature. Many lesbians in this study have different physical ideals that they strive for than those depicted in the mainstream. As discussed earlier (see Bergeron and Senn 1998, p. 45 in this thesis) a lesbian and/or feminist identity does not guarantee immunity from the heteropatriarchal notion that thin equals beauty in women of all ages. However, findings from my study confirm that in some cases, a lesbian and/or feminist identity does at least provide a buffer to this heteropatriarchal standard. Many participants emphasised their desire for being physically fit rather than dieting or undergoing cosmetic surgery in the quest for a physically attractive and/or thin body. Such a focus on women’s fitness at the time of menopause is lacking from much of the mainstream literature. Prevailing negative views and mainstream attitudes towards aging, weight gain and ‘losing one’s looks’ were seldom viewed as problems for the lesbians in this study.

However, an unexpected and disturbing finding was that some lesbians I interviewed had extremely negative and stereotypical views of lesbians. Celia Kitzinger in *The Social Construction of Lesbianism* (1987), details how studies about members of stigmatised and oppressed groups consistently reveal accounts in which these members accept the majority stereotype. Kitzinger asserts that this ‘acceptance of the normative definition of one’s own deviance has been widely noted’ (ibid, 91).

Although I did not investigate this issue in detail in this thesis, it was an interesting
observation that in the instances where such negative stereotypes about lesbians were voiced, the women concerned had previously been in long-term heterosexual marriages. I would not want to draw any firm conclusions from these findings, as such views were only voiced by two of the women I interviewed; however, I believe this issue deserves further examination and research.

8.1.2 Sex and Sexuality Findings

On the topics of sex and sexuality, the mainstream menopause literature reviews them invariably with reference to heterosexual orientation and sexual activity. Indeed this thesis, in particular Chapter Four, has clearly illustrated how sexual orientation is seldom considered as a variable. Very few studies have included discussions of sexuality, therefore implying that there exists only one form of sexual orientation – heterosexuality. This omission appears especially pronounced when studies are conducted with middle-aged women. When I have personally questioned researchers about the sexual orientation of study participants in their research projects, I have been told that women in these studies are older with the implication that if lesbians do exist they are not middle-aged.1

In terms of sexual practices and behaviour discussed in research studies and the medical literature, sex is once again defined from a heterosexual viewpoint in which sex refers only to sexual intercourse. Conversely, several participants in this study have highlighted the problematic nature of defining sex within such a narrow, heterosexist framework. They have remarked that the depictions and expectations of sexual activities, as commonly understood in the dominant heterosexual culture, are unfamiliar and irrelevant concepts for them. Some others, however, do view sex as it is seen in the mainstream, and have difficulty accepting that sexual activities may extend to anything other than genital contact (see p. 124). Nevertheless, even for these women the focus on dry vaginas and painful intercourse, as it is commonly featured in the mainstream menopause literature, is a misdirected and inappropriate focus. This study highlights the many problems associated with a culture that embraces a heterosexist view of sex and sexuality. Instead, the lesbian participants in

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1I asked this question of a researcher conducting a major Australian women’s health study. She responded that most of the women are over 40 years of age and explained ‘it’s [lesbianism] more common in younger women’ (13/3/99). Similarly, I asked another researcher at a public health forum about the number of lesbians accessing a preventative health screening service and was told that the target age group was 50 to 69 years (pers.comm. March 27, 2003). No-one in the audience challenged the responses of either speaker.
my project offer an alternative, positive approach to that of the medicalised, heterosexual view of sex for women at the time of menopause.

8.1.3 Lesbians and HRT

The question of HRT use by lesbians is an important issue in the light of more and more adverse findings regarding HRT (see pp. 73-78). Because of the previously indicated invisibility of lesbians in research on menopause it is difficult to determine how prevalent the use of HRT is amongst lesbians. Sexual orientation is seldom considered in large studies and as a consequence, it is not known if lesbians use HRT at the same rate as heterosexual women. I found it interesting that in my study only 16.3 percent of lesbians were taking HRT at the time of completing the questionnaire (the end of 2001). As mentioned earlier this is a lower number than figures cited in other larger published studies. In the Women’s Health Australia study, for instance, 23.2 percent of women were taking HRT (Women’s Health Australia 2002, 9). Interestingly, some of my study participants drew a link between the use of HRT and sexual availability and attractiveness to men (see pp. 130-132). I do not know if this is a commonly held view as such information is not recorded in other studies. Clearly, further research needs to be conducted exploring this issue.

8.1.4 Lesbians’ Experiences of Health Services

The strongest findings to come out of my thesis concern evidence regarding lesbians’ treatment by health care practitioners. Throughout, I have shown that the health system - as a microcosm of mainstream society - is based on heterosexual assumptions and that these assumptions have adverse effects on lesbians’ lives. Questionnaire and interview data clearly illustrate the extent of lesbians’ dissatisfaction with existing health services. Disturbingly, over half of the participants in my study experienced homophobia and/or heterosexism within the health system (52.6 percent). Many women revealed that they were unlikely to seek preventative health care due to the homophobic attitudes of many health professionals. And indeed, many health professionals I spoke with during the recruitment stage of this study, acknowledged that they had limited knowledge about lesbian life, culture and health-related issues. Health professionals commonly suggested to me that they believed lesbians need to be more ‘up front’ about their sexual orientation during interactions with health providers. Such remarks may be well meaning but they reveal a profound lack of knowledge of the hostility lesbians frequently encounter when they do ‘out’ themselves – even at the beginning of the
21st century. It is not surprising that many of my study participants stated they thought it was the responsibility of the health provider to be more inclusive and non-discriminating in her/his attitude towards lesbians. Moreover, this study has clearly shown that even when/if lesbian-specific health issues are identified, very rarely is menopause considered. As mentioned above, there exists an illogical assumption that lesbians are usually young women. Thus older lesbians remain triply invisible (as women, as old women and as lesbians).

8.1.5 Lesbian Invisibility

Invisibility has been another central theme identified throughout this study and was one of the most commonly raised issues by the study participants. Almost three quarters (71 percent) believe that lesbians are invisible within the western(ised) medical health system, whilst less than half (40.5 percent) felt lesbians were also invisible in the alternative/complementary health system. As my study has shown, this omission from research as well as health care has serious consequences for lesbians in terms of access to relevant information, and access to, and receipt of, quality health care. Perhaps even more importantly, this invisibility perpetuates the lesbian phobic myth that all women are heterosexual.

Invisibility, I assert, is a powerful tool used by heteropatriarchy to strengthen its power base. Celia Kitzinger and Rachel Perkins (1993) point out that there are valid reasons for fearing lesbians and explain, ‘... if lesbianism is a blow against the patriarchy, the bonding of women against male supremacy, then it is entirely rational for men to fear it’ (ibid, 59). Thus, lesbianism is invisibilised and rarely presented as a valid and alternative expression of identity for women. As a consequence, the dominance of the heterosexual culture remains intact, despite the fact that lesbian sexual activity is reported to be much safer than heterosexual sex in terms of sexually transmitted diseases (Wilton 1995). Similarly, lesbians are less likely to experience long-term harmful effects of contraceptives (idem). Yet this information is rarely presented in either medical or mainstream discourse when discussing safe sex. As lesbian visibility is an irritant at best and a threat at worst to patriarchy, it remains in

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92 Recently I was debriefing with a nurse colleague about a 'safe sex' session she had just presented to adolescents. She was horrified at my suggestion that lesbian sexuality should be discussed as a form of safe sex (notwithstanding the complications resulting from bisexual and queer lifestyles). Many nurses providing sex education in schools commonly share this view.
the interests of heteropatriarchal structures and institutions to keep lesbians hidden and perpetuate the myth that lesbians do not exist. As Nett Hart explains:

In societies constructed by misogyny, the act of loving a woman is revolutionary; loving ourselves as women, loving another woman as a sexual partner, loving women as a social class, undermines the hegemony of male favoritism. To love woman, love womanly, has no social support in heteropatriarchy, therefore it must spring from some impulse within us; it must come from itself. We come to this woman love by a desire that is not socialized (1996, 69).

Lesbian invisibility operates on many levels and in various guises. Examples include failure to provide an optional category for the nomination of sexual orientation on standard medical and health-related forms and census statistics. Inclusion of lesbians in research studies might be considered the most blatant omission.

Throughout this thesis I have highlighted the many ways lesbians are invisible within society. I contend that, unfortunately, the emergence of queer theory and politics is yet another turn to assimilate lesbians into the dominant mainstream culture, and thus continues - and indeed reinforces - lesbian invisibility.

8.2 Lesbians and the 'Queer' Problem

In addition to assimilating lesbians into mainstream, that is, heterosexual culture, there is the further problem of the disappearance of lesbians into gay men’s politics. Queer politics, as described by UK/Australian feminist political scientist, Sheila Jeffreys in Unpacking Queer Politics (2003) is based ‘quite explicitly upon a repudiation of lesbian feminist ideas’ (ibid, 2). Queer politics, Jeffreys points out, erroneously assumes that lesbians and gay men are capable of forming a unified stance based upon common interests. This ignores the fact that the theory and practice of lesbian feminism resulted from the realisation that the interests of women were - and continue to be - frequently excluded in mixed political organising groups (idem). The concept of queer fails to understand how patriarchy continues to oppress lesbians and aims to co-opt women to join a movement that, intentionally or not, furthers the interests of men.

Jeffreys points out that the actual word ‘queer’ is discriminatory (1994, 469). She explains how, in the past, generic words for homosexuality came to refer to men only and cites the examples of the terms ‘homosexual’ and ‘gay’ to illustrate her point.

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92 When I have asked services/organisations to consider a new category on their forms I am frequently told that this inclusion may a) alienate or offend heterosexual women, or b) that it is not relevant.
Whilst queer is regarded by its proponents as inclusive, lesbian feminists see the inclusion of such supposedly ‘transgressive’ or ‘alternative’ sexual lifestyles as problematic. As queer theorist, Cherry Smyth puts it:

*Queer means to fuck with gender. There are straight queers, bl-queers, tranny queers,lez queers,fag queers, SM queers, fisting queers in every single street in this apathetic country of ours (quoted in Smyth 1992, 17).*

This quotation highlights how one need not even be lesbian, or - indeed a gay man - to be included under the umbrella of queer. Queer may include bisexuals and even heterosexuals, as long as their sexual practices are unconventional in terms of straight sexual activity (Jackson and Scott 1996). Similarly, Sheila Jeffreys asserts that queer includes

...all those seen by Rubin as being outside the charmed circle of missionary position heterosexuality. These minorities include bisexuals and others who more clearly defy easy inclusion in traditional lesbian and gay politics, such as transsexuals, sadomasochists, paedophiles. This inclusiveness is seen at a time when the celebration of diversity is valued over any clarity as to political aims and ideals. Lesbian feminists have difficulty in accepting that their form of resistance, their practice of womanloving, is just a sexual practice similar to paedophilia or transvestism (1994, 469).

Julia Parnaby claims that queer’s approach is an appeal to be accepted into straight society, rather than the will to change the existing social structure (1993, 13). She writes:

*Queer is not an attempt to challenge the very basis of the heteropatriarchal society we live in, but rather a campaign for liberal reform to increase the ‘rights’ of the vocal few. For lesbians to be really free from oppression it is crucial that we engage in a struggle for much more fundamental change (Parnaby 1993, 14).*

Parnaby cites the example of the demand by the queer community for lesbians and gays to be allowed to marry rather than questioning the institution of marriage itself (*idem*). Evidence of ‘queers’ wanting acceptance by the dominant culture, is, I contend, widespread. In Australia, the high profile lesbian couple, Kerryn Phelps and Jackie Stricker, created much controversy when they married each other in the US in 1998. In *Kerryn & Jackie: The Shared Life of Kerryn Phelps and Jackie*

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*It is of interest that none of the 124 women who completed a questionnaire self-identified as ‘queer’.*
Stricker (Mitchell 2002), there is an underlying theme of seeking acceptance by the dominant culture. In their biography, Phelps and Stricker want the public to see them as 'normal women' who just happen to be 'gay'. The following quote illustrates this point well:

The filming of Australian Story involved not just the married couple but also Kerryn's parents, her children and Jackie's parents... Shots of Jackie and Kerryn getting Carl and Jaime off to school in the morning like any 'normal' parents reinforced the image of them as a well-adjusted, totally integrated and supportive family. They appeared, in fact to be a gay Australian version of the Brady Bunch and Mother Knows Best all rolled into one. Everyone was smiling, happy, supportive. How could anything be wrong with how they were living their lives? They were wanting the public to understand that marriage between two women involved exactly the same feelings as heterosexual marriage. It was love and commitment, not just sex (Mitchell, 2002, 89).

However, as the findings of this thesis demonstrate so clearly, not all lesbians wish to be viewed as 'normal women who happen to be gay.' The views expressed by many of my study participants strongly suggest that some lesbians do not wish to be mainstreamed – that is, I argue, further invisibilised - in this way. Many lesbians are not looking for acceptance and tolerance by the mainstream; rather they are seeking a transformation of sexual relations in our society (Auchmuty 1996).

UK feminist historian Rosemary Auchmuty explains how 'playing around with gender roles and 'sexualities' does not challenge patriarchal structures' (1996, 207). She asserts that this is due to the fact that masculinity and femininity are not equally valued gender roles in society. Similarly, she contends heterosexuality and homosexuality are not equally valued sexualities. As she puts it:

At bottom, 'gender-bending' merely reinforces existing gender norms by uncritically adopting imagery and behaviour which demonstrate, often in exaggerated form, society's institutionalised power relations between men and women, heterosexuality and homosexuality. Playing at being a man or a heterosexual woman does not alter the way society views (and treats) women generally and lesbians in particular (idem).

Sheila Jeffreys describes queer politics as 'a politics of outsiderhood' (1994, 469). She points out that queer politics accepts and celebrates the minority status of homosexuality. This stance towards homosexuality is in stark contrast to that of

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95 Australian Story is a television documentary series screened weekly on the ABC. It highlights the lives of extraordinary Australians. As indicated earlier (Footnote 83 on p.149), Dr. Kerryn Phelps is a high profile Australian lesbian especially given her position as AMA president from 2000 to 2003.
lesbian feminists who do not regard heterosexuality as inevitable and instead see lesbianism as a viable choice for women (idem). Jeffreys explains:

The lesbian feminist understanding that any woman can be a lesbian implies the rejection of minority status. It symbolises the progressive politics possible in a more hopeful time, one of opportunities for social change and brave thinking that we can only hope may re-emerge in the future. ‘Queer’ politics arises from a time of despair. It represents the Victorian values of the gay community (ibid, 470).

The rationale for using queer is often said to be that many young women do not wish to identify as lesbians and feel more comfortable under the more inclusive term of ‘queer.’ Jeffreys is highly critical of this rationale and reminds us that lesbians as a category do exist, and ‘hundreds and thousands of women choose to live their lives within it’ (Jeffreys 2003, 159). Lesbians’ unique experiences of menopause along with other aspects of their/our lives, I decisively assert, deserve acknowledgement.

Language, I suggest, is another strategy employed by the powerful to keep lesbians invisible within mainstream society. The nature of current ideas of ‘queering’ lesbian existence and reducing it to ‘same-sex attraction’ is, I argue, highly problematic for lesbians. As a lesbian researcher, I am concerned that if the trend of ‘queering’ lesbian existence continues, how will important gaps, such as those identified in this study be filled? If lesbians are not seen and are instead, as Jeffreys predicts, subsumed into a variety of gay men (1994, 471), how will knowledge about lesbians be generated and distributed? That this process is well under way is evidenced by popular texts, common terminology as well as criticisms of academic work that does not reflect a postmodernist approach, such as radical feminist theory and practice (see Bell and Klein 1996 for a discussion of postmodern trouble in academia). Moreover, the recent adoption of the term ‘same sex attracted’ which in octopus-like fashion is quickly spreading its tentacles far and wide, I argue, might lead to the further disappearance of lesbians.86

Susan Hawthorne (2003b) asserts that the term ‘same-sex attracted’ is more acceptable than the term ‘lesbian’ to fearful politicians and bureaucrats. However, Hawthorne writes:

86 This ‘queer’ language has found its way into all areas and disciplines. Recently I was an invited speaker at a women’s health forum organised by a women’s health service. The flyer read ‘A forum for same-sex attracted women.’ Today as I was writing this footnote (May 8, 2003) I received an email promoting another forum (organised by a different women’s health service) ‘for women attracted to women’. What ever happened to the term ‘lesbian’?
Same-sex attraction reduces lesbians to a mechanics of robotified sexuality. It is formalin-covered sex. Sex without fun, without emotion, without joy, without even the vagaries of distrust and betrayal. A clinical term stripped of feeling that does nothing for lesbian politics and cultures (ibid, 13).

A major striking and unexpected finding in this study has been the issue of offending heterosexual women97 (see p.96). According to the mainstream literature, the fear of offending heterosexual women is a valid reason for excluding lesbians. The Women’s Health Australia study (see Chapter Three) and studies conducted with medical practitioners (McNair and Dyson 1999), are two examples of such exclusion. McNair and Dyson’s study revealed how ‘few rural GPs would go to the bother of making their practice lesbian friendly’ (ibid, 12). Lesbians, we might surmise, in the eyes of mainstream, appear to be a ‘bother’.

The justification of excluding lesbians due to a fear of offending heterosexual women, is, I believe, further evidence of deep-seated homophobia. It is, in fact, another way of supporting, maintaining and reinforcing the dominant (heterosexual) culture. Were this rationale to be reversed, one might justifiably ask about the lesbian who is offended and perhaps insulted, every time she is assumed to be heterosexual. This situation, as my thesis has shown, repeatedly happens to many lesbians, particularly older lesbians. Despite the frequency of this occurrence, I have found no evidence that consideration is given to this issue. The right not to be offended appears to be the privilege of members of the dominant culture and certainly not of lesbians98. From this, it may be deduced that the powerful group, the dominant culture (heterosexuals), have more rights than members of the powerless group (lesbians).

Twenty years ago, lesbian feminist philosopher Marilyn Frye (1983) presented a compelling argument for the continued existence of lesbian exclusion which, unfortunately, still holds true in 2003. Frye contends that lesbians are outside of the

97 As an invited speaker at a large national conference (July 17, 2002), I had the experience of sitting with a group of three other women all from the same study. Despite each speaker being introduced by the session chair, the first speaker before giving her paper, made a point of reiterating that I was NOT part of her group and my study was in no way connected to theirs. This, I believe, was a deliberate action to distance my work on lesbians from hers that did not identify lesbians. Clearly she did not want to ‘offend’ or alienate heterosexual women in the audience. I assert this was an extremely homophobic action.

98 See Hawthorne 1998 for further discussion.
conceptual phallocentric scheme and explains how lesbians are excluded from that scheme. She points out how a lesbian is able to see things that those belonging to the scheme cannot see. It is, according to Frye, that which she sees which is the reason for her exclusion. Frye explains:

Lesbians are woman-seers. When one is suspected of seeing women, one is spat summarily out of reality, through the cognitive gap and into the semantic space. If you ask what became of such a woman, you may be told she became a lesbian, and if you try to find out what a lesbian is, you will be told there is no such thing. But there is (Frye 1983,173).

Lesbians, particularly at menopause, as this thesis has shown, are definitely not seen. But they do, most definitely, exist.

8.3 Dual Vision - A Vision for Short and Long-term Change

Throughout this thesis I have highlighted the many unique issues lesbians experience at the time of menopause and beyond. Menopause, as discussed in the Introduction, does not occur in a vacuum and is profoundly related to social context, specifically the increasing medicalisation of women’s lives. The social context in which a lesbian lives, unquestionably affects every aspect of her life, and therefore needs to be considered and addressed and incorporated into analyses of her different life stages. Whilst results from this thesis clearly have short-term implications for health policy makers and health care providers and, I suggest, require immediate attention, I believe the findings have even wider long-term application and ramifications. The broader issues identified by participants, both in the questionnaire and interview data, raise serious concerns about midlife lesbians’ wellbeing and seek long-term strategies for change.

In order to address these larger issues identified in this study, I have borrowed the concept of ‘dual vision’, or ‘two sights-seeing, near and far-sightedness’ from Janice Raymond (1986/1991). In A Passion for Friends, Raymond explains:

Dual vision includes, on the one hand, a keen recognition of the conditions of female existence in the man-made world. This means an acute near-sightedness that sees keenly with the ordinary faculty of sight. Realism of the world as men have fabricated it is necessary to maintain more than ordinary sight - or a feminist far-sightedness - that does not become far-flung or escapist. On the other hand, realism about the conditions of female oppression and the man-made manipulations of female existence in this world may carry us beyond hetero-relational structures, but at the same time there must be far-
sighted thinking and action that suggest where we are going (ibid, 207).

Dual vision thus enables us to see two worlds, one of materialism, that is, the material conditions of women’s lives in the here and now and the other, a hope for a better future, of idealism. The concept of near and far-sightedness, Raymond asserts, is not based on ‘false optimism nor disillusioned pessimism;’ rather it offers hope (ibid, 211). Hope, according to Raymond, allows us to realise that the present situation is not final and that alternatives actually exist (idem). This way of seeing is, therefore, deemed highly appropriate and, indeed relevant for incorporation into recommendations at the Conclusion of this study.

8.4 Near-sightedness: Short-term Vision

The focus on near-sightedness, or short-term vision, in terms of lesbians’ experiences of menopause, include the following demands for positive change:

➢ The inclusion of midlife lesbians in all research studies. Just as gender, ethnicity and at times, class are acknowledged and included as important variables, so too must sexual orientation be included. Funding bodies may need to list sexual orientation as a specific category, in order to encourage researchers to include this variable in their research projects and submit grant proposals in this area of research.

➢ Lesbians, as a separate group of women, must be acknowledged in health services and in society at large. This thesis has illustrated the many ways in which lesbians are invisible, not only within the health services, but also in western(ised) mainstream society. Cultural awareness training, in terms of sexual orientation, needs to be recognised as a priority for services working with women. Health and other workers, as well as lesbian consumers, will benefit from such training.

➢ Ageism is a further form of discrimination that requires special attention and discussion when connected to lesbian phobia and older women. As this thesis has shown, there exists an illogical view even among women’s health researchers (see p. 170) that lesbians are young women. A consequence of this viewpoint is that older lesbians are triply invisible within society.
Findings from this thesis as well as those from other published studies, confirm the need for an improved practice in terms of lesbian-sensitive health care. Health services need to understand and deliver lesbian-friendly health care. This would include the creation of a ‘safe’ environment for a lesbian to come ‘out’ and appropriate responses when she does. Educational resources and programs that are relevant to lesbians as well as heterosexual women must be developed and applied. The assumption of across the board heterosexuality requires constant challenging. Services must be encouraged to examine the benefits of providing specific programs for lesbians.

The medicalisation of menopause requires ongoing and persistent challenging. As this study has shown, many lesbians reject the notion of menopause as illness. The increasing medicalisation of a natural transition in women’s lives serves to disempower and pathologise women and increase their reliance on dangerous drugs. As several participants in this study have discussed, the use of HRT (and androgens and other hormones) may be connected to sexual attractiveness and availability to men. Findings from large international studies, such as WHI (p.74-76), WHIMS (p.76) and WISDOM (p.77) illustrate the dangerous side effects associated with HRT and advise against prescribing HRT for the majority of healthy midlife women. Attention should now be paid to non-pharmaceutical agents, such as strength training, weight-bearing activities, healthy eating and smoking cessation aimed at the prevention of osteoporosis and heart disease.

8.5 Recommendations for Further Research

This study has clearly illustrated the paucity of research conducted with healthy, midlife, Australian lesbians. In order to move from a ‘near-sightedness’ to a ‘far-sightedness’, it is imperative that more research be conducted with healthy, midlife lesbians. Findings from this study have identified numerous gaps in existing knowledge concerning different aspects of lesbian lives. I suggest that through further empirical studies in Australia and internationally, some of these gaps will be filled. As a result of this study, I propose that research be conducted in the following areas:
Lesbians, Midlife and Body Image

As this thesis has illustrated, very few studies exploring the relationship between lesbians and body image, have been conducted with healthy middle-aged lesbians. Much of the international literature includes clinical samples of young college students (see Chapter Three). Many of my study participants wrote and spoke of the importance of physical fitness in relation to questions I asked about body image. Many women commented that a lesbian and/or feminist identity provides some protection against the negative, internalised views of ageing that are frequently held by many heterosexual women. Clearly, more research is needed to explore this issue.

Lesbians and HRT Use

As discussed in Chapter Seven, a smaller percentage of lesbians in my study were taking HRT than in other larger, published studies (see p.131). Several study participants spoke of a possible connection between the use of HRT and sexual attractiveness/availability to men; however, without further studies it is not possible to draw any conclusions from these comments.

The Possible Connection Between Menopause and Repressed Memories

One study participant spoke of her experience of menopause triggering painful repressed memories of incest. Following this disclosure, I asked all study participants in further interviews if they considered menopause and/or midlife to be a trigger for repressed memories. A number of participants indicated that this was a time of deep reflection and, as a consequence, several women noted that they were recalling difficult and often painful memories. I suggest, that further follow-up research needs to be conducted to determine how common such experiences are.

Lesbians Coming Out at Midlife

Many study participants remarked that they came ‘out’ as lesbians just prior to menopause. A number of women spoke of the freedom that midlife brings and the accompanying sense of time for oneself. Some participants stated that menopause /midlife ‘allowed’ them to come ‘out’ (see Chapter Seven). Further studies need to incorporate ages at which lesbians came out and identify factors that assisted them in this process.
Previous Heterosexual Lives

Whilst I did not ask study participants if they had been in previous long-term heterosexual relationships, several women freely shared this information with me. An interesting and unexpected finding was that two study participants (both of whom disclosed that they had been in long-term marriages) expressed extremely homophobic comments concerning lesbians, and appeared to believe negative stereotypes of lesbians (see Chapter Seven). Whilst I do not wish to draw any conclusions from such a small number, I believe this issue deserves further follow-up research.

Lesbians’ Health Seeking Behaviours

As I have illustrated throughout this thesis, very little Australian research has been conducted on lesbians’ health seeking behaviours. Lesbians, in this study, were likely to have regular Pap tests for the prevention of cervical cancer, however, they were less likely to have mammography screening for the early detection of breast cancer. No explanation can be given for this inconsistency (see Chapter Seven). Presently in Australia, the Cancer Registries do not identify a woman’s sexual identity. This, I assert is problematic. Research that explores lesbians’ health seeking behaviours and experiences of their interactions with health professionals, would provide valuable data that is presently unavailable.

Even when these recommendations are implemented, I argue that this is within a short-term, near-sighted vision only, and a longer-term vision - far-sightedness - is needed. Indeed, there is a potential risk that these near-sighted changes may lead to mainstreaming of lesbians into ‘heteroreality’ (Raymond 1986) and thus, ultimately might contribute to further invisibility of lesbians. The use of new queer language, such as ‘same-sex attracted’ and pleas by the queer community to be accepted by the mainstream are, as discussed earlier, examples of this move toward further lesbian erasure from public life. In order for lesbians to be ‘seen’ in ways Marilyn Frye contends they/we are not, a far-sighted vision is urgently required.

8.6 Far-sightedness: Longer-term vision

Looking through a far-sighted lens, the aim is to create a world in which heterosexuality ceases to be the norm. Far-sightedness includes living in a world beyond patriarchy, in which lesbians will be seen. This vision, not surprisingly, is one that remains difficult for most people to even imagine. The failure of past and
current researchers to acknowledge sexual orientation/identity as a variable in research studies, is evidence of the ongoing heterosexist nature of patriarchy. The fact that I could locate only two other studies concerned with lesbians and menopause, is shocking proof of this invisibility. The common experience of homophobia, heterosexism as well as ageism for the majority of lesbians in this study, highlights the need for a different way of seeing.

In a society where heteropatriarchal relations cease to be the norm, an alternative way of seeing would be possible. This society would be woman-centred, a society in which women are truly free to choose their own sexual identity and expression. I share the view of Ellen Cole and Esther Rothblum (1991), who contend that it is only when women are freed from societal pressure to live their lives, that menopause might not be the negative experience that presently it is for many women. Findings from my own study confirm the many positive benefits for numerous lesbian feminists who are attempting to defy heteropatriarchy and live autonomous, self-defined lives. As lesbian academic and activist Ngahuia Te Awekotuku puts it:

Until women are free to choose, to chance, to challenge, to change, no-one is truly free. And the planet is derived of half its creative potential (1996, 58).

Studies such as this exploration of lesbians' experiences of menopause present challenges and exciting choices for women.
Appendix One: Plain Language Statement

Faculty of Arts
School of Social Inquiry

Geelong, Victoria, 3217
Telephone (03) 5227 1335 Facsimile (03) 5227 2018
email:

Dear

I would like to invite you to participate in this study titled: Lesbians’ Experiences of Menopause. This study is part of my doctoral research at Deakin University, Geelong. My supervisors are Associate Professor Renate Klein (Deakin University) and Dr Lynne Hillier (La Trobe University). This study is derived from my personal and professional experiences as a lesbian and a women’s health nurse. Whilst there is a great deal of information available on menopause, its focus is overwhelmingly heterosexual. Very few, if any, studies include lesbians’ experiences. I am not focussing on the biological/physiological changes that all women (lesbian and heterosexual) may experience at menopause, but am concerned with the assumptions of heterosexuality and the effects that may have on lesbians’ health and wellbeing at midlife. The aim of my study is to explore, document and make visible the experiences of lesbians at the time of menopause.

The study requires you to sign a consent form and complete a questionnaire. A follow up interview is planned with a smaller number of women who agree to participate. The questionnaire is divided into six parts. Part A asks for information about you – age, ethnicity, etc. Part B focuses on your reproductive and menopausal health. Part C asks questions about Hormone Replacement Therapy (HRT), Part D explores issues of sex and sexuality, Part E looks at issues of body image and Part F asks questions about your experiences’ of health services.

The questionnaire will be linked to the Consent Form by a code so that no identifying information will appear on it. Your identity will remain confidential. You may, if you prefer, choose to use a pseudonym (invented name). No information that could identify you will be used in the reporting of this study. The signed consent forms will be kept separately from the coded data. All information relating to the study including the questionnaires completed by you will be kept in a locked filing cabinet in an office at Deakin University in accordance with Deakin University guidelines. I will be the only person who has access to the data/information. Six years after the completion of the project, all identifying information will be destroyed.

Your participation is totally voluntary and you may withdraw from the study at any time. Results of the study will be available to you if you would like them. Should you find completing the questionnaire raises issues of concern for you, Monica Hingston, an accredited family therapist and social worker is available to provide one off crisis counselling if necessary.

If you would like any further details of this study please ring me on (03) 52 27 1335. If you know any other women who would be prepared to complete this questionnaire please feel free to pass on my details to them or ask them to contact me. Should you have any concerns about the ethical conduct of this research project, please contact the Secretary, Ethics Committee, Research Services, Deakin University 221 Burwood Highway, Burwood 3125 Tel No. (03) 92517123 or my principal supervisor, Dr. Renate Klein email klein@deakin.edu.au or phone 04........... (mob.) Thank you most sincerely for participating in this very important and long overdue study.

Jenny Kelly
Appendix Two: Consent Form

DEAKIN UNIVERSITY ETHICS COMMITTEE
CONSENT FORM:

I, of

Hereby consent to be a subject of a human research study to be undertaken by:

JENNIFER (JENNY) KELLY

and I understand that the purpose of the research is:

to redress the lack of information on lesbians' experiences of menopause and explore and document the effects of heterosexual assumptions on the lives of midlife lesbians.

This study seeks to provide an understanding of lesbians' experiences of menopause in relation to their general health and wellbeing.

I acknowledge

1. That the aims, methods, and anticipated benefits, and possible risks/hazards of the research study, have been explained to me

2. That I voluntarily and freely give my consent to my participation in such research study.

3. I understand that aggregated results will be used for research purposes and may be reported in scientific and academic journals.

4. Individual results will not be released to any person except at my request and on my authorisation.

5. That I am free to withdraw my consent at any time during the study, in which event my participation in the research study will immediately cease and any information obtained from me will not be used.

Signature: ___________________________ Date: ____________

NOTE: In the event of a minor's consent, or person under legal liability, please complete the Ethics Committee's "Form of Consent on Behalf of a Minor or Dependent Person".
Appendix Three: Questionnaire

QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. The information you provide will remain strictly confidential in accordance with Deakin University's Ethics Committee by which this study has been approved. Some questions require you to tick the appropriate response, others to write your experiences and/or ideas. If a question is not applicable please write N/A. If you need more room, feel free to use the back of the page. Please return the completed questionnaire in the reply paid envelope within one month of receiving it. Many thanks.

SECTION A: PERSONAL DATA

1. Your age:-----------------

2. Ethnic background (eg. Greek, English, Koori): -------------------------------

3. Highest level of education reached: ------------------------------------------

4. Your occupation: ----------------------------------------------------------

5. Your postcode:-----------------

6. Are you in the paid work force now?  Yes [ ]  No [ ]

7. Are you employed:
   Full-time  [ ]
   Part-time  [ ]
   Casual    [ ]
   Other     [ ]  unemployed, student ------------------------------------------

8. Do you consider your income as:
   Low    [ ]  Medium [ ]  High [ ]

9. What is your sexual identity? Do you identify as:
   Lesbian  [ ]
   Gay      [ ]
   Bisexual [ ]
   Celibate [ ]
   Queer    [ ]
   Other    [ ]---------------------------------------------------------------
SECTION B: REPRODUCTIVE AND MENOPAUSAL HEALTH

1. Do you have your own biological children? Yes [ ] No [ ]

2. Do you co-parent a child/children? Yes [ ] No [ ]

3. If you have children, do they live with you? Yes [ ] No [ ]

4. Have you had a hysterectomy? (removal of your womb) Yes [ ] No [ ]
   If yes, how old were you? Age ---------------
   If yes, did they take your ovaries as well? Yes[ ] No[ ] Unsure[ ]

5. Please tick which stage of menopause you feel applies to you:
   Perimenopause (having irregular and/or heavier or lighter periods than usual) [ ]
   Post-menopause (no period for 12 months or longer) [ ]
   Not sure [ ]

6. Prior to reaching peri/menopause what were your expectations of menopause?
   ---------------------------------------------------------------------
   ---------------------------------------------------------------------
   ---------------------------------------------------------------------
   ---------------------------------------------------------------------

7. Now that you are (peri/post) menopausal, does your experience match your expectations?
   Yes [ ] No [ ]
   Any comments?
   ---------------------------------------------------------------------
   ---------------------------------------------------------------------
   ---------------------------------------------------------------------
   ---------------------------------------------------------------------

8. In medical and public discourse, menopause is often viewed as an illness/disease. Do you
   agree or disagree with this view?
   Agree [ ] Disagree [ ]
Any comments?

9. Do you think there are different issues for lesbians at menopause than there are for heterosexual women?  Yes [ ]  No [ ]
If yes, please give details

10. Have you consulted any health professionals about your menopause? Yes [ ] No[ ]

11. If you have consulted health professionals about your menopause, who did you speak to? (Tick as many as applicable)
Naturopath [ ]
Chinese herbalist [ ]
Acupuncturist [ ]
Nurse [ ]
Doctor [ ]
Friends [ ]
Partner [ ]
Staff at a menopause clinic [ ]
Other [ ]
If other, please give details

12. Are you experiencing any of the following, which you believe are related to your menopause? Yes [ ]  No [ ]
Hot flushes [ ]
Night sweats [ ]
Cold sweats [ ]
Anxiety [ ]
Dizzy or fuzzy in the head [ ]
Tingling or creepy skin [ ] [ ]
Aching joints [ ] [ ]
Mood changes [ ] [ ]
Disturbed sleeping pattern [ ] [ ]
Bladder problems [ ] [ ]
Loss of interest in sex [ ] [ ]
Other [ ]
If other, please give details

13. Would you like to comment on this list?

SECTION C: HORMONE REPLACEMENT THERAPY (HRT)

1. Have you heard of HRT? Yes [ ] No [ ]
If yes, where did you first hear about it?
GP [ ]
Gynaecologist [ ]
Friends [ ]
Partner [ ]
Nurse [ ]
Lesbian magazines [ ]
Women's magazines [ ]
TV [ ]
Newspaper [ ]
Naturopath [ ]
Colleague at work [ ]
Books [ ]
Printed health information [ ]
Other [ ]
If other, please give details

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2. In your understanding, what does HRT do?

3. Are you taking HRT? Yes [ ] No [ ]
If yes, since when? .............................................................

4. Have you taken HRT in the past? Yes [ ] No [ ]
If yes, how long did you take it for? ...........................................

5. If you are taking/or have taken HRT what are/were the main reasons for doing so?
Doctor advised me to take it [ ]
It helps the discomfort I experience as a result of my menopause [ ]
Protection against heart disease and/or osteoporosis [ ]
Replaces my lost hormones and restores my body’s balance [ ]
It is the responsible thing to do at menopause [ ]
Maintains my sense of femininity [ ]
Keeps my skin soft and less likely to wrinkle [ ]
Keeps me youthful [ ]
Other [ ]
If other, please give details

6. If you have stopped taking HRT please tick the reasons for stopping it
Worried about long term side effects [ ]
Do not like taking drugs for a natural event (menopause) [ ]
Doctor advised me to stop [ ]
It did not improve the way I was feeling [ ]
Friends and /or others pressured me to stop [ ]
Weight gain [ ]
It caused troublesome side effects [ ]
Didn't like having a period every month [ ]
Other [ ]
If other, please give details

7. Please indicate if you agree, disagree or are unsure about the following statements. If you choose unsure, please explain your reasons in Question 8

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRT is a lifesaver; I don't know how I'd manage without it</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Taking HRT is the responsible thing to do at menopause</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>HRT treats menopause as an illness/disease</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>HRT keeps women youthful, attractive and desirable</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Women who take HRT have better sex lives</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>By resisting the pressure to take HRT, I feel more empowered and in control of my life</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>HRT is more popular with heterosexual women</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>HRT is another way the medical profession controls women</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Any midlife woman who doesn't take HRT is suffering unnecessarily</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

8. Please explain your reasons for choosing 'unsure'. Any other comments?

9. Do you think your experience of menopause has been affected by being a lesbian?
Yes [ ] No [ ]
If yes, please explain how

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SECTION D: SEX and SEXUALITY

1. Are you currently in a lesbian relationship?  Yes [  ] No [  ]
If yes, how long have you been in this relationship?  

2. Are you sexually active with your partner?  Yes [  ] No [  ]
If no, how long ago did you stop? 

Without wanting to pry, would you please give some reasons for this? (Remember this is confidential)

3. Is your partner experiencing menopausal changes? Yes [  ] No [  ]

4. How long have you identified as lesbian?

5. Are you 'out' (disclosed your sexual identity) to: (tick as many as you like)
Most people [  ]
Friends only [  ]
Family [  ]
Colleagues at work [  ]
Only myself and/or partner [  ]
Everyone [  ]
No-one [  ]

6. Has your interest/desire for sex changed since the start of your menopause? Yes [  ] No [  ]
If yes, please explain:

7. Has the type of sexual activity you enjoy changed since the onset of menopause?
Yes [  ] No [  ]
If yes please explain:

8. Has the frequency of your sexual activity since the start of your menopause:
increased [  ] decreased [  ] stayed the same [  ]

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9. Please complete the following:
The main factor/s affecting my sex life at this time of my life is/are:

10. Please complete the following:
Based on my experience, lesbian sex at menopause is

SECTION E: BODY IMAGE

1. Has your experience of menopause changed the way you view yourself? Yes [ ] No [ ]
If yes, please explain how this has changed

2. Have you noticed your body shape changing? Yes [ ] No [ ]
If yes, are you concerned about these changes? Yes [ ] No [ ]
Any comments?

3. How satisfied are with your body shape, size and weight now?

4. How important is physical attractiveness to you in your choice of, and/or maintaining a
relationship with a sexual partner? Please comment

5. Previous research studies suggest that a lesbian identity may protect lesbians from the
desire to be thin. Do you:
agree [ ] disagree [ ] unsure [ ]
6. Is there anything else you would like to add about your body image?

7. What does the word feminist mean to you?

8. Do you identify as a feminist?  Yes [ ]  No [ ]
SECTION F: HEALTH SERVICES, HOMOPHOBIA and HETEROSEXISM

1. Do you have a regular Doctor (GP)? Yes [ ] No [ ]
2. If you use alternative/complementary health practitioners e.g. Naturopath, Chinese herbalist, how often do you consult them?
   Once a week [ ]
   Once a month [ ]
   Once every three months [ ]
   Once every six months [ ]
   Other

3. Who do you regard as your primary health provider?
   Naturopath [ ]
   Chinese herbalist [ ]
   Acupuncturist [ ]
   Chiropractor [ ]
   Doctor (GP) [ ]
   Other medical specialist [ ]

4. If you tend to use a range of alternative health care providers please give your reasons

5. Where do you usually obtain information about your health? (tick as many as you like)
   Partner [ ]
   Lesbian friends [ ]
   Lesbian magazines [ ]
   Mainstream women’s magazines [ ]
   Medical services [ ]
   Community health centres [ ]
   Women’s health services [ ]
   Books/journals [ ]
   Websites [ ]
   Television programs [ ]
   Trust and rely upon my body [ ]
   Other [ ]

6. If your primary health provider is a doctor, are you ‘out’ to her/him?
   Yes [ ] No [ ]

7. If your primary health provider is an alternative practitioner, are you ‘out’ to her/him?
   Yes [ ] No [ ]

8. Does your health provider identify as lesbian or gay friendly? Yes [ ] No [ ]

9. If you are ‘out’ to your health provider, please comment on the reaction you received when you first disclosed your sexual orientation to her/him
10. If you are not 'out' to your health provider please tick the reasons for not 'outing' yourself (tick as many as you like).
- It is not relevant or necessary  [ ]
- Fear of the response I may receive  [ ]
- Do not want to be seen as different  [ ]
- It may be embarrassing to do so  [ ]
- I might not receive good care if she/he knows I am a lesbian  [ ]
- It is no big deal anyway  [ ]
- She/he might think differently of me  [ ]
- I will then suffer discrimination  [ ]
- Why should the responsibility be on me to 'out' myself  [ ]
- Other  [ ]

If other, please comment

11. Do you believe that lesbians are invisible within the western medical model of health care?  Yes [ ]  No [ ]  Unsure [ ]

12. Do you believe that lesbians are invisible within the alternative/complementary model of health care?  Yes [ ]  No [ ]  Unsure [ ]

13. Do you believe that the western medical health system could be improved to cater for the needs of lesbians?  Yes [ ]  No [ ]  Unsure [ ]

If yes, please explain how

14. Do you believe that the alternative/complementary health system could be improved to cater for the needs of lesbians?  Yes [ ]  No [ ]  Unsure [ ]

If yes, please explain how

15. If your primary health provider is a doctor, do you visit the nearest local doctor to you or do you travel away from your immediate area to see her/him?
- See my local doctor [ ]
- Travel a distance to see my preferred doctor [ ]
16. If you travel away from your home town/suburb to see a doctor please indicate how far you travel and reason/s for doing so

17. Have you experienced homophobia and/or heterosexism in your interactions with health professionals?
   Yes [ ] No [ ]
   If yes, please explain

18. Do you have regular (2 yearly) Pap tests?  Yes [ ] No [ ]
   Please give reasons

19. If you are over 50, do you have regular (2 yearly) free mammograms (breast x-rays looking for early signs of breast cancer)  Yes [ ] No [ ]

20. What, generally speaking, have your experiences been like with the health system?
   Good [ ]
   Fair [ ]
   Poor [ ]
   Excellent [ ]
   Average [ ]
   Less than satisfactory [ ]
   Other [ ]

   Please give details/examples

21. Is there anything you would like to add about your experiences of the health system?
22. Is there anything you would like to add about any other issues relating to your experience of menopause?
Thank you very much for completing this questionnaire. Your support and assistance is greatly appreciated. I plan to contact some of the women who completed this questionnaire for a follow up interview. Please indicate by ticking in the box over the page if I may contact you for an interview at a later stage. If you are happy to be contacted for an interview, please return your contact details to me.

Yes I would be happy to be contacted for a follow up interview. [ ]
I would prefer not to be contacted for an interview [ ]

If you ticked yes, what is the best way for me to contact you?

My contact details are:
Name
Address
Telephone
Email
The best day and time to contact me is

PLEASE NOTE

In the interview I plan to ask you to expand upon some of your answers given in this questionnaire. I will NOT ask any further questions on Section D – Sex and Sexuality.

Please be reassured that if you give me your name this information will remain with me only.

Once we organise a time for an interview we will agree on a pseudonym (invented name) chosen by you. If you do not wish to give me your real name, please phone the General Arts Office at Deakin University (ph. 52271335) and leave a message for me indicating that you wish to be interviewed anonymously. I will then ring you back and we can do the interview using an invented name over the telephone. Thank you once again.

Jenny Kelly

Yes I would be happy to be contacted for a follow up interview. [ ]
I would prefer not to be contacted for an interview [ ]
If you ticked yes, what is the best way for me to contact you?

My contact details are:

Name

Address

Telephone

Email

The best day and time to contact me is
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