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Attitudes Toward Postmenopausal Long-Term Hormone Therapy

Petra Kolip
Nicole Hoefling-Engels
Norbert Schmacke
University of Bremen, Bremen, Germany

In this article we address the question of why postmenopausal women undergo hormone therapy. Thirty-five women aged 46 to 75 years living in Bremen (Germany) and taking postmenopausal hormones for at least 12 months were interviewed. Following Fritz Schütze, the interviews were analyzed according to a reconstructive analytical procedure. Five different types of users were identified. They differed from each other in terms of their reasons for using hormones, their expectations of this type of therapy, and their personal habits and circumstances, including an integrity-preserving attitude, a performance-oriented attitude, a searching attitude, a faith-in-medicine attitude, and a benefit-generalizing attitude. The interviews show that there is a need for target-oriented counseling, taking into account the individual attitudes toward menopause and postmenopausal hormone therapy.

Keywords: *communication, doctor-patient; hormone replacement therapy; menopause; midlife*

The Women's Health Initiative (WHI) study changed the scientific evidence supporting the prescription of postmenopausal hormone therapy (HT; Writing Group for the Women's Health Initiative, 2002). Later publications on estrogen-alone and estrogen-plus-progestin combination therapy have confirmed the unfavorable balance between risk and benefit of extended treatment with these hormones (for the current state of research on each of these see National Institutes of Health, 2008). Although warnings of the risks of HT had been around for some time, particularly from those involved in women's health research, the 2002 WHI results presented the first solid data from a randomized, controlled study. They show that the risks of hormone therapy outweigh the benefits. In Germany, the results of the study have led to a change in the indications listed by the Federal Institute for Drugs and Medical Devices, which is responsible for the approval of medicines in Germany. As of 2003, postmenopausal hormone preparations might only be prescribed for the relief of severe menopausal symptoms, and in exceptional cases as a prophylactic for osteoporosis if other medicines cannot be tolerated. In the United States, the same restrictions on indications were passed by the Food and Drug Administration (Food and Drug Administration, 2008), and in Europe by the European Medicines Agency (EMEA) (2003). As a result, in line with many other industrialized nations, the prescription of hormones in Germany has fallen. At the height of postmenopausal HT in 1999, 1,156 million defined daily doses (DDDs) of estrogen preparations were prescribed to women covered by statutory health insurance. In 2004 this figure was only 483 million DDDs; this represents a reduction of 58% (Schwabe & Paffrath, 2006).

In spite of this sharp decrease, it should be noted that the new scientific evidence has not yet fully filtered through to all in the medical profession. Hormone preparations are still being prescribed to women over 60, and the indications do not always correspond to those scientifically recommended (Du, Dören, Melchert, Scheidt-Nave, & Knopf, 2007). There are many reasons for this, ranging from poorly expressed communication by doctors in private practice of the risks involved, to continued belief in the protective attributes of HT on the part of both doctors and postmenopausal women, to problems in transposing population studies onto medical practice, and to marketing strategies of the pharmaceutical industry (Bucksch, Kolip, & Deitermann, 2004; Coney, 1994;

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Griffiths, Green, & Bendelow, 2006; Hoffmann, Lindh-Astrand, Ahlner, Hammar, & Kjellgren, 2005; Hoffmann, Hammar, Kjellgren, Lindh-Astrand, & Ahlner, 2006; Ness & Aronow, 2006; Palmlund, 2006). Taking HT is a complex phenomenon (Stephens, 2002) influenced by several factors, such as need for relief of menopausal symptoms or the desire to keep up appearances (Kittell, 1998). There is no previous research in Germany on how relevant the attitudes of women are, what their opinions of HT are, how they assess the scientific evidence, and what bearing this has on their decision-making process. This is even more surprising given that attitudes toward the doctor–patient relationship have changed so dramatically in recent years. Patients are now given an active role in deciding on their therapy, culminating in the policy of shared decision making. This applies even more within the context of medical support during menopause, because in most cases there is no pressing need for action (Murtagh & Hepworth, 2003).

This article is written from the perspective of the women concerned and represents a qualitative study pursuing the question of how menopausal women view postmenopausal hormone therapy. The target group comprises women who decided to use hormones for at least a limited period, irrespective of whether this decision took place before or after the publication of the WHI study. Of particular interest here were the subjective logic for therapy, the motives for taking (or ending) hormone therapy, and how individual women weigh the risks against the benefits. Because potential risks have been the subject of discussion since the 1980s, the study also included women who took hormone preparations for an extended period of time before 2002. In this article, we examine the question of whether different groups of women requiring a different approach in the consulting room to enable them to to make an informed decision can be identified on the basis of their attitudes toward menopause and HT.

Method

Method of Interview

In this qualitative interview study, menopausal and postmenopausal women who had used hormone preparations for at least 12 months during menopause were interviewed. Two forms of interview were combined. The interviews began with a narrative stimulus, designed to encourage women to recount their experiences of menopause and how they coped with it, and designed to promote a structured account based on subjective criteria: "I'd like to ask you to think back to the time just before menopause. What your personal situation was and how you gradually became aware of signs of the start of your menopause. How you felt, what experiences and support you have gathered since then, and how you dealt and came to terms with it. Take your time—for little details, too, because I'm interested in anything that is important to you." During this phase the women were not interrupted. The narrative phase was followed by a semi-structured, guided interview, exploring individual aspects of the account in greater depth and raising topics that had not been broached.

Method of Analysis

The interviews were transcribed in their entirety and made anonymous. Then the first narrative part was analyzed according to a reconstructive analytical procedure after the manner of Fritz Schütze (1983). First, a formal text analysis of the impromptu account was made, dividing the account into individual segments on the basis of their form and content, and these were then divided into higher order topic supra-segments to identify any higher order topic areas. Based on the resultant sequential structure of the interviews, a structural-content description of the individual segments of the account was formed on the basis of a line-by-line analysis of the core sections. In this way the motives of the women using hormones and the internal logic behind them taking or ending hormone therapy can be deduced. This stage of the analysis was followed by an analytical abstraction in which a specific study of individual concise statements was referred back to the overall nature of the narrative. These results were supplemented by an analysis of the guided interview, which extended, supported, or qualified the initial results.

Different types of hormone therapy users emerged on the basis of the analysis of the individual interviews. Comparison dimensions and categories were determined using case comparison and case contrast to help identify similarities and differences. The interviews were analyzed and interpreted by a working party comprising six research workers (male and female) from different disciplines.

Recruitment

The research was carried out between March and August 2005 in the north German city of Bremen

(which has a population of 500,000) and its rural surroundings. The target group was menopausal or postmenopausal women who had used postmenopausal hormone therapy for at least 12 months, irrespective of whether or not they were actually taking hormones at the time of the interview and, in the case of ex-users, of whether they had discontinued treatment before or after 2002.

A number of different ways were chosen to approach the target persons initially. Most of the interested participants responded to an appeal in the regional daily newspaper. Eighty women responded to an article; a further 3 participants responded to an appeal in a Bremen-specific online magazine for women; 5 to a flyer left in pharmacies informing about the research, and 1 agreed when asked personally. Because it was not possible in view of the limited time and financial resources available to conduct interviews with all the women, 35 were selected for interview. The aim was to interview as wide a spectrum of women as possible, so that a wide range of motives could be included in a contrastive analysis. The selection criteria were age, sociocultural background, the period of hormone treatment, the duration of the treatment, and the type of hormone preparations (tablets, gel, or injection). The number and selection of the interviewees were in line with the logic of theoretical sampling and resulted from the research process itself or were structured by it. After the initial interviews were carried out and analyzed, the subsequent selection was made by means of a procedure based on Glaser and Strauss (1967), in accordance with the principles of minimum- and maximum-comparison selection. In minimum-comparison selection those data items that reveal a certain similarity are placed in relation to each other to obtain a saturation of the structures indicated in the individual instances. In maximum-comparison selection, on the other hand, those cases are contrasted that exhibit a maximum amount of difference. These procedures are designed to reveal the full scope of the data and the field concerned. In this way, further criteria, which could be significant for the decision for or against the taking of hormones, were formulated during the course of the research: gynecological events (e.g., hysterectomy), cancerous diseases, the nature of the patient–physician relationship, and employment status in middle age.

Interview Sample

Of the 35 interviews, only 31 could be included in the analysis. One interviewee had already been taking hormone preparations in the 1960s; two other interviews were overshadowed by experiences with a severe chronic illness; in one interview it was not possible to determine whether the interviewee had indeed taken HT preparations or contraceptive hormones.

At the time of interview, the age range was 46 to 75 years. Eleven women were 60 years of age or older, of whom 3 women were still taking hormone treatment. Sixteen women were between 50 and 59 years of age (8 were on hormone treatment at the time), and 4 were between 46 and 49 years of age (2 were on hormone treatment at the time). At the time of interview, 13 of the 31 women were taking hormones in the form of tablets, injections, or hormone gel.

A glance at the preparations and the ingestion patterns of the 31 women revealed the following: 11 women were using only hormone preparations, whereas 19 women alternated between hormone preparations and homeopathic medicines, or were combining these. One woman was using a preparation of yam root, which she considered to be similar to a hormonal medicine; this is the reason we included her in the analysis. Four women had used the preparations for up to 3 years; 5 women had used them for 3 to 5 years. Nine of the women interviewed had used hormones for 5 to 10 years, and 12 for over 10 years (not including the woman taking yam root).

Results

In the course of the analysis of the overall interview material, five types of user attitudes toward HT gradually emerged. These differed from each other in terms of their reasons for using hormones, their expectations of this type of therapy, and their personal habits and circumstances, and included

- an integrity-preserving attitude
- a performance-oriented attitude
- a searching attitude
- a faith-in-medicine attitude
- a benefit-generalizing attitude

The individual types that were developed from the material are described below and illustrated by excerpts from the interviews. It should be noted here that these are prototypes, which as a rule do not occur as the “pure” type. There is much overlap because attitudes toward hormone therapy are complex and sometimes even contradictory, and because the confrontation with hormone therapy and menopause progresses through a number of different phases, during which the various attitudes can alternate.

Integrity-Preserving Attitude

At the center of this group are women whose aim is to preserve their self-image and their sense of physical well-being. Menopause is seen as a derailment of the body and as uncontrollable. A sense of physical well-being is replaced by one of physical discomfort:

> Yes, yes, well this feeling of standing next to yourself, and feeling so absolutely helpless, well so, I felt, yes I felt myself completely at a loss. Didn't know what to do about it. . . . I felt simply helpless. To be at the mercy of my own body—and I couldn't, I couldn't do anything about it."

The changed experience is seen as foreign and adds to an underlying feeling of shock:

> And my self-esteem is done for, 'cos you look in the mirror and say, who am I then? I mean this monster, that was never me.

Thus the main reason for taking hormone treatment is primarily to regain a sense of balance; the hormone preparations are often acting as a life belt:

> Fundamentally, I'd say, that it's the stability that the hormone therapy provides, yes, that's the basis. Because I'd already tried everything possible to make myself feel better, and so I could develop somehow personally—or otherwise. But that just didn't have this effect. Of course, my personal development continued and I did some good things, but in spite of this I still kept getting these symptoms which every now and then kept throwing me off balance.
>
> Well, I guess I'd almost say it was you know like that. Like a life belt you'd throw to someone who's drowning. And then hold on tight so you don't sink.

Performance-Oriented Attitude

A second group clearly emerged from the interview material. Women with a performance-oriented attitude used hormone therapy to maintain their efficiency at work and at home so that they could continue to perform all their social duties to the full. The signs of menopause they experienced could affect women in their daily lives so severely that they really ought to have limited their physical and mental efforts, but considered this impossible for a number of reasons. Women with this attitude expected a quick fix from hormone therapy, which would enable them to continue living and working to the full as before, and some of them required this, at least in part, in earning a living:

> Yeah, because you can't sleep through any more. And if you've got a full-time job, well you just can't go on like that. 'Cos then my children were at home, too, I was a single mum, and then with my children as well, well it was just hell, it was.
>
> I just had to work. I'm single, I have to work and, well, I simply had no choice.

The interviewees not only referred to the limitations caused by reduced concentration and performance, but also indicated that they "[could not] afford" to have symptoms of menopause when their work involved contact with people (e.g., customers, colleagues, superiors, or pupils):

> My nerves suddenly wore thin and I kept bursting into tears, for absolutely no reason. At work the boss just came into the room and I burst into tears. He thought I'd done something terrible.
>
> Constantly bursting into tears and the sweating, those were the worst for me. It was terrible. Because it has such a terrible effect on my daily life. I was just sitting at work like. And my colleague says: Getting hot again? Oh, I didn't want to answer, I couldn't just say yes, because it was all too much, it was really bad.
>
> Well, I'm also grateful because at the time I was very, very busy both at work and with other things. And I can imagine that if I'd had a public engagement at that time, well, I would have found that really quite unpleasant.
>
> I'm a consultant. I can't risk suddenly turning red and breaking out in a sweat in the middle of a session, I'm on a pedestal. I'm a trainer and that just cannot happen. . . . And if I'm expected to so-to-speak "master" my menopause without hormones then I'd have to resign. I can't do my job in that state.

But a performance-oriented attitude also refers to slowing down the aging process in the hope of maintaining one's accustomed way of life.

> Yes, what convinced me was that it's a good thing to sort of put off the next stage of getting old a bit, yeah, that's what convinced me. Because I do wanna get old, so from that point of view, too, I don't need to start on the last stage before I'm fifty, so I thought [laughs].

Searching Attitude

Women with a searching attitude tried hard to make sense of the different information available on hormone therapy. They actively sought information about hormone therapy and other forms of treatment, but were often concerned that they might not have made the right decision. In some women this led to a constant fear that they might be doing themselves lasting harm. The women in this group were aware of the side effects of hormone therapy and of the risks of using hormones. Many women in this group had doubts and discontinued the hormone treatment, but often took it up again because the symptoms recurred or because their doctors did not advise them about how to phase out the hormone treatment.

> Should I keep taking the hormones or not? That's always the question, every time, every six months when I go there. . . . Because we always come back to the same thing, that I have a bad conscience and then she says—in the meantime she's even started to say er, you needn't have a bad conscience. . . . And then for a while I don't and I think, well, you're feeling all right and so on. But today, now for example, now I've read that about sudden hearing loss in this leaflet. Yeah, well, of course I think that it's not OK again, that's just not right, then I'm ruining my life now, and that's not on either [brief laugh]. So there really are quite a lot of doubts.

> And in March last year I said to myself, now stop taking all this stuff and because I'd heard and read like so many negative reports and all. And then I stopped for a year, but I had a really hard time sleeping and hot flushes. And then I went back to my gynecologist and she said: yes, hm, hm, hm, well, it's up to you whether you take something or not.

Women often felt abandoned by their doctors when looking for the "right" answer, because the medical profession offered little advice on alternatives to hormone therapy and pushed the decision for or against hormone treatment onto the patient:

> That about acupuncture, well I'd have liked to have read that tip somewhere else and not found it by pure chance in a chat room or such like.

> When I asked about something and asked her advice or something, I got an answer all right. Only sometimes I just wished that she'd say something off her own bat, like, that she'd tell me herself about the report and yes, basically, she always said it's up to me. There's only two ways about it, either I put up with it or take the hormones, that's how it seemed, yeah. So for me it was like that, I said to myself, I can't stand this at the moment, so I'll just have to grit my teeth and take the hormones.

Faith-in-Medicine Attitude

A fourth group put their faith in the opinions of doctors. This attitude was influenced by the traditional and firmly socially determined roles of doctor (professional) and patient (layperson); the interviewees with this attitude trusted in the opinion of their doctor and were happy to place the responsibility in the hands of the medical profession. The women felt they were "well cared for" by their doctors and that they were "in good hands;" they "[had] complete faith" in them because they were "really, really great" doctors. A personal, trusting relationship was important to them.

> But I have a very, really, very nice GP who's easy to talk to and . . . er . . . who's always straight about what's advisable and what's not advisable. That's what matters to me, you see.

This attitude is strengthened by the fact that the women could not deal with the conflicting information about hormone therapy and trust their doctor to make the "right" decision. Their belief in the efficacy of medicine was supported by the rapid success of hormone therapy in relieving menopausal symptoms.

> And my gynecologist then measured my blood estrogen levels in 1996 and said I hadn't got any left, and that right now I'd have to swallow some. And then I thought, OK, if the symptoms from this change of life thing are as bad as they say, then swallow the stuff, so you don't even go down that road.

> Back then when I took it and saw just how good I felt. Well, of course I was all for it. I told all my friends to take it, too. . . . I simply believed it all about these hormones, these hormones.

The doctor–patient relationship of these women was sometimes so extreme that they would take the hormone treatment just to please the doctor, and because they wanted to be seen as an obedient patient:

> He always examined me right thoroughly and oh how are you getting on with the hormones, and I'd say just fine, and he'd just say, I'm very pleased with

> you [brief laugh], and then I was happy too 'cos he was happy with me so to speak [brief laugh].

If the women had any doubts these were not clearly broached in consultation with the doctor, because the women themselves considered it a breach of faith to argue with the experts.

> Such a super modern doctor, really, absolutely fantastic, really open-minded. Of course I trusted her when she suggested it, like, yeah, it was her who suggested it, me—I didn't ask for it or anything, you know. And then when I began to have doubts, of course I asked her about it but then she just dodged the issue like, so she never said to me stop it or don't take it any more, so that never happened, no, but every time the topic just sort of fizzled out.

> I'd also have seen that as an affront to my doctor, I found—I really trusted her. And so if someone had told me she'd prescribed me something really bad, I just wouldn't have believed it.

Benefit-Generalizing Attitude

The benefit-generalizing attitude of women to hormone therapy was also based on a deep-seated faith in medicine, but it went well beyond this approach. It usually happened during a hormone therapy begun for menopausal symptoms, when other benefits were recognized that justified continued therapy. Here, feedback from female friends and colleagues was taken as encouragement to experience "other effects" for themselves:

> And the woman next door who was doing hormones—who was taking hormones, she said to me: yeah, and you get a smoother complexion, too, right. And er right, you might be storing more fluid. I don't know. And then I said to myself, yeah, right if you've got plans, that was, then I started taking ´em again.

The perceived benefits referred to different aspects, to an anti-aging effect as well as to effects on the psyche. Sometimes the indications were expanded by the doctors. One interviewee, who took hormones from 1984 to 2003 and then broke off treatment as a result of the WHI study, reported that her rheumatic complaints became more severe afterward. She was on the verge of consenting to an operation on her very painful wrist when her gynecologist recommended she start taking hormone preparations again:

> And then my gynecologist said, . . . "You're short of hormones." And I've been back on them now for five weeks, I don't need any exercises in the morning, my hands aren't stiff, well that's just so odd. I'm not taking any other medicine, and I've always needed powerful painkillers . . . but I don't think I'll ever be giving up the hormones now.

The interviewees in this group adjusted the dose according to need when a particular effect for a specific condition was required:

> And that I took a bit more, that was really only at the time when I was only on a quarter or a half. Mostly. That I, if I was ever on a whole one and then took another, well I put it down to the stress, that it wasn't always like that, and then I said, well now take one or take some more, it can only get better, yeah, it's just, er, it's no fun, just feeling down or stressed out all the time.

This group of women, who found hormone therapy enrichment above and beyond the actual medically defined scope, sometimes showed absolutely none of the skepticism about long-term hormone treatment that can be observed, at least in part, in the faith-in-medicine attitude of women of the previous group:

> I've been taking hormones now for nearly twenty years, regularly; they've become a part of my life, like early morning exercise, every morning. I've had a wonderful life, in every respect, everything, all my problems were gone. . . . So, I've never had any side effects, I've had all my check-ups. . . . Yes, the hormone time was actually a good time for me, I'd say.

Discussion

The results of this study demonstrate the ambivalent stance taken by several women toward hormone therapy. Women were aware of the risks of postmenopausal HT and confronted the issue to varying degrees. This ambivalence was most clear-cut in women with a searching attitude, because they explicitly expressed their struggle to find the right answer. They knew about the risks and constantly balanced them against the benefits, just as they also searched for possible alternatives to hormone therapy. This group included women who had at some time tried to discontinue hormone treatment, with better or worse medical support. Many interviews clearly indicated that the doctors who were unreservedly in favor

of HT gave bad advice to women wishing to discontinue their hormone treatment. Some doctors "threatened" the women with abrupt physical and mental degeneration, whereas others gave no information about how to phase out the hormones to end the therapy successfully. The women in this group were the least satisfied with their doctors because they felt poorly supported, or even abandoned, when they were looking for an answer.

The other groups of women also found the decision-making process complex, and even those who had an unequivocally positive attitude toward taking hormones were beset by doubts. Women with a faith-in-medicine attitude found it easiest to take HT for granted. These women trusted completely in the opinion of their doctor; his or her knowledge was perceived to be well-founded, and the doctor's opinion and attitude formed the basis for their own decisions.

As long as these women had no reason to doubt their decision, they were happy with hormone therapy: they trusted the professional expertise of the doctor, they were relieved of the burden of decision making, and they could feel for themselves the positive effects of hormone therapy. Menopausal symptoms were minimized, and in many cases positive effects on the psyche, the skin, and even on chronic ailments such as rheumatism were attributed to hormone therapy (and were experienced as such). This applied even more to benefit-generalizing women. In some interviews hormone therapy was credited with almost magical effects on a variety of physical phenomena, completely unsupported by any scientific evidence. From a medical point of view it is irrational that some of the women did not follow the recommended treatment and adjusted the hormone dose as needed on the basis of the perceived effect. If the hormones were credited with positive effects on the mental state, the dose was increased when the women felt they were in a stressful situation, or at times when they wanted to feel in a better mood. If women noticed that a rheumatic complaint was relieved by the hormones, the dose was increased when the joints were swollen. On the basis of the interviews, it is impossible to say whether or not this had been discussed with the doctor.

It almost seems as if it were particularly "easy" for women with this attitude, as they were not confronted with conflicting scientific studies and all sorts of media reports, but simply followed the advice of their doctor without question. This is true as long as the women were free of any doubts. As soon as they started to consider possible negative effects of hormone therapy, the doctor–patient relationship underwent a crisis of confidence. What is apparent is just how hard the women in both these groups worked to maintain this relationship. The relationship with the doctor was almost enthusiastically described as one of confidence and almost as friendship—although strongly influenced by a professional hierarchy. The women almost inevitably saw any doubt in the doctor's recommendations as a breach of confidence. As long as they wanted to maintain the relationship, they had to suppress any doubts and continue taking the hormones, primarily to live up to the doctor's assumed expectations. Many women in this group found such obedient behavior fulfilling. They were happy to put themselves in the position of a dependent, and were rewarded in that the doctor was proud of them. If their doubts gained the upper hand, many women described how daunting it was for them to change their gynecologist. This was not an administrative problem in Germany: Any woman covered by statutory health insurance who needs medical advice or treatment can decide each quarter year which doctor she wishes to consult. However, it is apparent that women did not see themselves as clients who were free to choose the most suitable medical service from what was available—a concept proposed by some recent studies to be the ideal type of a less hierarchical doctor–patient relationship. The personal contact built up over the years was significantly more important than evidence-based treatment.

Women with an integrity-preserving attitude also relied on a doctor–patient relationship based on trust, but the motivation behind this was different. Women with this attitude experienced menopause as a major crisis. The women were surprised by the changes in their bodies and by their reduced performance; they felt their bodies were out of control and saw this as a serious threat to their integrity. It was an existential crisis: When these women were interviewed, it was not unusual for them to express profound despair. The hormones were seen as life savers. On the whole, the women knew about the risks but could not see any alternative to restore their balance. Women in this group were less concerned about relieving menopausal symptoms than maintaining their identity. The interviewees wanted to feel like they did before menopause; they wanted to enjoy life, to be happy with their bodies, and to be able to power through the challenges of their daily life. To them, hormone therapy was their savior, keeping them from falling

into the depths of depression. Performance-oriented women described hormone use as similarly helpful, although they were less concerned about the psychological aspects than they were about the physical ones. We were impressed by just how frequently the interviewees said they used hormones to keep up their performance at work and in their daily lives. Women said that they could not afford to fail to meet demands. Insomnia caused by hot flushes and the resultant tiredness fit into these women's notion of life as little as sweating when in contact with people. Experiencing emotional weakness also worried the women, because they assumed that their social milieu could not cope with these signs of menopause. Whereas integrity-preserving women were mainly concerned with their own inner self, those with a performance-oriented attitude were concerned with the world around them. They did not want their social contacts to be affected by menopausal symptoms, and they did not want to be restricted in their ability to fulfill the demands placed upon them. Earning a living was of central importance to women in this group; some said that they would stop using hormones when they retired, because they could then afford to have a more relaxed lifestyle.

Our study findings agree to a large degree with the conclusions of the qualitative study just published by Stephens and Breheny, who emphasize that the development of a differentiated counseling concept for women in and after menopause assumes that the significance of the social context for health-related communication and behavior patterns has been understood (Stephens & Breheny, 2008). It underscores, by reference to the great importance attached to the topic of fitness for work, the relevance of the category of pragmatic embodiment of Stephens (2002), whereby the maintenance of integrity and social role expectation is of great significance for the decision-making models of women. Interestingly, this topic was not included in the study of Marmoreo, Brown, Batty, Cummings, and Powell (1998), whereas other topic areas such as agism and the quality of the patient–physician relationship on similar lines to our study occurred much earlier. The oft-cited anticipated or actual act of children leaving the nest (e.g., Banister, 1999) does not occur at all in our material as a backdrop for the attitudes toward menopause and HT. Therefore, we agree with the interpretation of French, Smith, Holtrop, and Holmes-Rovner (2006), that the differing preferences of women with regard to the conflict between the long-term risks of HT and the desire to alleviate symptoms need to be represented in the counseling concepts more effectively than hitherto.

Finally, the study shows the importance of qualitative research in determining the need of menopausal and postmenopausal women for information that is traditionally not freely expressed. There appears to be an urgent need to find a new source of nondirective consultation for women of this age group, which clearly begs the question: Which places, inside or outside the medical system, are suitable for this purpose? The interviews suggest that a medical consultation provides little scope for matters of great importance to women. Asking questions or mentioning symptoms relating to the change of life in a doctor-dominated consultation automatically leads to the prescription of hormones.

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Petra Kolip, PhD, is a professor of public health at the University of Bremen Institute for Public Health and Nursing Research in Bremen, Germany.

Nicole Hoefling-Engels, Dipl. Soz. Paed., is a fellow of the interdisciplinary public health graduate program at the University of Bremen in Bremen, Germany.

Norbert Schmacke, MD, is a professor of public health at the University of Bremen Health Services Research Coordination Center in Bremen, Germany.