PERCEPTIONS OF MENOPAUSE IN NORTHEAST THAILAND: CONTESTED MEANING AND PRACTICE

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Abstract—This paper draws on data collected from village-based ethnographic research conducted in northeast Thailand in 1990-1991 and highlights the polarities and contradictions of perceptions of menopause that exist between village women and health personnel with whom these women interact. For village women until recently, the menopause has been regarded as a simple and natural biological event; for health professionals, it is consistently represented as a 'medical problem' indicating treatment. The paper highlights women's construction of menopause, and their recognition and management of its physical symptoms. It draws attention too to differences among women and to the dynamic nature of their understandings and consequent health-seeking behaviour. The paper also describes the way in which health providers, through their own training and reading of professional and popular journals, increasingly represent the menopause as a pathological process and treatable condition. Through the exploration of conflicting perceptions of the menopause among contemporary Thai women, the paper draws attention to the heterogeneity and fluidity in understandings of biological processes that are related to and reflect the wider social and economic changes to which they are subject.

Key words—Thailand, menopause, social construction, medicalization

INTRODUCTION

Bodily states, products and processes, signs and symptoms of illness, etiology, diagnostic techniques and categories, sickness management and therapeutic practice are all constructed and given meaning according to cultural context [1]. Even so, considerable contradictions and variability exist within any population. This is the case for menstruation [2] and the menopause, in which latter case understandings of biological processes and products are imbricated with understandings of ageing, women's sexuality and its significance, women's reproductive ability and history, and their social relations and economic roles. In addition, perceptions of ageing are changing, in part due to the development and availability of medical technologies that have allowed for possible changes to biological processes. In Thailand as elsewhere, there has been increasing advocacy of HRT (hormone replacement therapy) as a chemotherapeutic intervention at the time of menopause, and changing notions of menopause now—from a natural and unproblematic process to an undesirable and treatable medical condition—have extended to and challenge village women's perceptions of ageing.

The following accounts of menopause from two village women and a gynecologist highlight the diversity of understandings of menopause. These are exemplary but not exhaustive of the possible accounts in northeast Thailand, where there is considerable variation in the attitudes and experiences of women, and the interpretation of these in interactions between women and health professionals.

PERSPECTIVES OF MENOPAUSE

Jun's account [3]

Jun, now 51 yr old, reached menarche at the age of 18 [4] with feelings of fear and shame, even though she knew that menstruation was normal for all women. Her daily life remained unchanged, although for a day or two before each period she suffered from a severe headache and fever. After each period, when all feelings of discomfort had gone, she felt healthy. Jun believes that menstruation is a means by which bad blood is drained out of the body; its retention causes headache, irritability and fever because the bad blood goes to the head. With regular menstruation, she says she was strong, healthy and able to work.

To let the menstrual blood flow as freely as possible, Jun used nothing to absorb the menstrual blood, but to avoid causing others 'disgust' [5], she limited her activities to the house and immediate environment whilst menstruating. She washed her genitals each time she urinated or had a heavy flow of blood, and bathed more often than usual. When she had to go out she used rags (and, once available, sanitary pads), but when she did so, she would return with a
headache. She thinks that sanitary pads obstruct the menstrual flow, causing the bad blood to 'go up', resulting in headache. The smell of menstrual blood that sticks on the cloth also caused dizziness and a desire to vomit.

When Jun was around 50, her menstruation became irregular and heavy. After her final menses, she felt 'uncomfortable' and for over a year experienced headaches, dizziness and occasionally fainted. She did not seek medical attention, however, because she did not believe that she was sick. Rather, she thought that because her body had stopped draining out the bad blood, the residual blood was causing temporary discomfort. Sometimes she wished she could menstruate again to gain 'good health'. Since cessation of menstruation, however, she has felt relaxed, free from headaches and fevers, free from the nuisance of washing blood-soaked cloth and rags, and from feelings of disgust. She enjoys greater freedom and mobility, which enhances her ability to maintain her economic independence and autonomy. Today Jun evaluates her health to be excellent.

Khob's account

Khob, a woman aged 53, lives in a one story house with her husband and the second of her four daughters. 5 yr ago, her first-born, second and youngest daughters went to work in a textile factory in Bangkok. Two of them married and settled in Bangkok. The second daughter came back home and lives with her parents. The third daughter married a local man and lives in a house within the same compound.

When Khob was 50, her periods became irregular; 3 months later, they stopped completely. She reported that she felt weak and irritable, her appetite was poor and some nights she could not sleep. She said that she was sick because she worried too much about her daughter who remained single and had no stable income. She was afraid that her daughter would be lonely in old age and that no-one would take care of her.

Khob cultivates a jasmine flower garden, producing flowers from which garlands are made for votive purposes. Family income is supplemented through the sale of the garlands. She also looks after two young grandchildren (2 and 3 yr old) when their parents work in the rice fields. When Khob became sick, she could not continue with the jasmine flower business; her daughter took over and her husband helped her to look after the grandchildren. She visited the general and psychiatric hospitals on a regular basis for 2 yr.

She considers menopause as the beginning of old age, which she associated with poor health. However she does not associate menopause with emotional problems, and considered that her own problems were due to family problems.

Dr Chaaj’s account

Dr Chaaj is a gynecologist in his early forties. He believes that menopause should "no longer be seen as natural event", but rather as a state of estrogen deficiency that causes several deteriorations and serious illnesses such as heart disease and osteoporosis. He believes that estrogen deficiency should be treated, that hormone replacement therapy (HRT) is used to promote 'quality of life' in industrialized countries, and that its use in Thailand would ensure that Thai women have a 'happy' post-menopausal life.

Dr Chaaj’s descriptions of menopause derive from his biomedical training and his reading of the contemporary professional literature; his approach is disease-oriented. Hence his description of perimenopausal and postmenopausal women as "hormone deficiency patients" whose problems can be resolved by medical treatment: HRT is the 'magic bullet' that will relieve vasomotor symptoms, control periods, and prevent osteoporosis and ischaemic heart disease.

These three accounts were collected as part of a study conducted in northeast Thailand (Isan). It included village-based ethnographic research, and semi-structured interviews and focus groups with health personnel and perimenopausal women in the nearby provincial capital, Khon Kaen. The study explored the ways in which village women in north-eastern Thailand describe, explain and experience menopause and their health-seeking behaviour related to symptoms of menopause. In addition it explored the association of experiences of menopause with other factors, including personal and domestic factors and changes in older women's social and economic status. Such changes affect women's understanding of ageing.

METHODOLOGY

Ethnographic research was undertaken during 1990–1991, in Baan Tapiti (pseudonym), a village located 10 km north of the centre of Khon Kaen, a province of northeastern Thailand. The village was selected for the study because of its accessibility, its ethnic homogeneity (Isan, i.e. Thai-Lao and Buddhist), and the rapid social change to which it had been subject. The latter process has been influenced by electrification and other improvements to communications, the introduction of irrigation and other modern technologies to rice farming, cash-cropping and subsequent shifts in crops and related primary production activities which have, inter alia, increased village dependence on cash income and the increasing involvement of women in the tertiary sector in Khon Kaen town as well as in primary, income-generating production.

Qualitative and quantitative methods were used to enable triangulation. In addition to participant observation in the village, 150 women aged 35–55 were
asked to explain their experiences of menstruation, pregnancy, delivery and menopause, four focus groups were conducted, and 23 perimenopausal and postmenopausal women participated in subsequent in-depth interviews. Fifteen gynaecologists and five psychiatrists were also interviewed, and these data were further supplemented through participation in conferences on the topic of menopause in a teaching hospital, and observations of the treatment of menopausal patients in clinical settings. The 150 women who were interviewed can be characterized as follows. The majority were married (89.3%), with 7.4% widowed and 3.3% divorced; 25.08% were aged 35-40, 17.82% aged 41-45, 24.42% aged 46-50, and 31.68% aged 51-55. Over half (54.7%) were premenopausal (that is, they had not yet experienced signs of menopause), 11.3% were perimenopausal (women who had experienced some changes in menstrual flow and/or absence of menses due to the natural aging of ovaries over the previous 12 months), and 34% were postmenopausal (no menses during the preceding 12 months) [8]. Average reported age at menarche was 15.93 [4].

This paper summarizes women’s perceptions of menstruation, then turns to the perceptions of health personnel to explore ways in which menstruation, its meanings and its management, are being contested in contemporary Thailand.

MENSTRUATION

Six words are used for menstruation: peniyad², radau, rorb dyan, prachamdyan, men, and fajdeang. The term peniyad² ('has blood') is the oldest Isan word for menstruation, and women over 40 use this term most often. The term radau ('blood that drains from the womb') appears to have been borrowed from central Thai, and is rarely used idiomatically. Rorbdyan (monthly cycle) is similar to prachamdyan (pracham is regular, dyan means month) and both refer to a regular monthly event. These three latter terms are regarded as formal or polite, used by women primarily when talking about menstruation in a clinical setting. The word men appears to derive from the English word 'menstruation', and women learnt the term from younger women who have learnt it in English language classes in school or in magazines. If this derivation is correct, women use the term without knowledge of its origin, and they regard it as the polite and modern term that an educated person would use. Fajdeang ('red right') is slang, derived from road traffic rules (i.e. red means stop!); its use signifies menstruation as an event that obstructs or inhibits activities such as sexual intercourse and hard work. This term is used in very casual contexts, among friends or between husband and wife. In general, the terms used for menstruation are connotative of the physical and biological event, alluding to the regular passage of blood: only fajdeang alludes to its social implications, including restrictions on behaviour. These restrictions cannot be taken to imply that the menstruating woman is ritually polluting, but they do affect women’s mobility in a variety of economic, social, religious and ceremonial contexts.

With first menstruation, a young girl becomes pensaaaw⁴ ('a young woman'). Many women said they were ignorant of menstruation at the time of menarche and all reported that they felt fear and shame. Menarche is not acknowledged ritually or ceremonially [9], although it marks the young woman’s marriageability and is highly significant given the central importance of marriage and motherhood for village women.

Ideas of menstrual blood being dirty—'bad blood'—expelled from the body—and disgusting remain constant. Women say that menstrual blood can be 'poison to the body', that men are 'disgusted' by the sight of menstrual blood, that women are also disgusted by it, that they are 'ashamed' of their menstrual blood, and would be embarrassed if someone saw signs of spotting or staining. Yet menstruation is also regarded as necessary for good health and considered normal and ‘natural’, resulting in apparent contradictory attitudes: "It does not cause shame within the family but from outsiders it should be kept secret". Following this, although woman’s role as reproducer is highly valued, its processes prevent women from being socially equal to men. Menstrual blood is regarded as a sign of good health and a symbol of reproductive ability, and contrarily, at the same time, as dirty, messy, disgusting and by some as a source of negative power for use in amulets.

MEA’VAJ': BEING ‘GRANDMOTHER’ IN BAAN²MA’LI³

Menopause: sud’lyad², sud’luuk²

Peniyad² ('having menstrual blood') or prachamdyan ('monthly') is a sign of womanhood. Mod’lyad² or sud’lyad² ('run out of menstrual blood') or mod‘prachamdyan ('run out of monthly period') is regarded as a sign of ageing, the transition from one set of activities, interests and concerns to other, equally valued ones. Like menstruation, the terms used for menopause relate to the physical and biological event, the cessation of menses. But menopause has further cultural significance, for women understand that they are now no longer fertile: the local idiom, sud’lyad², sud’luuk² (no menstruation, no baby), underlines the significance of motherhood and is highly significant given the central importance of marriage and motherhood for village women. Menopause in northeast Thailand 1547
woman, grandmother or mea²yaj¹ is relatively independent of menopausal status.

In Baan²Ma³li³, in general few divisions exist between younger and older adults in terms of age, personal responsibility, political or ritual status, and economic activity; rather a continuum of characteristics and behaviours defines individual status and individuals shift categories over the course of their life [10]. To some extent, however, women's status is age-related, since a woman becomes a mea²yaj¹ (grandmother) when her adult children marry and have children. The mean age at marriage for women is c. 20 [cf. 11], and women become mea²yaj¹ at around the age of 45. Childless women also become mea²yaj¹ when their younger kin have children, and hence grandmother status is not tied to reproductive status or ability. To the extent that it is linked approximately to age, however, it is possible for women in Baan²Ma³li³ to regard themselves as 'middle-aged' at this time, although without the negative connotations nor economic, social or political advantage [12]. Elderly women are also called mea²yaj¹, and the difference between these two groups of women is largely distinguished by their own perceptions of ageing. A mea²yaj¹ considers herself and is considered by others within the community to be 'middle-aged' whilst she is physically fit and in good health, 'old' when her faculties begin to fail, she is increasingly unwell, or loses her independence. These assessments are independent of menopausal status, although cessation of menopause is regarded as an aspect of ageing with implications for women's health, as indicated in their own accounts of menopause discussed further below.

In the past, becoming a grandmother signified a change of status from reproductive adulthood to another stage in the life cycle, a stage that in culturally ideal terms should be less ego-centred and more concerned with others. Ideally, a woman should live and act in the interests of her children and their offspring, passing on the benefits of her knowledge, wisdom and experience to those younger than her. In turn, her children should accord her respect. Today, however, children receive knowledge through the formal 'modern' education system and this, together with the impact of mass communication, accessibility of sophisticated technologies, and the greater valency of materialist (as opposed to spiritual) values, has led to changes in perceptions of ageing and attitudes towards the aged. Elderly people believe that their knowledge and experience is valued less: "Nowadays the one who is rich, is the one who is respected. I have to build up some assets to make sure that my children won't leave me alone".

Social changes concomitant with modernization have led also to specific changes to women's roles at mid-life. Increased monetization of the economy, the outmigration of men and younger women in search of wage labour, and increases in the number of female-headed households, have made it imperative for women to remain economically active. Since ageing is associated with decreasing work capability and greater physical and financial dependency, old age is now viewed ambivalently if not negatively, and the end of menstrual periods, increasingly regarded as a sign of approaching old age, appears to be taking on new meanings that reflect these changes.

The average age of menopause among women interviewed in Baan²Ma³li³ was 47.3 yr, although women themselves regarded 50 as the 'appropriate' age for natural menopause. A woman who reaches menopause before 50 is considered to have reached menopause prematurely, and this is regarded as unhealthy.

Menopause clearly demarcates reproductive and non-reproductive potential (and experience) in Baan²Ma³li³, although it is not marked ritually in any way. Within Baan²Ma³li³ and other Isan villages, other changes to individual status are acknowledged as rites of passage, and these include marriage (avyan) and pregnancy (miiitorn³), both of which operate to define and consolidate kinship (and hence economic and political) ties. The stated purpose of the marriage rites is to ensure that the couple share a prosperous life; pregnancy rites are held to give the mother strength and an easy delivery. Both also mark a change of individual role and status: from childhood to adulthood in the case of marriage, from childlessness to motherhood with pregnancy. The latter change in status is especially important [13]. In contrast, as already noted, neither menarche, marking the beginning of reproductive potential, nor menopause, marking its cessation, receive special attention and there are no rituals for them. Neither menarche nor menopause have a necessary and special relationship to a woman's role and status within the family or society, although failure to menstruate clearly would have a significant affect on a woman's status, insofar as her putative inability to reproduce would prevent her marrying. The biological uncertainty of the timing of menopause is only part of the reason for its lack of celebration; the change from fertility to infertility that occurs with menopause does not affect a woman's status within the household or the wider community, although it is concordant with other expectations of how older women should conduct their lives.

The ambivalence of menopause

Generally women welcome what they regard as freedom from the burdens of menstruation, pregnancy and childbirth. But reaching menopause is also a recognized biological marker of ageing, and old age a time when energy is believed to decline and health deteriorate. As noted, women expect that at around 50, menses will stop and fertility cease. With menopause, they are able to relax from personal menstrual taboos such as those that restrict their mobility, and enjoy greater independence as a result,
and most women interviewed in this study desired to
reach menopause because of this:

After the final cessation, I felt I was not as strong as before.
It might be the result of the ageing. However, when I
reached menopause I didn't have menstrual blood, so I no
longer felt disgusted, (there were) no feelings of irritation
because of the flow, and I was free from washing rags and
from the smell. I am so glad that it (menstruation) is over.
I felt it was a release. Now I can go to the temple without
anxiety of menstruation or spotting. I can go to other places
very far from here to make merit as well.

In sum, 82% of women aged 35–55 indicated that
there were advantages to reaching menopause,
including freedom of anxiety about menstruation
(37.33%), absence of menstrual blood that causes
disgust (28.67%), and convenience when travelling
(21.99%). Women also referred to freedom from
pregnancy, end of menstrual cramps, saving money
from buying sanitary pads, feeling healthy (although
other women believed that menstruation was a pre-
condition and determinant of good health), and
the absence of unpleasant odour. However, several
referred to conflicts between their desire to cease
menstruation and to remain youthful:

Four months before the final period, I got an unusual heavy
flow, especially in the last period. It poured out like tap
water. There was heat going up and down inside my body.
At night I got sweaty. These symptoms have gone with the
absence of menses. Since then, I have felt that my body has
been heavy. (I've had) headaches, muscle-bone pain, bad
moods, and have felt irritable. I want to menstruate again
because if I have a period, I will feel great and light.

The desire to remain young is problematic, since
menstruation is both associated with youthfulness,
energy, and good health, and with limited mobility,
feelings of being dirty, and disgust. Further, Buddhist
ideology emphasizes the impermanence of life, and
ideally women are encouraged to accept the age-
related decline of bodily functions.

Although women associate menopause with old
age, no direct causal links were made by them
between menopause and ageing, or menopause and changes
in women's roles, except with respect to
sexuality. Fertility is associated with sexuality, and
sexual desire and activity should appropriately cease
with the cessation of fertility. This is both a norma-
tive and descriptive statement, that is, sexual activity
is considered to be inappropriate for older women.
Many women reported a decline in libido, in their
qualitative experience of intercourse (pleasure), and
in its frequency, because "I am old and the old do not
think much about such things (coitus)"; not being
concerned with sexuality was seen as 'releasing' and
'relaxing'. The decline of sexual desire and enjoyment
was reported by and expected and accepted by almost
all postmenopausal women. In the words of one
woman:

Now I am 50, my last period was 3 yr ago. I still have sex,
one a month, not more than that, to serve my husband's
needs. I love making at my age is just like riding a bike
without air in the tyres.

And again:

I don't want to touch my husband. I feel irritated whenever
he touches me. It is good because when I practice meditation
or preaching, this thinking (sexual) does not come to my
mind.

As indicated, freedom from desire gave women the freedom to concentrate on religious activities.
Another informant amplifies this perception:

Now I feel free and released from the marriage problem. I
have realized that nothing is permanent. I am old and
concerned with nothing. Now I have no sexual desire, it is
easy to cut off the problem. Now I don't think about him
(husband). At this stage I feel free to devote myself to
practice religious activities for peace (of mind) and merit
making. Also at this stage my physical condition does not
allow me to do hard work.

In addition, ideas of 'calmness' and 'coolness'
as appropriate states for older people encouraged
women to view menopause as a gain rather than
loss. In line with the classification of both physi-
ological and emotional states as hot or cold, fol-
lowing Thai medical categorizations and elaborations
of humoral medical theory [14], at menopause
women are no longer in a 'hot state' due to the end
of 'hot' menstruation and the decline of 'hot' sexual
desire. Both bodies and emotions are 'cool' and
therefore 'calm', qualities worthy of respect in the
elderly.

Individual accounts and variation in menopause

Women consistently regarded menopause as a
welcomed state that freed them from their bodies.
Summary accounts of the physical experiences of
menopause similarly followed a common narrative.
This emphasized dizziness associated with beliefs of
'bad blood', and loss of energy associated with
general understandings of ageing and unhealthiness.
As noted, menstruation is considered to be a mechan-
ism that allows the body to discharge 'bad blood'.
With menopause the body loses its capacity to do this
and the consequent residual bad blood 'goes up to the
head', causing dizziness:

When my periods stopped, I would feel bad. There were
some months when my period didn’t come, then my face
went dark and pale. I felt uncomfortable and I couldn’t go
out because of dizziness.

Another woman explained:

Before menopause, menstrual blood is cleared out monthly.
A good clear out preserves good health. Some women
regard the heavy flow at the final period as the last clear
out. Unlucky women whose last clear out was not ‘good
enough’ would have some residual (bad blood) in the body.
The retention of bad blood causes dizziness and headache.
The residual blood will be drained out later, but in different
forms such as sweating and urinating. When all the residual
is drained out, all distress will go.

Such understandings derive from the observational
experiences of bodily elimination. Villagers note that
sweat, urine and faeces are unwanted substances that
the body has to drain or clear out. If the body fails
to clear them out, they cause discomfort. This notion is also applied to menstrual blood and lochia.

Yet the experience of menopause proved to be highly individual (see Table 1). Some women experienced many symptoms, others relatively few, symptoms included those that might be regarded as vasomotor, somatic/physiologic or psychological in a clinical context. This division of course was not salient for village women. Further, a number reported no symptoms and were barely able to recall when their last menses was; others experienced only a heavy or irregular flow prior to complete cessation of menstruation.

A minority mentioned hot flushes or night sweats, in contrast to other Thai studies or studies of western women [15]. In Baan 'Ma tl', only 23% of women reported hot flushes; 14% of postmenopausal and 17% of perimenopausal women had experienced sweating. No specific word for 'hot flushes' exists and women use the term orkh horn' waaup waaup' (‘heat sensation intermittently’). This is the same term used to describe the sensation of heat caused by a burn or by touching a hot chilly; it was described as being qualitatively very different from fever: like being in contact with fire, like a burning sensation inside the body, or burning skin. Women said this was so uncomfortable that they became irritable, and identified focal points of heat: at the ankle, at the waist, or from the inside to outside of the chest, running down to the leg and up to the face. None mentioned cold flushes and only three mentioned night sweats.

Of all symptoms, only headache and dizziness were associated with cessation of menstruation, and the list of symptoms was generated through a series of prompts and tracer questions. Among perimenopausal women, headache was the predominant health problem which women experienced, which they reported caused irritability, loss of concentration, and affected their ability to work. Postmenopausal women were most likely to have mentioned blind spots before their eyes, forgetfulness and sleeplessness, but they regarded these as ‘normal’ due to ageing and did not consider them to warrant medical attention. They associated sleeplessness or disturbed sleep patterns, pounding of the heart, poor appetite, poor concentration and/or depressed mood with penprasaat (‘having mild emotional problems’). The two women who experienced these symptoms had been presented to the psychiatric hospital and were told that their problems were not serious and typical of menopause; they were prescribed psychotropic drugs and multi-vitamins. Women associated ‘pounding of the heart’ and ‘excitability’ with heart disease, and where the symptoms persisted and affected their ability to work, they would seek medical attention.

Women also reported numbness of extremities and paraesthesia (‘pins and needles’), which were regarded as annoying but not requiring action.

Women who experienced somatic symptoms at menopause believe that these were temporary and did not seek medical attention. Further, as noted above, since sexual inactivity is regarded as appropriate in older people and loss of libido with ageing is regarded as both natural and appropriate, no perimenopausal or postmenopausal women sought help for this. Emotional symptoms were considered to be a consequence of stressful economic or personal problems, and were not associated with menstrual irregularity.

Since menopause is regarded as a natural event of a woman’s life, the changes that come with menopause are not seen as illnesses. But where the changes affect a woman’s daily life so that she cannot work as usual, she might seek help from either a traditional healer such as mor* tham (magic healer), mor*yaasamun* phraj (herbalist) or health practitioner [16]. Even though heavy flow is regarded as indicative of ‘good’ menses, individual woman may regard an unusual or heavy flow as an indicator of a serious illness such as cancer. Perimenopausal women who experience an uncharacteristically light or heavy flow,
or experience irregular menses, seek help to ensure 'good menses'. They may seek advice from a village elder (often a kinswoman or a neighbour) or a herbalist for herbal medicine to encourage menstrual flow, consult a health practitioner at the local health centre for prescriptions (for vitamins, for instance) to improve their health status, or present to a private clinic; they rarely present for such problems to the hospital. Women who regarded menstruation as a mechanism for draining bad blood out of the body, and who therefore regarded themselves post-menopausally as unhealthy, may also seek to have 'good blood' and be healthy by taking various medications to relieve key symptoms: Paracetamol to relieve headache and dizziness, Fersolate (ferrous sulphate) to increase haemoglobin, and Diazepam to relieve insomnia. In addition, perimenopausal or postmenopausal women with complaints of chronic dizziness and severe headache might seek further medical help; since they relate headache to mental health problems they frequently present to the psychiatric hospital.

THE CLINICAL INTERFACE

Beliefs in the relationship of menstruation and health, together with beliefs in the efficacy of western medicine, encourage women to seek biomedical care. During the consequent clinical encounter, medical understandings of the menopause are transmitted to women by doctors. Some women—in this study, urban not village women—are labelled as having 'menopausal syndrome' and are introduced to hormone replacement therapy (HRT). These women tend to view menopause not as a natural event, but as one that can be controlled, treated or prevented to avoid serious illness.

Although Isan village women view menopause positively and as a natural event, each year a number present with menopause-related health problems at medical institutions, including on rare occasions the village health center at Baan‘Ma’ti and more often to the gynecological department of the general hospital, the psychiatric hospital, or to a private medical clinic. Consistent with the predominant symptoms experienced during menopause as described above, most women present because of an unusually heavy flow, headache or dizziness. Complaints of hot flushes are very rare. In this respect, data from the psychiatric hospital are instructive. From October 1988 to January 1990, 32% of women who came to this hospital were aged 40–59, and 2% of these women (n = 73) were diagnosed as having ‘menopausal syndrome’. Women reported complaints categorized as somatic, psychosomatic and psychological, with the latter categories predominating. In particular some 83% of women presented with headaches, 77% with insomnia, and 59% with irritability; a further 43% experiencing ‘feelings of suffocation’ and 43% poor appetite [17]. All other symptoms associated with menopause were reported by less than 25%.

Observations of clinic sessions at the psychiatric hospital provided corroboration of the patterns indicated by these case records. 42 of the 43 women aged 40–59 presented for medication; the exception sought investigation for pregnancy because of amenorrhoea and dizziness. None of the other cases were diagnosed as experiencing menopause-related symptoms; 18 women who reported irregular menses or amenorrhoea with headaches, dizziness or insomnia were diagnosed as having an anxiety state and prescribed tranquilizers. Women’s own accounts of their health problems fitted comfortably with this psychiatric diagnosis: they did not associate their menopausal status and experience of headaches, dizziness or insomnia, nor did they associate menopause with emotional problems. Rather, they related their symptoms to ‘stress in daily living, economic and family problems’. This notion is similar to that given by women in Baan‘Ma’ti: “If the absence of menstrual blood causes mental illness, why are our relatives or all the old not mad? I think family problems cause mental illness”.

PERCEPTIONS OF MENOPAUSE AMONG HEALTH PERSONNEL

Despite these common sense pragmatic understandings of menopause there is increasing evidence in Thailand of a growing interest in the menopause by medical practitioners, and a shift to reconstruct menopause as pathology. This interest is reflected by the increase in menopausal research, undertaken to assess and identify the magnitude of menopausal problems. Papers presented to the Sixth International Congress on the Menopause held in 1990 in Bangkok, Thailand, for example, indicated the predominant interest in medical aspects of the menopause and its construction as a deficiency. Here, the basic assumption is that with increased life expectancy, Thai women can expect to have increased health problems caused by the menopause—or more correctly, by oestrogen depletion—especially osteoporosis and vascular risks.

Interviews with psychiatric staff and gynaecologists illustrate the divergence of their understandings of menopause from those of village women, described above. Psychiatric personnel tended to view menopause as a biological pathology that leads to emotional disturbance, loss of ‘feminity’, and old age—here collapsing conventionally descriptive statements of menopause with value-laden assessments. ‘Menopausal women’ are likely, in their mind, to have bad moods, be irritable, insecure, emotionally labile, feel that they are ‘incomplete’ (since they are now devoid of menstruation that is the ‘mark of womanhood’), teangthaw‘taoy (asexual and infertile), and lack ‘sex appeal’. Such characterizations of women are on the whole negative, and inconsistent
with women's own, more positive evaluations of the same biological events and physiological outcomes. Other descriptions preferred by psychiatrists incorporate more positive perceptions of ageing, as a time of increased respect and a time for 'release' of burden: "She is becoming old and receives more respect", "It is time (for her) to go to the monastery and give more emphasis to religious practice". But all believed also that menopausal women are at high risk for mental illness, although especially where the woman has a 'poor personality' or is experiencing stress or conflict in her daily life. Interviews with gynecologists (n = 15) provided further evidence of the negative connotations of menopause within medicine, as well as indicating the growing popular perception of menopause, whether surgical or natural, as an oestrogen deficiency disease which should be treated with HRT for both curative and preventive purposes [2, 16]. This view has been encouraged by the promotion of drugs by pharmaceutical companies [6]. The following two examples give some indication of the way in which menopause is currently subject to medicalization:

Dr Suporn (pseudonym) is a female gynecologist, aged 54. She prescribes HRT to all of her patients with total hysterectomy, bilateral ovariectomy, or who suffer from severe reported vasomotor symptoms. She believes that all peri-menopausal and postmenopausal women should be treated with HRT, and plans to use HRT as a preventive measure for osteoporosis and ischemic heart disease. Now she is establishing a menopause clinic in her workplace.

Dr Pitt is a male gynecologist in his late 50s. He describes menopause as an event in the ageing process that causes 'loss of liveliness' in the older woman. He states that physicians have to help menopausal women by prescribing HRT. Only HRT can help those women be happy, the same as when young.

Some health professionals are cautious of the prescription of HRT, although primarily for economic rather than social and cultural factors since the cost of HRT is relatively high. Physicians' assessment of the utility and feasibility of its prescription does not, therefore, take account of the way in which the use of HRT renders pathological a natural process of ageing, placing women in a position of dependency and in a 'sick role' for a substantial part of her life [19]. Further, the putative benefits of HRT lead most physicians to conclude that if the benefits can be proven to outweigh the risks, women should be on medication to remove the short term vasomotor symptoms and to prevent osteoporosis and ischaemic heart disease which are 'consequences' of menopause.

**CONCLUSION**

Even though the magnitude of health problems related to menopause in Thai women has not yet been investigated, television programs and articles in Thai women's magazines now describe menopause as a 'crisis' stage of middle-age women that women should seek help from medical personnel. HRT is offered as a 'magic bullet' to maintain health and youth, and to prevent a loss of bone mass and heart disease. In this context—in addition to the questionable promotion of HRT as a preventive rather than therapeutic agent—youth is privileged over ageing, and western technological approaches over village understandings and values.

A growing literature has drawn attention to the variability of women's experiences of menopause, with respect both to the reported or perceived physiological experience of menopause, and to the psychological and social meanings ascribed to the climacteric, cessation of menopause, and the end of fertility. The work of researchers such as Beyene among Mayan and Greek women, Lock among Japanese women, Martin in the United States, Davis among Newfoundland, Canadian women, and Goodman in Hawaii [2, 6, 20] point to the fact that the perceptions, recognition and experiences of unpleasant symptoms associated with menopause are distributed very unevenly within and across cultures. They draw also attention to differences in the value placed on the body and its processes, including those associated with menstruation and its cessation, and with ageing, sexuality, and fertility. These views are not fixed, however.

In *Baan* Ma'li we have noted that menopause is considered to be a normal biological event associated with ageing. But this perception is changing, and some women now view the biological changes and related experiences of menopause negatively, consider them disruptive, and therefore seek medical attention. These women talk about a medication that they have heard about from medical doctors, although none are currently on such medication. As one woman said:

'My menses are irregular and I felt unhappy so I went to see a doctor. The doctor told me about a kind of pill that can control an uncomfortable feeling during this period but he was not sure that I could afford the pill's cost so he decided to give me a vitamin instead.

From this point of view, menopause is now seen to be controllable and avoidable. As women's economic welfare and personal and social status is increasingly tied to their ability to remain economically active, so too is there a growing interest to prolong menstruation, and to control the process of ageing, loss of vitality and energy, and health. *Baan* Ma'li women have considerable confidence in the power of biomedicine, in contrast to older alternative sources of knowledge and healing methods: of relatives, neighbours, friends, and professional healers and traditional healers. Village healers are now marginal to acute care, although they continue to play an important role in palliative care and the relief of chronic symptoms [14]. Biomedical services in modern Thailand have been extended to cover not only the control of infectious disease, the
provision of ante- and post-natal care, and growth monitoring for infants and small children, but now also other biological processes which have been medicalized and subject to surveillance. Popular understandings of menstruation, pregnancy, childbirth, and menopause, all of which were once perceived as natural events of women's reproductive life, have become matters subject to medical management.

No research has yet been conducted to indicate the appropriateness and safety of HRT for Thai women. The few available studies related to menopause indicate simply wide variation in the experience and/or reporting of vasomotor and other physiological symptoms of the menopause, and women's limited concern about these symptoms or other effects such as loss of libido, vaginal atrophy, and dyspareunia. There has, in addition, been little research about Thai women in mid-life, although the research on which this paper is based [6, 17] indicates that village women continue to regard menopause as normal and desirable, and do not associate it with a broad range of health problems that might occur with greater frequency with ageing. Women tend to minimize any discomfort associated with menopause. Perceptions of menopause as a natural event, one that signals a different stage in the life cycle that is a productive and highly valued culturally, lead women to view menopause positively. These understandings are challenged by biomedical representations of menopause, the publicity given to HRT within the popular press in Thailand, and by diagnostic and prescriptive practices that have medicalized menopause as a problem of oestrogen deficiency.

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REFERENCES


3. Italics terms and names are transcribed from the northeastern (Isan) language using Pininding's system. Tone markers can be null, 1, 2, 3, or 4. The null tone is unmarked.


5. Because menstrual blood is regarded as 'bad blood', which is dirty and is associated with the genitals.


9. As is the case for Mayan women, for instance, see Beyene, Ref. [8].

10. For example, men's participation in monastic life is not dependent on age and men may serve as monks at any stage, and more than once, in a lifetime.


15. Sukavatana et al. reported that 80% of the study population experienced hot flushes; Chompootaweep reported that 58% did so. In contrast though, Chaiphibalsarisdi's study of Thai women gives a figure of 29%, and no Mayan women were reported to...


