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Menopause Narratives: The Interplay of Women's Embodied Experiences With Biomedical Discourses

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Abstract

Conventional approaches to menopause tend to contrast the biomedical position on menopause with women's actual experiences of it. Rather than focusing primarily on the tensions between these perspectives (biomedical vs. lay), our emphasis here is on the impact of biomedicine in shaping participants' perceptions of their status as menopausal. Based on interview data gathered from 39 women in Ireland, we argue that the cultural authority of biomedicine shaped participants' experiences of the body and how they constituted their health identity. We assert that, ironically, this was particularly the case among those who most strongly contested biomedical definitions of their situation. In addition, biomedical practitioners' definitions had a strong normalizing power in how the body was experienced. We conclude by noting that our analysis problematizes the notion of privileging "women's experiences" as advocated by some feminist perspectives. The heavy influence of biomedical discourses in shaping participants' embodied experiences demonstrates the pervasive impact of prevailing discourses on women's experiences.

Keywords

embodiment/bodily experiences; ethnography; interviews; Ireland, Irish people; medicalization; medicine; women's health

In menopause literature, there tends to be two broad and largely opposing versions of menopause presented. The first, and older of the two, is the biomedical menopause characterized as a biological event, albeit with some definitional variations. The second, a more recent emergence, is a feminist perspective that draws attention to medicalization of menopause and the framing of menopause in a negative way as a hormone deficiency. Most accounts of the latter point to biomedicine's failure to understand women's embodied experiences, the wider psychosocial impact of menopause on women's lives, and the diversity of women's experiences in relation to it, including positive aspects. Based on a study of women in an Irish context, we take a slightly different approach to that, which contrasts the conventional biomedical position on menopause with women's actual experiences of menopause. Rather than focusing primarily on the tensions between the dominant biomedical definition of menopause and women's own experiences (which were indeed substantiated in our data), our emphasis here is on the impact of biomedicine in shaping participants' perceptions of their status as menopausal. Our analysis will tease out the way in which the biomedical construction of menopause mediates and moderates the embodied experience of menopause for some women. It will also illuminate how women who challenge biomedical knowledge of menopause can simultaneously reinforce the cultural dominance of doctors as the ultimate arbitrators on the status of menopause.

Understanding Menopause From Different Vantage Points

We begin with an account of some of the background literature on menopause, including tensions within feminist thought about how the female body should be viewed. We also explore central tenets of the debate between the biomedical definition of menopause, and the feminist challenge to this definition. We then turn to the study's methodology, findings, and finally to a discussion in which we highlight the specific contribution of the study to scholarship in the field.

In recent years, a new wave of research undertaken predominantly by feminists has opened up, seeking to understand women's embodied experiences of menopause and the meaning of menopause for women from their perspectives (Dillaway, 2005a, 2005b, 2006). Much of this work arose to countermand what was deemed to be narrow biomedical definitions of menopause as a deficiency syndrome—a body of work that focused on women's bodies as different from those of men but with a much different emphasis than that of the feminist work that followed. In short, biomedical accounts have been castigated for directly and indirectly constructing menopausal women as deficient (in hormones) and thereby in need of interventions

(hormone replacement), whereas "difference" feminists—those who highlight rather than play down bodily differences between women and men—have focused on women's experiences (as being different from those of men) to help identify the type of social order that might best accommodate women's needs.

The medical menopause has taken various guises over the past few decades. The focus during the 1960s was the promotion of estrogen as a youth-preserving treatment (Fugh-Berman & Scialli, 2006) and the construction of menopause as a deficit of hormones amenable to correction through hormone replacement therapy (HRT). Hormone therapy promised to be the "elixir of youth," enabling menopausal women to remain "feminine forever" (Wilson & Wilson, 1963). Following a decline in the popularity of HRT in the wake of scares about an increased risk of endometrial cancer in the 1970s, HRT reemerged in the late 1970s and early 1980s as a prophylaxis against disorders of middle age, such as osteoporosis and cardiovascular disease (see Murtagh & Hepworth, 2003a). However, as Palmlund (2006) put it, the HRT bubble finally burst following the results of two seminal studies, the Heart and Estrogen/Progestin Replacement Study (HERS) and the Women's Health Initiative (WHI), both of which demonstrated negative health results of HRT. Because the focus of this article is on how women's subject position and identity are constituted in the context of biomedical "truths" about menopause, it is not intended to go into detail about the HRT debate, but rather to highlight the centrality of hormonal determinism in biomedical definitions of menopause. Although a number of versions of what menopause is are advanced within biomedicine, Wendy Rogers (1997) noted that what constitutes menopause is evasive, and that it is impossible to establish menopause with complete certainty, even with the recent availability of hormonal tests. However, virtually all biomedical perspectives focus on hormonal levels, the absence of menstrual periods, and chronological age.

Feminists have challenged the prevailing biomedical model, objecting not only to the definition of middle-aged women as deficient (Hunter, O'Dea, & Britten, 1997), but also to the "equation of women with their reproductive capacities" (Dillaway, 2005b, p. 290). Feminist approaches therefore seek to supplant this pathological approach to menopause, asserting instead that it is a "normal, life-change" transition (Goldstein, 2000). Within this emancipatory feminist discourse, menopause is reconstructed as a positively significant "rite of passage" that provides space for reevaluation and new-found freedom. Moreover, the end of menstruation is redefined as a gain, as opposed to the discourse of loss which characterizes the medicalized menopause (Coupland & Williams, 2002). The idea of uncovering a "natural" woman with a "witch-like" status (Greer, 1991), separate from biomedical influences, whose subject position is constituted without reference to a

medical framework, situates feminists like Greer (1991), Coney (1993) and Klein (1992) as modernist feminists. These feminists have criticized the biomedical construction of menopause on account of the universal nature of its definition of menopausal women (Murtagh & Hepworth, 2003b). Nonetheless, just like the biomedical model, this feminist model has drawn criticism. Murtagh and Hepworth (2003a) argued that significant similarities exist between those positioned on the feminist and medical sides of the debate. Crucially, both models profess to hold an "immutable truth" about menopause. Both produce a knowable subject: for feminists, this is constructed as a "natural" menopausal woman who should shun medical intervention; for the dominant medical ideology, this consists of a woman at the "mercy of her hormones." Both models, they assert, serve to restrict the options accessible to menopausal women.

Indeed, the new wave of feminist research seeking a broader understanding of what menopause means for women has tended to find that the theoretical demarcation between biomedical and feminist definitions collapses when women's experiences are examined. Although the "hegemonic status" of the medical menopause is sometimes presented in opposition to "the voices of women" (Morris & Symonds, 2004), research has found that there is a great deal of diversity in how women experience menopause, and indeed how they relate to biomedical constructions of menopause. Although Kafanelis, Kostanski, Komesaroff, and Stojanovska (2009) classified most women in their study as "inventive copers" who viewed menopause as a natural process, there was a sizeable minority whom the researchers coined "troubled copers," who were found to embrace biomedical understandings of menopause. Similarly, in Kolip, Hoefling-Engels, and Schmacke's (2009) study of why postmenopausal women take HRT, the researchers found that although several women were ambivalent about using HRT, others endorsed its use wholeheartedly, attributing to it "almost magical effects."

Other studies have found that individual women shift between biomedical and natural discourses when recounting what menopause means for them (Guillemin, 2002; Hunter et al., 1997; Morris & Symonds, 2004; Stephens, Budge, & Carryer, 2002). Based on interviews with 45 women, Hunter et al. found that women's perceptions of menopause and HRT were not fixed. When asked about their decision-making processes in relation to HRT, a commonly mentioned theme by participants in their study was to question whether it is "natural" to take medication for menopause, prompting concerns about disturbing the natural rhythm of their cycles. However, neither this notion of naturalness, nor menopause itself, were static concepts. Where women experienced significant symptoms and problems, menopause migrated from being a

"natural process" into the realm of illness and disease, and therefore became a legitimate target for treatment. Similarly for Guillemin (2002, p. 451), it would be a fallacy to construct the official, medicalized account of menopause as distinct from the lived experiences of menopausal women because the menopause-as-hormone-deficiency view was a crucial organizational concept in the menopausal accounts of participants in her study.

Stephens et al. (2002), using focus group data from 48 participants, explored the varying discourses utilized in creating their understanding of menopause. Women in the study were found to draw on the biomedical discourse, which enabled them to utilize medical terms (i.e., symptoms, hormones, sides effects, risks) to describe their experiences of menopause. The drug discourse, incorporating as it does negative images from recreational drug use such as "pill popper" and "dependence," was often drawn on by participants to oppose the use of pharmaceuticals such as HRT. The natural discourse was used to redefine the construction of menopause as a time of threatening change, and similarly to resist the use of artificial synthetic hormones, with HRT constructed as unnatural, and by corollary, unhealthy. Based on the accounts of 11 menopausal women, Morris and Symonds (2004) argued that obtaining medical help for hot flushes and other symptoms is simply seeking relief rather than an ideologically driven act based on a blanket acceptance of all that the pathological, medical model entails. In fact, they found no deeply held confidence either in the medical model of menopause or in the treatments it offers. Instead, women utilize a range of alternative discourses on menopause, including notions of naturalness, prompting them therefore to seek remedies from homeopathy, diet, and other forms of alternative therapies alongside any medically based assistance they might utilize. The authors assert that although at times women appeared to accept the dominant model of menopause as a pathological condition, this often coexisted with other models. Women's conceptions of menopause and HRT were often contradictory, with competing discourses informing their understanding. Thus, alternative discourses are often utilized in women's accounts, in conjunction with the pathological model.

A final study that we consider is Goldstein's (2000) analysis of experientially constructed versions of health and illness among a self-help Internet group of women dialoguing with one another about menopause. By emphasizing the natural and unproblematic nature of menopause, these women felt that the feminist perspective served to silence the voices of those who felt in need of medical attention. They rejected the right of either feminist or medical model to claim universal knowledge of menopause or the women experiencing it.

What is particularly interesting about this study in light of the argument that we are pursuing—namely, that formal biomedical diagnosis of menopause impacted on women's bodily experience and health identity—is that women in this Internet group endorsed elements of the medical menopause, yet created "a distinct medical culture" outside of the formal biomedical setting. Although primacy was given to subject experience, Goldstein argued that the group had built a "vernacular health theory" (p. 314). Even though the notion of vernacular theory arises from the work of McLaughlin (1996) and is theoretically close to Foucault's (1980) notion of "subjugated knowledges," what Goldstein meant by this is a community-based theory with a focus on empowerment by those excluded by established institutions.

We revisit this notion of vernacular theory in our discussion, but first let us briefly summarize what existing scholarship imparts about how menopause is constructed. Theorizations of menopause are crudely split between the biomedical menopause in which menopause is viewed as a hormone deficiency, and feminist perspectives from which it is viewed as a natural process influenced by social context. However, empirical studies that have emerged in recent years have found that both versions intersect to varying degrees in women's constructions of menopause. In this article, we push this issue a little further by drawing on the voices of menopausal women to elucidate the cultural authority of biomedicine in shaping their experiences of the body and in altering their subject position and health identity.

Method

The aim of this study was to describe and analyze a sample of women's experiences and understandings of menopause. Thirty-nine women between the ages of 42 and 63 from a range of socioeconomic backgrounds and with representation from both rural and urban areas in Ireland participated in the study. Data were collected through 36 individual, in-depth interviews and one group interview, and were analyzed using a thematic analysis. Ethical clearance for the study was processed through the Human Research Ethics Committee at University College Dublin.

Inclusion criteria for the study were that women identify themselves as menopausal, irrespective of whether or not they had sought help for particular symptoms. Participation was confined to those who currently defined themselves as such, or who regarded themselves as such up until the previous year. What became clear during the collection of data was that the self-ascribed status of being in menopause was far from clear-cut, as menopause did not tend to have a definitive end point, which accounted for some women in their 60s among those who participated. Recruitment to the sample was as follows: A selection of women's

organizations was identified among those listed as associations affiliated with the National Women's Council of Ireland, details of which appear on the Council's Web site. In the process of recruitment, this type of purposive sampling was combined with an established sampling technique called snowball sampling, whereby participants selected through the agencies were also asked to identify others whom they believed to be suitable participants for the study. The specific organizations approached were those that were likely to engage with women in their midlife years, and were based in both rural and urban areas in Ireland. The nature of the work of the organizations was taken into account when identifying those to contact, so that women with diverse life experiences and from a range of socioeconomic backgrounds would be reached.

The initial contact with these agencies was via an email message sent concurrently with an identical letter forwarded by regular mail. The letter outlined the study, and stressed that a diverse range of experiences were sought; it indicated that participation was open to those who had an unproblematic menopause as well as those who had more difficult experiences. A few days after the letter was sent, a follow-up telephone call was made to the organization. This telephone call was central in the recruitment process, because the rapport established with the coordinator and her enthusiasm often determined the effort made to make the information available to women connected with the organization. Of the 23 women's organizations contacted, eight facilitated the selection process, yielding 23 women. Twelve women were recruited by snowball sampling, one was accessed via the Women's Health Council, and 3 via a Traveller's (Irish ethnic group) organization. Of the 39 women who were interviewed, 17 were recruited from rural areas. Eighteen women were middle-class (although at least 3 of these were from working-class backgrounds), 18 were working-class, and 3 were from the Traveller community. The women's ages ranged from 42 to 63, with a mean age of 53.5 years. (This age range is comparable to that of participants in extant qualitative studies on menopause.) Of the 39 participants, 8 were lesbian and 31 were heterosexual. Written informed consent was obtained from each participant.

Data were collected through interviews, a method well suited to the study's aim of uncovering women's experiences and understandings of menopause. All, apart from one, were individual interviews; the exception was a focus group comprised of three participants who requested a group rather than individual interviews. A topic guide was used to focus the interviews, and was based on a number of key issues. The guide was sufficiently loosely structured to afford flexibility in the manner, order, and language of questioning. With the permission of each participant, interviews were audio-recorded and later transcribed. Interviews

took place in a variety of locations, including a room at the organization from which the participant was recruited, the participant's home, a café, a hotel lobby, and the researcher's office. The average length of the interviews was 50 minutes.

As is consistent with qualitative research, data analysis for this study commenced as soon as the first few interviews were completed, and continued throughout the data collection phase. This involved organizing data into conceptual themes by following an analytical technique referred to as *thematic networks* (Attride-Stirling, 2001). The steps in the analysis were as follows: (a) the extraction of basic themes of the lowest order variety; (b) aggregating basic themes into a more abstract organization of themes; and finally (c) constructing macro themes that brought together lower-order themes. This process was facilitated by the computer software program NVivo **[AU Q: 1]**, which enabled the large volume of data to be organized. Because the organization of data using computer software facilitated an empirically based descriptive level of analysis, as the steps of the analysis advanced, a finer, more theoretical analysis was also conducted to explain what was going on in data in relation to the wider social context.

Findings

The Impact of Biomedical Definitions of Menopause on Women's Embodied Experiences

Although a minority of participants never sought biomedical help in relation to bodily changes that they associated with menopause, most (30/39, or almost 77%) were influenced by the authority of medicine in diagnosing menopause, predominantly because of the doubt and confusion surrounding their bodily changes that affected their usual sense of well-being. Narrative after narrative in this study told of women thinking that they were "going loola," "losing the plot," "going mad," and "going off [their] head," until such time as a confirmation of menopause emerged from a doctor. The underlying feeling of uncertainty is epitomized in the case of a woman who began to observe the vagaries of her body associated with menopause at the age of 37, and had an extremely strong sense prior to receiving the hormonal laboratory test results that they would confirm her menopausal status (as they did). She nonetheless described her sense that the test affirmed that her symptoms were indeed "real." This was in spite of her having suffered severe bodily vicissitude, and of reportedly "knowing" with conviction that she was in menopause:

Participant (P): I knew myself even before the tests came back.

Interviewer (I): Did the test results make a difference to how you felt?

P: Well I was sure myself anyway, but they did add that bit of certainty, that this was absolutely down to something definite, and made what I was feeling real. (Andrea, middle-class) **[AU Q: 2]**

The significance of confirming one's bodily changes as menopause-related, even when distressing bodily experiences remained unappeased, was clearly evident in another case. Following a gynecological procedure, the woman in question began to experience a range of symptoms, such as severe fatigue, night sweats, severe forgetfulness, panic attacks, and headaches from the age of 32. However, she remained undiagnosed until age 37. Unlike some other participants who suspected that they were menopausal when going to the doctor, this participant merely thought that she was "losing it," and going insane. In a "totally suicidal" state, she attended a general practitioner (GP) who had just replaced her regular physician. The new GP suspected that the woman might be menopausal. When the latter received a confirmation of test results to substantiate her menopausal status, the strength of her urge to commit suicide abated:

I have to say now though, since it [menopause] was diagnosed, more than the fact that I was actually on HRT, even before the HRT, helped regarding the suicidal feelings. Because it was like, "Hey this is okay," you know? I suppose it was thinking that there was something wrong with me that made me feel so depressed and that. (Nuala, working-class)

Clearly, a biomedical pronouncement to establish aberrant bodily experiences as menopausal and not figments of the imagination was important to the majority of participants. Indeed, most did not have hormone-level testing at all, but happily relied on the doctor's judgment about their status. In spite of mixed feelings that some women had about being menopausal and its connotations of aging, the medical endorsement of menopause as the basis for the vagaries of the body usually also brought feelings of relief. The minority who had chosen not to go to their doctor either experienced few bodily changes or were sufficiently confident about their status so as not to require further affirmation; however, even a few of these indicated an uncertainty that problematized their identity in term of menopause. One woman who had a strong affinity with alternatives to biomedicine and who displayed a strong affiliation to a natural discourse in her narrative overall (such as her resistance to routine scanning during her pregnancies and her decision to opt for home birth) nonetheless suggested that biomedicine would be the ultimate adjudicator in establishing her status, and admitted to having considered a blood test:

P: Yeah, I probably have a slight doubt [that bodily changes are owing to the menopause]. I suppose everyone has a doubt. Like you kind of think these are hot flashes, but they mightn't be menopause. . . . To be honest, I would like to know for definite.

I: You mean for a doctor to confirm it?

P: Yeah, yeah, it's funny, isn't it? It's that kind of, "Am I, or am I not?" That's the tricky one. I mean I have thought about going and getting a blood test to see . . . **[AU Q: 3]** I mean, I don't even know what it tells you, but it gives you some indication. . . . And I'm generally not one . . . I never went for scans for the children. (Breeda, middle-class)

Another participant, also strongly disposed in her outlook toward alternative therapies, preferring "flower remedies" to pharmaceuticals to alleviate symptoms, nonetheless invoked a biomedical perspective on menopause to construct her identity and to make sense of her experiences. In the following quotation we see how her identity was bound up with a biomedical definition of menopause (one year without menstruating) because of its dominant public presence, despite her skepticism about biomedicine more generally:

P: At the moment it's [changing bodily experiences] still quite kind of fluctuating. And my theoretical twelve months will be up on quite specifically the 14th of September. . . . I am looking forward to that as being a new start. . . . It's so spurious that twelve months. . . . But nonetheless I've decided to take that as a date in which I can consider myself officially a crone, and start wearing purple and poisoning people!

I: Is it a medical definition that you're taking?

P: Yeah. . . . For all what I've just said [participant had been criticizing biomedicine] . . . I have a very low faith in medical opinion—a very low faith.

I: But nonetheless, you're going to see this year after your periods stop as a turning point?

P: Yeah. I just want something to hang my hat on, some kind of deadline, that I can go, "Okay, after today, I'm going to be this way."

I: So there's an identity to this? You see yourself now as menopausal and after the September date as postmenopausal?

P: And I will see myself as officially postmenopausal on September 14th. . . . And I mean, I'm using the medical setup to base that on, because I have nothing else to base on. . . . And I did kind of go surf the net [Internet] a little bit, and all that was coming up for me was kind of a medical . . . no I didn't do it very much, but medical doctors' opinions of what's going on—not facts. (Winifred, middle-class)

In this subsection, we have considered some of those situations in which participants did not experience difficulty in having their menopause affirmed by the medical profession, either because they did not go to the doctor, or because the doctor readily offered a menopause diagnosis. But what of those women who sought such a confirmation but did not readily receive it? In the next section we consider the situation of participants who sought a confirmation by the medical profession that their bodily experiences were menopause-related, but whose self-assessed menopausal status was not affirmed by their doctor.

Contesting Biomedical Definitions of Menopause While Affirming Biomedical Dominance

The subset of women who actively sought, with little or limited success, to legitimate (with their doctors) their bodily experiences as menopausal was comprised of 5 participants. They recounted remarkably similar narratives about how they attempted to attain biomedical validation that the bodily changes they experienced were indeed menopausal. Most narrated a change in menstruation, such as more irregular or heavier periods, but periods continued contemporaneously with other bodily changes. They usually discussed these changes with other women in their social networks and compared the extent to which others' symptoms equated with their own. Based on such peer comparisons and their own reading on the topic, such women suspected (or said they were convinced) that they were experiencing early menopause and all sought medical help to determine if indeed they were menopausal. This subset of participants recounted feelings of disappointment, and in some cases extreme distress, that a biomedical legitimation of menopause was not conceded, because this perpetuated the uncertain status of their embodied experiences and indeed their own sense of disquiet about what was happening in their bodies. Such women reported that they would have positively embraced a biomedical affirmation of menopause because this would have validated their sense of morbidity as normal:

P: That is all part of the change. And for somebody to actually say that to you [that you are menopausal] when you think you're going off your head, it makes a huge difference.

I: So it's just reassurance?

P: Well, it's reassurance that you're really not losing the plot.

I: Were you not convinced by what your friends were saying?

P: Well, you need the medical reassurance really. (Ida, working-class)

You do think you're going mad because you're. . . . Early on, in the early stage, before I really realized, I kind of had this inkling, but the doctor kept saying it wasn't. And I kept saying, "Well he must know, he's a doctor." And then I thought, "No, hold on, this is not right." But, when the doctor's saying, "No," you do think you're going mad, because this thing is happening that you have no control over. . . . Well it's like anything, once they put a name on it, you then can start . . . well at least you got a reason. (Margaret, working-class)

After undergoing several clinical investigations to eliminate any underlying pathologies, these participants described the frustration arising from the lack of formal recognition afforded by the authority of a medical diagnosis of their bodily aberrations. Such women also tended to be less than satisfied with the manner in which their bodily experiences were dismissed by medical professionals, whom, they contended, placed too much emphasis on chronological age and on the fact that menstruation was still occurring, and too little emphasis on other physical changes normally linked to menopause. These women challenged the validity of the dominant, ostensibly objective, biomedical definition of menopause that was at variance with their own bodily experiences. The language of empowerment rather than passivity was evident in the narratives of these women:.They spoke of the significance of listening to their own bodies; they described their assertiveness (and sometimes described this as "bolshiness" **[AU Q: 4]**) in approaching their doctors; they proposed a diagnosis of menopause to the doctor (who rejected it); and they reportedly invoked arguments of family history (mothers and sisters with early menopause) or accounts from books and magazines that they had read. In spite of most having spoken to other women about their bodily experiences, all related their sense of isolation—feeling that they were the only ones with these experiences—and some questioned their own sense of sanity. Although feelings of isolation and psychological anxiety were a dominant feature of the experiences of women with more distressing bodily experiences across the study, they were particularly so for this subset of women.

The determination to acquire a biomedical verification of menopause came from the women themselves, in most instances, when the status of menopause was being disputed::

> Then when I started getting the night sweats, I thought, "Al right," and I more or less pursued the journey of trying to get a blood test. It was two years before I was actually diagnosed with, "Yes, it is the menopause." . . . I started to kind of get hot flushes, to feel tired, to feel irritable and that, but it was two years before my GP agreed to do a blood test to confirm that it was the menopause. I was going back and forward to him, yeah. I kept going and saying . . . and he kept going, "You're too young, you're too young." . . . I felt like, well, I'm listening to my body and I know what's going on, and why can't you? (Margaret, working-class)

> P: Night sweats and I shaking all over the place, look at me the wrong way and I would cry, shaking a lot. . . . I went to the doctor . . . and I said, "I am going through the menopause," and he said, "Don't be ridiculous, you are too young." Now I was 42 at the time . . . and he gave me this prescription and I went and I got it in the chemist [pharmacy] and I said, "These are tranquilizers, aren't they?" and she [the pharmacist] said, "Yes, it is going to take about three months for them to build up in your system," and I put them in my bag and six weeks later walked back into his [the GP's] office and I said, "There you go, you can have them back, I still think I have the menopause."
> I: Was it important for you to get medical [participant interrupts]
> P: No, I was not keen on HRT. Just to listen to what I was saying.
> (Patrice, working-class)

In the following example, the participant believed that her experience of her body became more negative as a consequence of the lack of biomedical acknowledgement of her status:

> The girls [friends] had said that it was the menopause, so I goes, "I think it's the menopause," and he [GP] asked me about my periods, which I still was having then, and he goes, "No, you're too young." I felt so mad. . . . I went back a few times more, and actually felt worse because I was still coming up against a brick wall. (Joyce, working-class)

One working-class participant explained how, after being sterilized at the age of 30, she had kept a careful diary of her bodily changes (which she presented to her doctor), and observed changes in her body dating from her late 30s. These changes included hot flushes, tearfulness, insomnia, extreme exhaustion, and

altered presentation of her preexisting eczema. She demonstrated a high level of literacy about her body and had eagerly sought out whatever information she could locate on menopause from books and magazines. Multiple medical tests obviated the presence of a pathology that might explain her bodily experiences. Disappointingly for her, an estrogen blood test eliminated the possibility that she was in menopause (as defined in dominant biomedical texts). However, she strongly contested the definition of menopause rooted in chronological age and the cessation of menstruation advanced in medical textbooks, and went to great lengths to present her case to the doctor:

> You say to the doctor, "I'm going through menopause." . . . I brought my diary with me. I showed it to them. . . . My vagina has dried, my skin has gotten drier, which would be normal anyway with this skin. The itch, it's not much, but I know the difference. He'd say, "You couldn't be because you have your period." . . . But my whole body was saying something else. . . . I kept telling them that my mother was 45 and my friends that are not even 50 have finished. They [doctors] don't want to know. . . . Once you have a period and you're in your forties, they don't want to know. . . . I think the doctors are going through textbooks. They go by books that are ancient and old. (Ida, working-class)

Yet, in spite of this participant's own conviction about her menopausal status, which was acknowledged by other women in her social circle, and her resistance to what she perceived to be the narrow biomedical definition of menopause, she desperately wanted her GP's affirmation of her status:

> P: When I was going through it bad I had talked with a lot of women—to talk, just because I was going mad. I talked to other women, people I worked with and all. Number one, I had because of my mother. I knew she wasn't 50 when she started. She was nearly 50 when she was finished. A girl I worked with, her and five of her sisters, were finished before they reached the age of 50. And every symptom that I was telling her, she was telling me yes. . . . And only for I to tell **[AU Q: 5]** a few friends what way I was feeling, what was happening to me, and they come back and tell me, "Yeah, that's premenopausal." . . . All I wanted was for someone to tell me, "Yes, you're premenopausal." I just wanted someone to tell me, "You're going through menopause."
>
> I: Isn't this what your friends had been saying, though?
>
> P: Ah yeah, but the doctor was saying, "No." (Ida, working-class)

Eventually, after several visits, the suggestion was made by a doctor that she was likely to be at the stage of perimenopause (which she referred to as premenopause). Even this weak acknowledgement of a perimenopausal status afforded her some degree of atonement and altered her embodied experienced to some degree. However, the lingering doubt also affected her experiences of her body:

> P: Nobody has actually completely talked around to me and said, "Yes you are." The only one that really said, at the end, when I went through all of those different blood tests, all the different scans in the hospital. Literally she turned me practically inside out and upside down. And she said to me, "Well, there's nothing wrong with you, you're healthy as a horse. You're telling me these symptoms. The only thing that's left is that you're premenopausal, even though you're so young." But she wouldn't actually put a stamp on it and say it. She wouldn't go over that far and say, "Yeah, you are." I still have doubt, even though I'm happy enough that she said it.
>
> I: By doubt, do you think that maybe you're not?
>
> P: No, but . . . how can I put it? There's something unfinished—I'd just feel way better if I was told I definitely was. (Ida, working-class)

Ida was prescribed one month's supply of night sedation, and one month's supply of HRT, which effectively abated her symptoms, a response that buttressed her conviction that she was actually was in menopause. One might reasonably question whether women in this subset were canvassing for a definitive biomedical menopause diagnosis for the purposes of acquiring HRT, attainable solely through a biomedical prescription. However, for two of the five women, HRT was contraindicated by virtue of their family medical history, and these participants accepted that they could not be prescribed HRT. A third woman was opposed to the use of HRT and stated that she would not take it in any case. This suggests that a biomedical affirmation had a privileged status independent of the need for biomedical intervention. Another participant similarly believed she was in menopause—a contention that was disputed by a blood test—yet she was put on antidepressants, although she did not define herself as depressed. This exacerbated her sense of self-doubt:

> Well I actually I had a test done and it said I wasn't [in the menopause], but I know I am. . . . I went to the doctor and I told him that this seems to happen. . . . I told him but he wouldn't say anything. And that's the time when he put me on antidepressants, then. . . . I didn't think I was depressed. . . . I'm not a depressive person. I get very upset and I worry about things, but I'm not really a person who

gets depressed. And that actually worried me that he was telling me I was depressed, because then I started thinking, "Well, maybe you are.". . . I said it to him but he just didn't seem to listen. . . . You think you're losing your mind because there's no definite, "Yes you are [menopausal]." (Sinead, working-class)

The antidepressants made little difference to Sinead's bodily experiences. However, she noticed an improvement following a change in lifestyle, namely foregoing tea, coffee, and chocolate, and commencing supplements believed to allay bodily distresses associated with menopause. She had not experienced a panic attack for almost 6 months prior to the interview. For Margaret, the eventual affirmation by a doctor that she was menopausal impacted positively on her approach to her bodily experiences, as she described:

P: And it was actually . . . it was another GP, he was on holidays. And I went and he kind of said . . . he kind thought that it's the menopause. He couldn't figure out why the other fella [GP] felt, you know . . . I wouldn't be one for going to the doctor that often, so I kind of feel if I do go, I know there's something wrong.

I: How did you feel when you eventually heard?

P: Relief! But mad with the other guy for making me feel like this was all in my head. . . . But it changed how I felt. Not the symptoms, but I felt I could deal with them better, sort of accept them better.

(Margaret, working-class)

Sinead, who at the time of the interview was still negotiating her status with her GP, described her feelings about the uncertainly of her status and how she believed biomedical affirmation might alter her experiences:

P: I know I am, but there's a little of you . . . that last missing piece isn't there. Even taking part in this study, will you think that I am a real person for the study?

I: Would it be important to you to get a medical verification?

P: Absolutely. I'd be really happy then. It would make no difference to the, you know, things like the heat [describes a symptom], but it would make a big difference to me. (Sinead, working-class)

The narratives of the 5 women on which this section has been focused indicated not merely a clash in how the medical profession defined menopause relative to how the women constructed it, but also how important a biomedical diagnosis was to women being able to validate their own bodily experiences, and to their construction of a specific health identity.

Discussion

Based on the preceding data, we argue that the cultural authority of biomedicine shaped participants' experiences of the body and how they constituted their health identity. Furthermore, we argue that, ironically, this was particularly the case among those who most strongly contested biomedical definitions of their situation.

That doctors tended to focus on objectively measurable indicators such as the presence or absence of periods, hormonal levels verified by a laboratory test, and chronological age when constructing menopause, whereas the women focused on their bodily experiences, their altered emotions, and how these disrupted their everyday lives, substantiates the findings of other studies (see Ballard, Kuh, &Wadsworth, 2001). However, our data also found that how women actually experienced menopause altered toward either more positive or negative positions depending on how the medical practitioner interpreted it. Thus, biomedical practitioners' definitions had a strong normalizing power in how the body was experienced. Across the sample as a whole, many participants revealed a sense of "going loola" **[AU Q: 6]** until their frame of reference for making sense of their bodily discomposure shifted to give way to a revised understanding of their bodies, irrespective of whether or not hormonal levels were altered though biomedical intervention (an issue that we consider in a separate publication). The vagaries of the body were transformed from uncertain status, possibly as pathological, until biomedical affirmation, when they were rapidly redefined as natural vagaries, altering menopause experience and health identity of the women.

Biomedical "diagnosis" helped women to alleviate the sense of disquiet arising from uncertainty and doubt, and to redefine their interpretation of what they were experiencing as a normal process, and an experience shared with other women within the culture. In this sense, women "actively create[d] themselves in relation to available discourses" (Davies & Harré, 1998), with biomedical discourses heavily influencing the constitution of such an identity. Thus, hormone levels did not appear to dictate the experiences of participants; rather, there appeared to be an interplay between hormonal influences and how the women

interpreted their bodily experiences in the social context in which they arose, with the influence of biomedical verification being particularly poignant.

As indicated, the definition of menopause was contested in a number of cases, with women invoking the language of resistance, questioning their doctor's knowledge, taking ownership of their bodies, and seeking knowledge outside of the biomedical encounter. Here, these women were producing their own "truths" about their experiences, and through this knowledge, were empowering themselves and resisting expert constructions of their circumstances. As Foucault (1980, p. 52) noted, "it is not possible for power to be exercised without knowledge . . . it is impossible for knowledge not to engender power." It was this knowledge that enabled those women who contested the biomedical assessment of their experiences to resist. However, even in those cases of resistance, participants nonetheless pursued biomedical verification of their status. Other studies have also found lay people to be vehement in their quest to get a medical categorization of their condition, as in the case of those with repetitive strain injury (RSI) and chronic fatigue syndrome (Arksey, 1994; Broom & Woodward, 1996). We argue that in the case of our study, in bringing their subjective experiences to the medical encounter, in articulating their experiences, and in seeking validity for them, participants also had the potential to redefine medical definitions of menopause and to rescript these narrow biomedical definitions (albeit without much success, according to their narratives). Arksey (1994) argued that in relation to RSI, "there is an opening for persons commonly assumed to be technically incompetent to acquire (lay) medical power with regard to the construction of scientific facts" (p. 464). However, she cautioned that even though medical experts might incorporate the lay person's knowledge into their understanding of a particular condition, this knowledge might be appropriated by the medical profession and not credited to the (nonexpert) individual.

If we return to Goldstein's notion of vernacular health theory, in which validity of particular experiences is not dependent on "the approval of the established regimes of thought" (Foucault, 1980, p. 81), we find that in the case of those participants who sought verification that their symptoms were indeed menopausal, such approval was indeed sought. Moreover, biological "truths" about whether they were really in menopause were sometimes vested in the authoritative status of the doctor rather than in objective scientific laboratory tests, although some women did undergo hormone-level testing, the doctor's word was often enough to produce a stable menopause identity.

Data in this study suggest that participants whose own assessment of their status pointed to menopause displayed agency in seeking a medical diagnosis of their hypothesis, and in having their experiences legitimated by biomedical authority. However, findings also indicate the power and cultural position of biomedicine as the final arbiter in conferring legitimacy to this midlife experience of women: whatever these participants' friends and others in their networks imparted to them about their bodily aberrations being related to menopause, they wanted to hear it from a doctor. In this sense, women, ironically, sought medical verification to confer on them a status of normality; yet their stance could hardly be described as passive. Notwithstanding that participants might be prone to exaggerate their assertiveness in retrospectively recounting the interaction in medical encounters, they nonetheless problematized the manner in which their knowledge of their own bodies was dismissed in favor of biomedical, objective tests. Indeed, their accounts smacked strongly of the way in which the expert knowledge of biomedical practitioners took precedence over women's self-knowledge of their own bodies in Ann Oakley's classic study of women's experiences of pregnancy and childbirth (Oakley, 1980).

Let us consider one final issue: namely the way in which our analysis problematizes the notion of privileging "women's experiences" as advocated by some feminist perspectives, such as the feminist standpoint position **[AU Q: 7]** (Davis, 2007). The heavy influence of biomedical discourses in shaping participants' embodied experiences demonstrates the pervasive impact of prevailing discourses (including apparently oppositional ones; for example, discourses of resistance and conformity) on women's experiences. The unique and authoritative characteristic of such experiences thus become questionable. Nonetheless, our theorization of women's experiences of menopause in light of such discourses illuminates the context and network of power relations that form the backdrop to these experiences.

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[AU Q: 8]

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