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Passage or Pathology: Current Attitudes Toward Women's Aging in the Literature of Menopause

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PASSAGE OR PATHOLOGY: CURRENT ATTITUDES TOWARD WOMEN'S AGING IN THE LITERATURE OF MENOPAUSE

by

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ABSTRACT

PASSAGE OR PATHOLOGY: CURRENT ATTITUDES TOWARD WOMEN'S AGING IN THE LITERATURE OF MENOPAUSE.

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Menopause is currently portrayed in the medical literature as a pathological process resulting from "hormone deficiency." However, feminist writers contend that the climacteric is part of the normal female aging process and oppose the medicalization of menopause and the consequent inevitable hormone replacement therapy (HRT) promoted by the hegemonic medical and pharmaceutical industries. This paper explores the historical development of these two paradigms of menopause and their manifestations in samples of three classes of contemporary literature on the subject: gynecological textbooks, popular advice books written by physicians, and women's accounts. Five major themes are investigated using quantitative and qualitative content analysis to assess the extent of agreement of the three samples of literature with the contradictory biomedical and feminist models. Gynecological texts, as expected, fit most closely the negative biomedical paradigm. Popular advice books by physicians also agree strongly that menopause requires medical "management" and treatment with hormones. They are a powerful tool for persuading women to comply with increasing medical and social pressure to take HRT. Women's accounts of the climacteric reveal a much wider range of experiences and reactions to the mid-life passage. Many women also question the safety of HRT and recommend a variety of alternative treatments. Since the pathological

biomedical ideology dominates the popular media, it is vitally important for women seeking information on the menopause to read widely on the subject and especially to examine works by other women. It is also essential that women continue to give voice to their own experiences and definitions of the climacteric in order to challenge the stigmatization of menopause by the hegemonic biomedical model.

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TABLE OF CONTENTS

Page

Chapter

LIST OF TABLES

CHAPTER I

INTRODUCTION: THE SOCIAL CONSTRUCTION OF FEMALE BIOLOGY AND ITS RELATIONSHIP TO PERCEPTIONS OF MENOPAUSE

Women's writings on menopause attest to a far wider range of experience, ideological perspectives, and opinions on methods of dealing with this midlife transition than do portrayals of the climacteric by physicians in gynecological and popular advice literature. It is widely understood that American society idolizes youth and does not give aging people the respect granted them in other cultures. In addition, there is a substantial disparity between the treatment accorded men as they age and that given women. One of the means by which women are marginalized and thwarted just as they have reached a period in their lives when they may have gained self-assurance and freedom from family obligations is the pathologizing of the experience of menopause.

Discussions of the climacteric in recently published gynecology textbooks and medical advice literature depict a process of disease and decay and reflect the continuing power of the dominant sexual ideology which informs and perpetuates socially constructed negative attitudes toward middle-aged and older women and affects the health care given them. Nonetheless, American culture does not speak with one voice on the process of female aging. Competing with the hegemonic stance of the biomedical establishment and its offshoots in popular advice literature is a multiplicity of women's

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The model for this thesis is the MLA Handbook for Writers of Research Papers.

voices, individual and collective, that offer a wider spectrum of viewpoints and reactions ranging from expressions of dismay and depression to new zest and empowerment.

The topic of menopause has only recently emerged from taboo status and become a matter for public discourse. The large and increasing numbers of women of the aging Baby Boom generation who have entered or are approaching the climacteric have helped bring about the new openness on the subject. While it has also been the focus of much current medical research, "[r]emnants of ancient myths, taboos, and superstitions" are still evident in attitudes toward the menopause in both the biomedical community and society at large (Formanek 3). There is an enormous body of literature on the menopause, but until recently the bulk of writing on the subject has been done by male physicians for an audience of their peers.

The word menopause, "derived from the Greek words for month and cessation," was coined in the 1870s. Prior to that time various euphemisms such as "'the changes,' 'Indian summer,' [and] a 'physical Rubicon'" (Formanek 5) had been used to refer to that period of a woman's life, usually around 50 years of age, which is marked by the end of ovulation and menstruation and thus signals the transition from the reproductive to the second nonreproductive phase of female life. In most of the modern medical literature, the word menopause is used to refer specifically to the permanent cessation of menstruation--the last menstrual period--while the term climacteric is used to designate the whole transition period. In addition, physicians and others frequently use the terms premenopausal, postmenopausal, and perimenopausal to precisely delineate stages of menstrual status within the climacteric. Throughout this paper I use the term menopause

in its broader popular context as synonymous with the term climacteric.

The etymology of the word climacteric is interesting in that it is derived from the Greek word klimakterikos, meaning literally the rung of a ladder and also a critical or crucial stage. In the medical literature, the term climacteric is often used in the latter sense, defining menopause as a period of crisis fraught with potential danger. This connotation is evidence of the continuing prevalence of long-standing negative perceptions within the medical community of this natural and universal female process.

Marilyn Yalom has commented that the double prejudices of agism and sexism in Western culture date at least to the Middle Ages and probably even to classical antiquity. She avers that the literature "testifies to an almost universal lack of esteem for women in their later years," and that social perceptions which link youth with beauty and old age with ugliness have existed for centuries (461-462). Negative cultural attitudes toward menopause are attributable in part to the fact that it is associated with aging and thus ultimately with death, but to a greater extent they are due to the biosocial construction of gender which dictates that the primary role for the human female in American society is that of wife and mother.

Patriarchy, Science, and the Biosocial Construction of Female Gender

The female body--its cycles of bloody menstrual flow, its diffuse sexuality, its wondrous capacities for conception, pregnancy, birth, and nourishment of new life, and its evolution in midlife from a reproductive to a nonreproductive state--has represented

for men a kind of terra incognita whose mystery and power must be mapped, understood, and, above all, tamed. Accordingly, woman's body has been given meaning within a social context in which its power can be defined, controlled, and dominated by males; for much of human history that social milieu has been patriarchy. All patriarchal cultures, regardless of their many forms--agrarian, capitalistic, and socialistic, to name only a few--are predicated on "the heterosexual structuring of consciousness and institutions" (Bleier 164). A basic assumption and organizing principle of patriarchal societies is that men have the right to control female sexuality. Moreover, while endeavoring to control women's bodies, patriarchal culture in the West has also attempted to use female biology to define and control women's minds and spirits as well.

However, as Nancy Theriot asserts, "sexual ideology is a human product," one which is fabricated by both men and women (14). Therefore, women are not simply victims of the social construction of femininity but also participate in its creation, "out of a distorted understanding of the physical and material conditions of their lives and a search for meaning and value within the constraints of patriarchal structure" (157). Furthermore, women pass their concepts of the meaning of womanhood to their daughters and in this way transmit sexual ideology to the next generation. Thus "feminine ideology is both woman-creating and woman-created" (Theriot 16).

The circumstances of women's lives vary according to their race, class, age, and the cultural values of the time and place in which they live. By setting physical, legal, and economic restraints on women's lives "men influence women's concepts of femininity" (Theriot 10). A woman's identity is not unchanging but is rather an

outgrowth of the interaction between "body and society, individual and culture, private and public. The core of self is the gendered body" (Theriot 12). In a male-dominated society, women's social roles have been more or less inextricably bound to their bodies and especially to their ability to bear and nurture children. Even if they have other obligations as adult females, those responsibilities are often shaped by their reproductive and nurturing functions. Men's roles, however, usually have not been limited or defined by their procreative function. Thus, males have been free to engage in careers and accomplishments in the areas of government, education, religion, commerce, the arts, and other areas of public life.

Men have also dominated the public sphere of science and have particularly used the power to construct scientific and medical knowledge to influence cultural attitudes toward the functions of female bodies and thereby to control the direction of women's lives by limiting the work and career options available to them. However, despite the reverence generally afforded the pronouncements of modern science, a cursory review of the history of any scientific discipline from astronomy to zoology reveals that the scientific "truths" of each age are frequently challenged, refuted, and changed by the scientists of succeeding generations, who in turn substitute their own version of reality for the "verities" which they have deposed. As Anne Fausto-Sterling has asserted, "[T]here is no such thing as apolitical science." It is "inseparable from the societal atmosphere of its time and place." Therefore, individuals who conduct scientific research "are influenced--consciously or unconsciously--by the political needs and urgencies of their society" (207-208). Far from being value-free, scientific inquiry has generally

reflected the dominant values of the culture which produced it, in both the questions which it asks and the methodology which it uses to investigate them.

Qualities valued in scientific research, such as logic and impersonal objectivity, have been traditionally viewed as "male" attributes, while properties not in accord with orthodox scientific method, such as emotionality and subjectivity, have been regarded as "female." Thus, not only has science been used by men as a tool to objectify and oppress women, it has also been a province of inquiry where women have long been denied participation because of their "nature." As Emily Martin has stated, "It is no accident that 'natural' facts about women, in the form of claims about biology, are often used to justify social stratification based on gender" (17).

Pre-nineteenth Century Perceptions

From the time of the ancient Greeks until the beginning of the nineteenth century, medical literature depicted female reproductive organs as strikingly similar to those of males. The major structural difference was thought to be that women's genitalia were located inside the body rather than on the outside (Martin 27). However, while seen as similar, women's bodies were also deemed inferior, a second-rate copy of the more perfect male prototype. When considered in light of the present discussion on menopause, it is ironic that these early scientists considered the male body superior because they believed it possessed more "heat" than the female body (Martin 28-30).

Early social roles for women seemed to parallel the similar-but-inferior scientific model of female biology. Although "a host of religious, political, and legislative

restraints" limited their ability to earn wages and own or inherit property, women of all classes in the pre-industrial era shared the work of economic production in the home and shop or on the farm. They produced textiles, made clothing, produced and processed food, and functioned as midwives and healers (Smith-Rosenberg 15). Ruth Bloch writes that, before the late eighteenth century, two ideal images of femininity appeared in writings produced and read in America. The first, associated with New England Puritanism and later with the American Enlightenment, was that of the woman as "help-meet." In keeping with biblical patriarchal models and cultural attitudes which viewed women as intellectually, emotionally, and morally inferior to males, the help-meet ideal asserted the need for woman's subservience to men. However, at the same time this model stressed comparable standards for both sexes: "[f]aith, virtue, wisdom, sobriety, industry, mutual love and fidelity in marriage, and joint obligations to children" (Bloch 102). The uxorial paragon was valued for her piety, frugality, and industriousness (103).

The second type of feminine ideal appealed more to the middle and upper classes and emphasized the importance of beauty, refinement, and "accomplishments" in the arts such as fluency in French, drawing, and playing musical instruments. Derived from the romantic love tradition, this womanly ideal was valued not as a help-meet but as an attractive ornament for a gentleman's drawing room. As Bloch notes, neither of these models accentuated motherhood but instead "dwelt primarily on woman's relationships to God and man as Christian, wife, and social companion" (103). Motherhood was, of course, still a primary duty of women, but it was not idealized and was given "less normative emphasis and symbolic appreciation" in the literature of seventeenth- and

eighteenth-century America than other areas of women's lives (103-104).

Nineteenth Century Developments

During the late eighteenth century, the public perception of the maternal role began to change, and in the nineteenth century, motherhood came to be regarded as a full-time occupation "requiring not only heightened concentration, but also special expertise" (Bloch 111). Parental responsibilities which had previously been performed by fathers or both parents became solely the duty of mothers (113). A progressive "realignment in the familial division of labor loosely coincided with this cultural redefinition of motherhood" (114). Industrialization and urbanization brought profound economic and social changes which eventually resulted in "the gradual physical removal of the father's place of work from the home" (114).

At the same time that women were becoming less involved in independent economic production, they became increasingly "preoccupied with their maternal roles" (Bloch 114-115). Changing perceptions of children and the romanticization of childhood contributed to the notion of the centrality of the mother's function in child-rearing. Among the urban middle classes, the need decreased for children's labor and assistance in family economic production. Furthermore, the religious doctrine of infant damnation gave way to a belief in the child as born innocent, indeed as a tabula rasa whose unformed, impressionable moral character needed a mother's guiding hand. In middle class culture, the ideal of the modern nuclear family -- "small in size, emotionally intense, and woman supervised" -- was born (Morantz-Sanchez 36).

As those charged with the responsibility of producing, rearing and educating the next generation, mothers were depicted as the transmitters of culture, wielding a powerful influence in society. Bloch observes that, "[t]his was, of course, a particularly compelling argument to those seeking to justify the restriction of women to the ever-narrowing domestic sphere" (115). Women, formerly seen as the less spiritually developed sex, were characterized in the literature of the Victorian era as more pure, virtuous, selfless, and moral than men. In fact, it was believed that women had a civilizing influence on men as well as on children (Bloch 116).

In the nineteenth century, the earlier notion of male-female anatomical similarity with a hierarchy based on body heat was replaced by the assertion that the social roles of man as wage-earner and bread-winner and woman as wife and mother "were grounded in nature" due to biological differences between the sexes which were believed to originate at the cellular level. Male scientists and physicians began to describe the physiology of both sexes using economic metaphors of spending and saving, business loss and gain, and conservation of energy. They also began to depict female reproductive processes such as menstruation and menopause, which had no analogues in more static male physiology, as distinctly negative and debilitating or even pathological (Martin 32-33).

Nineteenth-century medics believed that the human body was "a closed-energy system" in which the organs were forced to compete for a limited supply of blood (Formanek 12). Hugely overestimating the role of the uterus and ovaries, physicians thought that an ample supply of blood to the female reproductive organs was essential for good health and that the blood supply to the brain was less critical (13-14). This false

notion led doctors to discourage young women from higher education and intellectual pursuits in the belief that overstimulation of their brains would be detrimental to their paramount function of procreation. Insanity in women was believed to be a result of blood which had not been properly discharged during menstruation entering the brain and causing derangement (14).

The nineteenth century also saw the rise of American medicine as a profession, with male physicians eventually forcing midwives and women healers out of their vocation (Formanek 9). Two of the first of the medical specialties to develop were obstetrics, which focuses on pregnancy and childbirth, and gynecology, which focuses on the diseases of women. Gynecologists increasingly began to focus on "a direct connection between reproductive functioning and the mind" (Formanek 15). They believed that the uterus and ovaries were powerful organs which influenced a woman's entire well-being but particularly her mental health. Physicians asserted that women had a "special predisposition both to physical illness and to insanity" (Formanek 16). Treatment of women's "diseases," such as menopause and hysteria, brought increasing prestige and income to the practitioners of gynecology and psychiatry, and American gynecological surgeons developed the ovariotomy and hysterectomy as treatments for mental illness. These operations were first practiced and perfected on poor women and slaves and later performed on middle-class women who could afford to pay the physicians (Formanek 15-16).

An important social construction that developed during the last half of the nineteenth century was the medical depiction of women, particularly those of the middle

and upper classes, as inherently frail and sickly. This phenomenon was an outgrowth of complex social changes created by industrialization. immigration, and urbanization. As Carroll Smith-Rosenberg has observed, the "medical rhetoric" which characterized women as fragile beings ruled by their reproductive organs was "a symbolic language reflective of fundamental social transformations" (26).

Poor and working-class women, who suffered from overwork, malnutrition, industrial injuries, overcrowded living conditions, tuberculosis, typhoid, pneumonia, other contagious diseases and the dangers of too many pregnancies, were virtually ignored by the majority of the medical profession who "sturdily maintained that it was affluent women who were most delicate" and therefore most in need of their services (Ehrenreich and English 101-102). Working-class women, whose lifestyle did not provide the leisure time for extended medical treatment nor the means to pay for it, were believed to be more "robust" and less in need of the physicians' attention. Thus the class differences in the perceptions of female illness "meshed conveniently with the doctors' commercial self-interest" (103-104).

Smith-Rosenberg has observed that anxiety and social instability produced by radical changes in patterns of work and family life helped to elicit a "male medical vision of women's physiology and sexuality" which "served to reinforce a conservative view of women's social and domestic roles." As alternative options for women emerged, enabling them to move beyond the restrictive realm of marriage and motherhood, "male allopathic physicians began systematically to transpose the Cult of True Womanhood . . . into a medical and scientific dogma." Any attempts by women to step outside the

prescribed roles, including "demands for education or for employment outside the home, or the practice of fertility control" through contraception or abortion, evoked "furious jeremiads" from the medical profession. In the view of physicians, "[t]he nonreproductive woman endangered society--and herself" (23). Furthermore, as the self-appointed guardians of the nation's health and morals, male physicians allied themselves with state legislators to control female sexuality through laws that banned or regulated abortion, birth control and prostitution (23-24). This effort represented a type of medical social control.

The Italian Marxist Antonio Gramsci (1891-1937) posited two forms of social control that may be exercised by a dominant group or class: external (domination or coercion) and internal. The legislative initiatives mentioned previously constitute a form of external control. Internal control, or hegemony, is a stronger form of power characterized by "intellectual and moral leadership." Hegemonic control is grounded in economics and achieved by shaping cultural ideology through mass media and educational and religious institutions which influence the way people "perceive and evaluate problematic social reality." In hegemony, therefore, the dominant group rules "by consent rather than force" (Femia 24). Furthermore, the dominant group obtains the acquiescence of individuals because of its prestigious position and the trust it has acquired through its function in the social order (Femia 42). Thus "[t]he reigning ideology moulds desires, values and expectations in a way that stabilizes an inegalitarian system" (Femia 45).

During the late nineteenth century, male physicians used popular medical advice

literature to disseminate their ideology, expand their influence and authority, and thereby achieve hegemonic control in the realm of women's health. As Fellman and Fellman have noted, at this period in history "science had not yet been split overtly from moral instruction" (18). Thus medical advice literature, predominantly written by physicians, offered counsel and admonition on matters of virtue and duty as well as health and hygiene. The advice manuals purported to provide individuals in a changing and anxious society with the means to understand and control their own bodies and thus "gain at least the illusion of ordering their social world" (15).

A large portion of the counsel and exhortation in the literature was concerned with sexuality. Middle-class anxiety over sweeping societal changes and a decreasing birth rate for "well-educated white, Protestant women, in an era of intense racism, led to widespread fears of 'race suicide'" (14). Many advice writers condemned "the separation of sexuality from procreation" and were critical of women who utilized abortion and contraception to limit the size of their families. They asserted that it was women's duty to produce children and that the use of birth control "could debase the quality of the moral relation between husband and wife, would license promiscuity, and would lead to marital breakdown" (80-83).

Toward the end of the nineteenth century, many women began to envision themselves in roles other than the reproductive one and to actively disagree with the theory of innate female sickness (Formanek 29-30). More women began to demand the right to pursue a university education and to vote. Smith-Rosenberg notes that the 1870s saw the rise of "the single, highly educated, economically autonomous New Woman"

(245). The phenomenon of the New Woman was very threatening to men because "[h]er quintessentially American identity, her economic resources, and her social standing permitted her to defy proprieties, pioneer new roles, and still insist upon a rightful place within the genteel world" (245).

The Victorian belief in women's moral superiority and caring nature encouraged the emergence of a female popular health reform movement which, in turn, led some women to aspire to formal medical training and admission to the profession of medicine (Morantz-Sanchez 27). In addition to propelling women who sought self-determination into the medical profession, health reform also allowed other women "a means of moving into the public world without wandering too far from traditional womanly concerns" (43). The movement's study groups, lectures, and journals provided Victorian women with a way to meet and communicate with other women and share their common health concerns and experiences (Morantz-Sanchez 38-39).

A growing dissatisfaction with the therapeutic methods of traditional medicine promoted the ascendance of alternative medical sects such as hydropathy and homeopathy. Sectarian medicine rejected "heroic" measures, such as bleeding and purging, of conventional medical practice in favor of more "natural" therapies. The sectarians believed that the body was capable of healing itself if given the proper stimulus. The rise in popularity of patent medicines such as Lydia Pinkham's Vegetable Compound, "first marketed in 1875," also attested to women's distrust of "physicians' harsh medicines and dangerous gynecological operations" (Formanek 22-23). Educational institutions which trained sectarian physicians "often welcomed women

students, and consequently middle-class women initially gravitated to sectarian medicine. Many of the first generation of women doctors received their degrees from sectarian institutions" (Morantz-Sanchez 31). Some women doctors, influenced by "a common medical education" and "the same social environment" as their male counterparts, held medical and social opinions "on the subject of women's role, puberty and menopause, marriage and motherhood" that were similar to those of the male doctors (218). However, some female physicians were among the first to challenge the medical dogma that women were "weak, emotional, sickly, and hysterical" and ruled by their uterus and ovaries (Morantz-Sanchez 216).

The development of women's discourse on female health exemplifies the questioning of a form of social control by an intellectual elite. Antonio Gramsci regarded such insurgency as a fundamental mechanism of social change. He envisioned the perpetual existence of such counterhegemonic forces which constantly challenge and modify the dominant cultural views. He theorized that "[c]oncrete experience is the essential raw material of human reflection. But . . . the products of this reflection then proceed to modify the social reality from which they emerge" (Femia 132).

Gramsci believed that because the dominant ideology is "highly institutionalized and widely internalized," a "frontal attack" or direct assault is usually doomed to defeat (Femia 51). However, he theorized that social change may be accomplished by the "gradual dissolution" of the ideological and institutional foundations of the hegemonic group. Intellectual leaders may precipitate this change by giving voice to existing dissent, thereby raising the consciousness of the "underclass" (Femia 55-56). Women

health reformers and physicians functioned in this way by openly disagreeing with the biosocial construction of female sexuality proclaimed by the male medical establishment.

As Carroll Smith-Rosenberg has noted, the negative notions that male physicians of the Victorian era held about female anatomy and physiology "served as an absolute biological justification for woman's restricted role." These ideas also disclose "a characteristic and revealingly inconsistent ambiguity toward woman's sexual and social nature" (195). On one hand, woman was viewed "as a higher, more sensitive, more spiritual creature;" but, on the other hand, she was regarded "as a prisoner of tidal currents of an animal and uncontrollable nature . . ." (195-196). Thus, the power of female sexuality was simultaneously acknowledged and made less threatening "by subordinating it to the limited ends of child-bearing and nursing" (196). Formanek suggests that medical theories of inherent female frailty resulted from the combined influence of three factors: the patriarchal notion of women as inferior, the "professionalization of medicine," and "men's irrational fear of women [which] provided the underlying impulse to viewing women in general as ill and menopausal women as insane" (10). These crucial developments in the biosocial construction of femininity were key to the pathologizing and medicalization of menopause which developed in the Victorian era and have continued to the present time.

Pre-nineteenth Century Attitudes Toward Menopause

Formanek states that it is difficult to ascertain attitudes toward menopause prior to the nineteenth century for a number of reasons: "systematic references to the subject are

virtually absent;" pertinent books and papers are no longer in print; "the terms denoting menopausal changes are often unclear and euphemistic;" and it is nearly impossible to "reliably assess the significance of extant sources" (5).

One of the first scientists to attempt to explain health and illness in the female body was the second-century Greek physician Galen, who theorized that the human body contained four types of fluids or "humors," one of which was blood. He believed that illness was caused by the lack or overabundance of one or more of the humors. An excess of a particular humor was designated as a "plethora." Although he did not specifically refer to menopause, he considered amenorrhea, the cessation of menstruation, to be symptomatic of a blood plethora and regarded it as the primary source of ill health in women. The preferred treatment, of course, was blood-letting. Galen's theories continued to be very influential until the eighteenth century when ideas about menstruation and menopause began to be "influenced by a commitment to logic and direct observation of nature" (Formanek 5-7).

The first book on menstruation, Emmenologia, by John Freind, was published in Latin in 1703 and was translated into English in 1729. Freind was an English physician and scholar of history and mathematics. He explained anatomical and physiological changes in terms of mathematical formulas and "such concepts as velocity, the sine of the angle of incidence, momentum, pressure of liquids, inertia, conservation, and the like" although he still used the terms humor and plethora (Formanek 7). He wrote, "[A]s old Age creeps on, the Humours become rigid and hard; so that a Plethora can neither be accumulated at that Age, nor if it be, can it be discharged, because of the tenacity of the

Vessels" (qtd. in Formanek 8).

According to Freind, nature's wisdom deemed that menstruation should decrease and finally cease as women grew older, and therefore "no very bad symptoms happen in elderly Women, although the Menses should be wanting" (qtd. in Formanek 8). He differentiated between amenorrhea and menopause and held that menopause helped preserve the health of women as they aged and was not a pathological condition (Formanek 8). During the nineteenth century, this benign view of the menopause was to change radically.

Nineteenth-Century Views of Menopause

Marilyn Yalom has commented that when Victorian poet Robert Browning penned his well-known and supremely optimistic lines "Grow old along with me! / The best is yet to be, / The last of life, for which the first was made," he obviously did not have women in mind (452). Because the Victorians were obsessed "with woman as a reproductive creature," the climacteric signaled "the end of a primary sexual identity." Menopause was regarded as the threshold of senescence "which a woman passed at the peril of her life" (Yalom 453).

Since their value depended on their youth, beauty, and ability to bear children, women in the Victorian era had valid reasons to view with dread the period of their lives when they would be old, unlovely, infertile, and often poor as well. Aging women were at a distinct social and economic disadvantage during this period because their social status almost invariably depended on male members of their family--their fathers,

husbands, or sons--and only rarely on themselves (Yalom 453). Even though they might still be bearing children, females of more than forty years of age were deemed old. Therefore, popular moral tracts and advice literature of the period admonished women in their fifth decade to deport themselves and dress in a style regarded as appropriate for "the 'decline of life'" (Yalom 454).

Physicians considered menopause a very dangerous time, and they viewed any discomfort or disease a woman experienced at the climacteric as an indication of "indiscretions" that she had committed at an earlier stage. Thus, writers of these popular manuals blamed women for their own sickness (Formanek 20). A woman who violated "nature's laws" risked a dangerous change of life followed by years of painful or debilitating illness. These "violations" were seen to include "[e]xcesses of any kind, whether in . . . dress, reckless use of stimulating foods, prurient reading, contraception, or solitary vice [masturbation]" (Haller and Haller 134). As Fellman and Fellman have noted, some authors regarded postreproductive female sexuality to be "against nature"--and therefore either indicative of ailments or liable to precipitate them--and urged abstinence from sexual intercourse for menopausal women. Other writers counseled moderation, recognizing that sexual relations might serve other functions besides procreation (103-104). The advice manuals exacerbated the medicalization of menopause by popularizing and disseminating the negative conceptions about it which prevailed in the Victorian medical community (Formanek 20).

One of the most influential physicians writing on menopause during the nineteenth century was British gynecologist Edward John Tilt, whose 1882 book The

Change of Life in Health and Disease was widely read in the United States as well as in his own country (Formanek 16). As the following excerpt from his book demonstrates, Tilt's case histories and descriptions of menopausal women are paternalistic and distinctly misogynistic, portraying his patients "as dizzy, stupid, and bewildered" (Formanek 18). At the same time, he depicts himself as the caring, multi-talented physician assiduously and efficiently "managing" the pitiful menopausal patient:

> During the c. [change] of life, the nervous system is so unhinged, that the management of the mental and moral faculties requires great attention, and often taxes the ingenuity of the medical confidant. The study of the patient's character will teach him, however, what occupation and pursuit is most likely to engross her mind, and effectually replace those of former times. If he be not prepared to be at once a divine, a moralist, and a philosopher, without ceasing to be a physician, his medicines will in some cases, be of little use. (qtd. in Hellerstein, Hume and Offen 463)

Although Tilt acknowledged that the change of life did not involve "the loss of all personal attractions," he counseled women that their salvation in the post-menopausal years lay in directing their attention to diversions such as music or gardening and in selfless devotion to good works:

> Time dulls the eye, robs the cheek of its bloom, delves furrows in the forehead, but cannot quell the seraphic fire burning in the heart of women, prompting them to deeds of charity, and to heal the deep wounds which afflict society. (qtd. in Hellerstein, Hume and Offen 464)

Tilt asserted that the ovaries were the source of menopausal illness because they disturbed "the viscera, the center of nerve power and the cerebrospinal system." His book lists over 100 diseases attributable to menopause including "epigastric faintness and sinking, fainting, prolonged and intense debility, chlorosis, [and] palpitations." In addition, he stressed that the menopausal woman was particularly susceptible to various

forms of insanity. Among these were "delirium, mania, melancholia, suicidal tendencies, . . . perversion of moral instincts, uncontrollable peevishness, dipsomania, impulse to deceive, demonomania, erotomania, [and] apoplexy" (Formanek 18-19). Tilt's portrayal of the menopausal woman and her myriad maladies masqueraded as science but was in reality a manifestation of the ideology of pathological female sexuality requiring male control.

Some women in the nineteenth century presented a version of menopause, drawn from first-hand experience, which differed significantly from the gloomy scenario proffered by male physicians. One of these dissenting voices was Eliza Farnham, an American prison reformer, lecturer, and advocate for women's suffrage. She gave the following account of the change of life in her 1864 volume Woman and Her Era:

> . . . the individual is to have a period of repose from the taxes and cares which Maternity lays upon her--a period when the powers are ripened for growth, and when life, through the fullness of experience, has become a majestic, flowing river, whose current passion and sense are no more to lash into foam or break into roaring rapids. Or a lofty mountain is it? whose calm summit has pierced the clouds and now rises in grand repose above their changing, shifting haste and fury. After the earnest, self-sacrificing, absorbing struggles of the maternal years, this season fitly comes--a sabbath interlude of harmony and peace, to be followed by Heaven. (qtd. in Hellerstein, Hume and Offen 466)

Farnham's positive perception of menopause was not, however, shared by all women of the Victorian era. Smith-Rosenberg comments that her study of diaries, letters, and medical literature has revealed "that women viewed menopause with utter ambivalence" (193). Many doctors commented that their female patients feared the change of life and were depressed by its approach, an understandable reaction given that many women probably internalized negative medical and societal views on menopause.

However, many other women, like Farnham, enjoyed improved health after menopause and relished the freedom from menstruation and pregnancy that it brought (194-195). Numerous female physicians also challenged the ideology of menopause formulated by the male medical establishment. In fact, the misogynistic attitudes of male doctors toward aging women may even have motivated some women to pursue medical careers. "[O]ne woman physician, in a valedictory address to the 1864 class at Woman's Medical College in Philadelphia, cited such animosity as an important reason for women's becoming physicians" (Smith-Rosenberg 193). Women doctors such as A. M. Longshore-Potts, Mary Melendy, Clelia Duel Mosher, and Emma F. Angell Drake began to portray menopause as a period "not synonymous with disease" during which "women could continue to live productively after their reproductive years were over" (Formanek 30-34).

Twentieth-century Developments in Perceptions of Menopause

A significant development in perceptions of menopause occurred in the early twentieth century with the formal consolidation of the medical specialties of obstetrics and gynecology. The official alliance of "two exclusive gentlemen's clubs," the American Gynecological Society and the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, began in 1920 with the founding of the American Journal of Obstetrics and Gynecology (Summey and Hurst 137). During the 1920s and 1930s, the profession further established and defined itself. It was also during this period that the specialty's "interventionist" ideology emerged in the practice of

obstetrics by so-called "radicals," whose "foremost concern . . . was not the safety of childbirth . . . but the control of childbirth" through the use of forceps and anesthesia (140). Summey and Hurst assert that this interventionist philosophy has become "the dominant ideology of the obstetrician/gynecologist" (138).

Undoubtedly, the most important twentieth-century development in relation to medical intervention in menopause was the scientific discovery of sex hormones. Estrogen was discovered in the 1920s and one of its forms, estrone, was isolated in the laboratory in 1930, with the isolation of estriol and progesterone soon to follow. Ironically, the original motivation for research on sex hormones was the desire of aging men to maintain their virility and capacity for sexual activity (Formanek 37). However, it is women who have overwhelmingly been the focus of modern hormone research and the recipients of hormone therapies.

The new information on sex hormones had both positive and negative consequences for women. It replaced many of the inaccurate notions which physicians had held about the cyclic nature of the female reproductive system and the processes of menstruation and menopause. However, rather than totally debunking the old myths of female physiology, knowledge of sex endocrinology led to the creation of some new ones. A fundamental change occurred in the way doctors viewed the climacteric. In addition to regarding it as a critical period which predisposed women to pathological conditions, physicians began to define and treat menopause as a disease in and of itself.

Susan E. Bell asserts that the medicalization of menopause began in the 1930s and 1940s when "a small, elite segment of American medical professionals" conceptualized

and defined menopause as a "deficiency disease" caused by the cessation of ovarian function and a subsequent lack of estrogen (45). These physicians, thirty-seven in number, "were influential in education and policymaking; all had published papers about menopause in medical journals." Seventeen of them taught at medical schools and thirty had been designated as "experts" on the use of diethylstilbestrol (a synthetic form of estrogen also known as DES) by the Food and Drug Administration (47). The physicians' perspective on menopause was skewed, however, by the fact that their research data were drawn only from women who had experienced difficulty during the menopause and sought medical treatment. Although they knew that most women did not experience problems with menopause, "DES offered them the possibility of treating all menopausal women." Thus, medical men simultaneously defined menopause as a pathological condition and presented its "cure" (52). Once menopause was defined as a medical problem, the "implicit message was that all menopausal women should see physicians, who could prescribe the appropriate [estrogen replacement] therapy" (Bell 60).

The treatment of menopausal patients with estrogen reached a high point in the 1960s and early 1970s. One of the most enthusiastic advocates of estrogen replacement therapy was gynecologist Robert A. Wilson, whom Sandra Coney has dubbed "the Hugh Hefner of menopause" (69). His 1966 book Feminine Forever described natural menopause as "castration" (40), inevitably accompanied by "the loss of womanhood and the loss of good health" (92). Wilson touted estrogen as an anti-aging panacea which could (among other things) "make the skin smooth, supple, and taut again" (79) and

prevent or cure "atrophy of the breasts and sexual organs" as well as depression (207). As Gail Vines has commented, "Wilson's language makes it clear that rather more than a woman's health is at stake here; women's continued attractiveness and sexual availability are high on the agenda" (126).

Dr. David R. Reuben further helped to stigmatize menopause in his 1969 bestseller Everything You Always Wanted to Know about Sex. He characterized the climacteric as "a defect in the evolution of human beings" (288) which causes a woman to become "[n]ot really a man but no longer a functional woman" (292). Furthermore, he stated, "To many women the menopause marks the end of their useful life . . .. Having outlived their ovaries, they may have outlived their usefulness as human beings" (293). Like Wilson, Reuben's cure for this "disease" was hormone therapy. Both Reuben and Wilson assured their readers that estrogen therapy was not carcinogenic.

All members of the medical community, however, have not been ardent promoters of hormone therapy. More conservative physicians have been reluctant to prescribe powerful hormones for healthy women and have recommended that hormones should only be prescribed for a limited number of severe menopausal problems and, even then, only for the briefest possible time. Barbara Seaman, founder of the women's health movement in the United States, writes that "in the 60s, 70s, and 80s most discussions of menopause permitted several points of view" on appropriate treatment measures. Unfortunately, however, the pharmaceutical industry now exerts enormous power in the mass media because of its extensive advertising. The drug companies are therefore able to "exercise unofficial censorship" and to, in most cases, keep their "critics out of the

magazines and off the air." Seaman continues, "As a result of the vested interest pharmaceutical advertising supports, the conservative view on hormone therapy is no longer admitted on talk shows and is rarely seen in magazines that seek advertising." The "spectrum of positions" is no longer widely available to the public because "only extreme and middle-of-the-road proponents of estrogen therapy" are given mass media exposure. Seaman asserts that although "long-term hormone treatment is still controversial, still experimental, still considered dangerous by more than a few authorities," this fact "is concealed from general viewers and readers" (in Coney 5-8).

Opposition to the conceptualization of menopause as a disease and to indiscriminate estrogen use arose outside the medical community in the late 1960s as feminists began to challenge the myths of menopause constructed by the medical establishment. Women activists asserted that "menopause is a normal experience of normal women" (McCrea 118). They contended that "[t]he health care system legitimates sexism, under the guise of science, by depicting women's physical and mental capabilities as dependent on their reproductive organs" (McCrea 117). Feminists declared that women had the right to control their own bodies and urged women to demystify medical knowledge by learning about female anatomy and physiology. They advocated self-help and support groups, preventive health measures, and natural or alternative remedies as means by which women could take charge of their own health care. The women's health movement accused physicians "of reflecting and perpetuating the social ideology of women as sex objects and reproductive organs" and defined hormone therapy as "exploitation and an insidious form of social control" (McCrea 111).

In 1975, the wholesale use of estrogen plummeted when data from two independent medical studies indicated that women who had taken estrogen had a conspicuous increase in cancer of the endometrium. However, medical researchers soon discovered that taking progestin diminishes the risk of endometrial cancer associated with unopposed estrogen. With this news, many doctors began advising virtually all menopausal women to take hormone therapy consisting of combined progestin and estrogen, despite the dubious wisdom of prescribing one powerful hormone to offset the iatrogenic effects of the other.

Physicians now commonly prescribe a combination of estrogen and progestin for most women, recommending unopposed estrogen only for women without a uterus. In addition, many physicians recommend that once women begin taking HRT they should continue indefinitely. However, scientific evidence of the safety and efficacy of HRT is poor and conflicting. Accordingly, The National Women's Health Network has taken the following position on hormone therapy: "We are critical of the routine prescription of hormones for healthy women because of the known risks associated with the drugs used and the lack of complete data on risks and benefits" (2). Nevertheless, according to an article in the October 1993 issue of Good Housekeeping, Premarin, a form of estrogen derived from pregnant mare's urine, is the most frequently prescribed medication in America.

An important factor in the increased use of HRT is the advertising and research activities of pharmaceutical companies promoting the benefit of HRT in the prevention of osteoporosis. In 1985 Wyeth-Ayerst, makers of Premarin, "hired a public relations firm

to conduct a public-education campaign aimed at encouraging all women over thirty-five years to consider taking estrogens to prevent osteoporosis . . ." (Worcester and Whatley 4). The pharmaceutical giant transformed osteoporosis from a relatively unknown condition to a "household word," created a climate of fear about this disease, and thus produced "an enormous market for their product" (Ford 33-34). In addition, HRT is being touted as a preventive for heart disease because of estrogen's effect of raising levels of HDL (the "good" cholesterol). Many authorities, however, believe that the addition of progestin in HRT may cancel the cardiovascular benefits of the estrogen.

Much of the current ideology associated with menopause may be traced to the social construction of female biology that grew out of economic and cultural developments in the nineteenth century. As we have seen, it was during that time that women came to be valued primarily as mothers, the medical profession became established, and menopause, as well as other uniquely female physiological functions, came to be associated with disease. Themes such as the "management" of the menopausal patient, the "power" of the ovary, the association of menopause with mental illness (particularly depression), the menopause as the end of woman's sexuality, and the postmenopausal woman having outlived her ovaries (and thus her usefulness as a human being) reoccur again and again and are still evident in the professional and popular medical literature of the late twentieth century.

Gramsci's social and political analysis helps to explain how the scientific and medical establishment exerts a form of internal, or hegemonic, social control over public perceptions of menopause, women's interpretation of their own menopausal experience

and its relationship to aging, and, perhaps most important in regard to women's health, their willingness to comply with questionable treatments that physicians deem necessary and proper. Carroll Smith-Rosenberg has observed that "the human body, known only through the social body's conceptual categories, has never existed as a 'natural' entity" (51). The way in which female bodies are described by science and medicine affects both how women perceive their own bodies and their perceptions of how doctors view female bodies (Martin 14).

Madeleine J. Goodman states that various members of the biomedical community are presently depicting menopause in three ways in relation to disease. It is seen as a disease in and of itself; it is regarded as pathogenic, causing conditions such as osteoporosis; and it is considered a "biological marker," associated with the onset of potentially fatal cardiovascular disease in women (148).

Frances B. McCrea asserts that the socially constructed "disease" definition of menopause is "inherently political" and based on four ideas about aging women. "These are: (1) women's potential and function are biologically destined; (2) women's worth is determined by fecundity and attractiveness; (3) rejection of the feminine role will bring physical and emotional havoc; (4) aging women are useless and repulsive" (111). Furthermore, she avers, "the medical model individualizes the problem" by defining menopause as a disease, thereby "deflect[ing] responsibility from the social structure which assigns aging women to a maligned and precarious status" (120).

Negative perceptions and paradigms of menopause are particularly powerful within the context of our contemporary medical system because of certain existing

dynamics that frequently work to the benefit of medical providers and to the detriment of medical consumers. Two such forces are inequitable physician-patient relationships and fee-for-service economics. In current doctor-patient exchanges, "the physician is [generally] active, instrumental, and authoritative while the patient is [often] passive and dependent." The disparate nature of this interaction "institutionalizes" medical authority and therefore "decreases the status and the autonomy of the patient while increasing the status and power of the physician" (113). In addition, our capitalistic health care system, "based on fee-for-service, is conducive to defining more and more life events as illnesses" since this practice "serve[s] the interests of both the medical profession and the pharmaceutical industry" (120).

However, a multitude of contemporary women's voices, in counterpoint to the hegemonic medical view, attest to the variety and complexity of experiential realities in this female life passage that transcends the physical boundaries which have defined it in male-dominated American culture. The feminist paradigm, while not denying that menopause is a difficult transition for some women, asserts that it is a normal part of the life of women and does not automatically require medical intervention. Indeed, it can be a phase of life characterized by better health, new zest, and wider personal horizons for many women.

Women who are speaking out on menopause include well-known authors Germaine Greer and Betty Friedan as well as relatively "unknown" women whose writings have been included in anthologies on menopause such as Women of the 14th Moon, edited by Dena Taylor and Amber Coverdale Sumrall, and Each in Her Own Way,

edited by Elizabeth Claman. These dissenting voices are increasingly being heard as the new openness on menopause encourages women to share their personal experiences and the proliferation of feminist presses provides them the means to reach a wider audience. The challenge that these women's voices present to the dominant view may eventually significantly alter negative societal perceptions of both menopause and aging women.

CHAPTER II

METHODS

The research objective of this study is to examine the manifestations of two distinct paradigms of menopause, the medical model and the feminist model, in three types of writings on the subject. The medical model defines menopause as a pathological state and discusses it in terms of disease, deterioration, and hormone deficiency and imbalance. The feminist model, on the other hand, views the climacteric as a normal and natural, albeit sometimes difficult, transition period of a woman's life. I have utilized content analysis to investigate depictions of the climacteric and its concomitant physical and emotional changes in three categories of literature: gynecological textbooks, popular advice books written by physicians, and women's accounts.

I employed both quantitative and qualitative content analysis to uncover the ideologies that inform the two paradigms of menopause represented in the sample. I discovered five major themes in the writings I examined, following Reinharz's dictum that "[c]ultural artifacts invite grounded research if the researcher allows the analytic categories to emerge from the artifacts themselves" (161). I therefore formulated sets of paired indicators--representing the biomedical and the feminist paradigms--for each of the five themes. The quantitative analysis consisted of counting the number of mentions for each topic in the text samples and measuring the amount of page space devoted to these indicators to determine the depth and amount of detail with which they are discussed when they are mentioned.

In qualitatively analyzing the sample, I concentrated on the tone of the language used to describe menopausal processes and aging women. I also noted what the writers implied as well as what they directly stated and what material they omitted as well as what they included.

Design

The biomedical paradigm and the feminist paradigm represent two fundamentally different ways of viewing menopause. In the biomedical model, the climacteric is seen as a biological phenomenon that all women who live approximately fifty years or longer will experience. The biomedical model thus tends to equate the universality of female reproductive organs and physiology with a corresponding sameness of experience of and reaction to menopause. This model concentrates its attention on the menopausal woman's body, its organ systems and physiological processes. This reductionistic view is both cause and effect of the dominant social constructs about femaleness and the ways in which menopause affects femaleness. The medical model interprets menopause as a departure from the "normal," a disorder resulting in bodily deterioration and hormonal imbalance. Accordingly, it is viewed as pathological, having dire consequences for many body systems. As a condition that is both "unhealthy" in and of itself as well as one that causes further disease and decay, menopause, according to the biomedical model, is a condition that mandates medical treatment and supervision.

In contrast to the biomedical pathology model, the feminist model regards menopause as a biological process that is profoundly affected by culture, race, class,

heredity, individual temperament, and many other factors. Thus, it is a unique experience for each woman. The feminist model does not limit its focus to the menopausal woman's body but also considers her intellectual, spiritual, and emotional aspects and potential. The climacteric is considered a normal transition that is part of the natural aging process. In the feminist model, menopause is not seen as pathological and does not automatically warrant specialized medical care or treatment. It is rather a time when special attention to self-care and a wholesome lifestyle can result in a long and healthy life.

The wide-ranging depictions of the climacteric found in the works of this sample represent a continuum with each of the contrasting models at either end. While no single work I examined conforms completely to either of the two extreme positions, a text's relative placement on the continuum may be inferred by the language it uses to describe the processes and experience of menopause, by the frequency with which it raises certain topics, and by the amount of page space it devotes to various themes.

The conflicting perspectives on menopause and women's aging that are reflected by the biomedical and feminist paradigms have enormous potential consequences for older women's physical and mental health. Examining samples from three categories of writing about menopause enables me to evaluate their contents on several levels. It allows me to compare and contrast the extent of the opposing perspectives in the various literatures, to document the wide range of views, to assess the degree to which feminist perceptions and ideas have been incorporated or co-opted by the medical model, and to illustrate and explain the confusion women experience when confronted by such glaringly different views of this transition period. The three types of menopause literature I chose

to study are gynecology textbooks, popular advice books written by physicians, and women's writings on their own experience.

These three types of menopause literature have what Shulamit Reinharz describes as "a naturalistic, 'found' quality" because they were "not created for the purpose of study." In addition, these "cultural artifacts" are "noninteractive" sources which, unlike human research subjects, "are not affected by the process of studying them" (147). Therefore, by employing "feminist subversive intertextual reading," (149) I have attempted to uncover how some of these sources construct the "reality" of menopause on a foundation of sexism, agism, patriarchy, and capitalism.

Gynecological textbooks in the sample indicate what eminent gynecologists, the cultural "authorities" on women's health, are telling their colleagues about menopause and its effects on women. Perhaps more importantly, these texts provide a record of what medical students, the physicians of the future, are currently learning about the climacteric and women's aging. The popular advice books reveal how medical practitioners of both sexes from several different specialties are "instruct[ing] women to feel and define their experiences" in the climacteric (Reinharz 151). These books are written for the purpose of elaborating for women the nature and consequences of menopause and convincing them of "appropriate" courses of action for safeguarding their health. The accounts from women indicate how individuals who have directly experienced the menopause view and describe this part of their lives.

Women's experiential narratives are particularly important because these accounts are often selectively used by popular advice authors to validate their negative discourse

on the nature of menopause. For example, in Dr. Wulf Utian's text, Managing Your Menopause, a "very personal note" from his coauthor Ruth Jacobowitz serves as the introduction to the book. Jacobowitz describes "the horror" of her "devastating menopause experience" and relates how she became a "devotee" of the Utian Menopause Management Program. Part of her motivation for helping to write the book, she states, was her concern for "other unknowing women and what might be happening to them" (xi-xiii). It was the major dissimilarity between Jacobowitz' dreadful experience of menopause and my own relatively painless transition that gave rise to my curiosity about what other women might have to say about their own experiences with the climacteric.

The contrasting viewpoints among women also provided me with the impetus to compare the women's accounts with those in gynecology textbooks and popular advice literature. As Susan Markens has stated, ". . . feminist attempts to include women's experience in knowledge creation need to consider how this experience can be used both for and against women in the current practice and lay understandings of medicine" (emphasis in the original) (52). By analyzing and comparing these three types of sources, I have endeavored to uncover the extremes of the medical and feminist views on menopause as well as more centrist positions where evidence of the influence of both paradigms might indicate changing social norms.

Sample

I analyzed chapters on menopause in nine gynecology textbooks, eight popular medical advice books on menopause written by physicians, and eight women's published

works on their experiences of and response to the climacteric and aging. These three classes of literature represent three distinct voices on the subject of menopause and women's aging. All the works I selected for study were published between 1983 and 1994.

Gynecology Textbooks

The gynecological textbooks in this study represented a convenience sample of texts I found readily available in the libraries at the Eastern Virginia Medical School in Norfolk, Virginia and the Medical College of Virginia in Richmond, Virginia. I particularly sought to include textbooks that had been published in multiple editions and selected the latest edition of these works. I reasoned that such treatises would be the ones most widely used in medical schools throughout the United States. In each work, I surveyed only the chapter that specifically dealt with menopause since the other chapters did not directly address the issues central to my thesis. All the authors of the material I examined were medical doctors specializing in gynecology and obstetrics. The nine chapters were written by a total of seventeen authors. Fifteen of these were males, and two were females. Please see Appendix A for a listing of the gynecological texts selected for the sample.

Popular Advice Literature

The most important criterion for inclusion in the popular advice category of the sample was that the books were written by physicians for a readership of midlife women.

Four of these works were co-authored by writers who specialize in health or medical books and articles, but in each case the medical doctor was the primary author.

The works in this category were also a convenience sample, and all were readily available in bookstores in the Tidewater region of Virginia. Managing Your Menopause by Wulf Utian was the book which my own gynecologist recommended when I asked him about sources of information on menopause. Five of the physicians/authors in this category are females and four are males. Of the coauthors who are not doctors, all four are females. A number of medical specialties are represented by the writers in the sample. Utian, Cherry, Gillespie, and Notelovitz are gynecologists. Utian is the founder and Gillespie is a founding member of the North American Menopause Society. Greenwood and Budoff are practitioners of family medicine. Jovanovic and Nachtigall are endocrinologists, and Runowicz specializes in gynecological oncology. Please see Appendix B for a list of popular advice works included in the sample.

Women's Writings on Menopause

The third group of sources for this study, women's accounts, was also a convenience sample. In this category, I again chose books which I found readily available in local bookstores or those which I had seen mentioned in The Women's Review of Books. In order to distinguish this grouping from the popular medical advice category, I selected for inclusion only those books written or edited by women who were not physicians.

I sometimes selected only portions of these women's writings to examine. For

example, in the book Ourselves, Growing Older, by Doress and Siegal, I eliminated several chapters from my analysis, including only those that directly addressed the themes under consideration. I excluded poetry except when a poem's subject matter was very specifically related to one of the indicators in the study. For example, the poem "Meaning Menopause" by Dori Appel (in Taylor and Sumrall 180-181) is about the author's adverse reaction to her gynecologist's use of the term "ovarian failure." Therefore, I included this poem in the count of the indicator that measures the usage of that particular term. Please see Appendix C for a list of women's accounts chosen for the sample.

Coding Scheme

Themes and Indicators

The conceptual framework for this study is based on two distinct paradigms of menopause: the biomedical pathology model and the woman-centered feminist model. I have predicated my analysis on five major themes in the menopause literature. Each of the themes is divided into two opposing views, one typical of each of the two paradigms. Varying numbers of specific paired indicators for each theme provide evidence of the paradigm on which the writer or writers based their exposition of menopause. Please see Table 2.1 for an overview of the five themes and their indicators.

Theme I: Universality versus Individuality of Experience

In the "disease" model, the biological nature of menopause dictates a similarity of

Table 2.1: Themes for Analysis and Indicators

Theme I: Universality of Menopausal Experience

Biomedical Model	Feminist Model
Biological nature of menopause indicates similarity of experience for all women.	Menopause a biological process mediated by cultural and individual differences.
Indicators:	
1. Hot flashes regarded as uniformly negative experience.	Hot flashes can be negative, positive, or neutral experience.
2. Menopause represents loss of femininity and womanhood.	Represents new stage of possibilities for women.
3. Menopause looked upon with apprehension.	Regarded as period of growth and new zest.
4. Time of crisis and potential catastrophe.	Time of change, transition.

Theme II: Reductionist vs. Holistic Emphasis and Interpretation

Biomedical Model	Feminist Model
Body seen as primary, emphasis on negative consequences of menopause.	Person seen as primary, emphasis may be both positive and negative.
Indicators	
1. Loss of reproductive capacity viewed as negative.	Emphasis on beginning of freedom from menses, contraception, and pregnancy.
2. Stresses reduced attractiveness caused by wrinkles, sagging, redistribution of body fat.	Attractiveness not seen to depend on conventional standards.
3. Regards women's sexuality as reduced because of body changes.	Sexuality continues, may even be enhanced.

Theme III: Interpretation of Physical Changes

Biomedical Model	Feminist Model
Body seen as decaying, declining.	Body undergoing normal changes of aging.

Table 2.1 (continued)

Biomedical Model	Feminist Model
Indicators:	
1. Refers to ovarian/gonadal failure, atrophy, decline.	Refers to cessation of ovulation.
2. Refers to estrogen/hormonal deprivation, starvation, deficiency.	High levels of estrogen seen as unnecessary for nonreproductive state.
3. Refers to hormone imbalance or endocrinopathy.	Refers to new, different balance in hormonal relationships.
4. Refers to genital/urinary atrophy.	Refers to genital and urinary changes.
5. Refers to hot flashes as result of vasomotor "instability."	Refers to hot flashes or flushes as normal sign of menopause.
Theme IV: Perceptions of Menopause as Pathological/Nonpathological	
Biomedical Model	Feminist Model
Menopause seen as disease, disease-causing or as a marker for pathological states.	Menopause viewed as natural, normal transition period.
Indicators:	
1. Menopause seen as primary cause of osteoporosis.	Osteoporosis seen as result of aging, heredity, and lifestyle.
2. Consistent use of "symptoms" to describe menopause.	Uses "signs" more often.
3. Discusses menopause in terms of "epidemiology."	Discussion couched in demographics.
4. Menopause seen as cause of genitourinary atrophy, vaginitis, urethritis, incontinence.	Aging and other factors seen to play a part in these problems.
5. Menopause seen as source of blood lipid changes associated with atherosclerotic cardiovascular disease.	C-V disease ocurring after menopause may not be caused by it, lifestyle and heredity important.

Table 2.1 (continued)

Biomedical Model	Feminist Model
6. Insomnia in menopausal women caused by hot flashes and night sweats.	Insomnia may also result from other factors in life of women.
7. Menopause causes psychological problems, depression.	Depression in midlife can be caused by many other factors in life of individual woman.
Theme V: Views Regarding Treatment/Therapy	
Biomedical Model	Feminist Model
Views medical intervention as necessary for continued health of perimenopausal and postmenopausal women.	No need seen for special medical intervention; alternative or nonmedical therapies recommended.
Indicators:	
1. Menopausal women need hormone treatment with ERT/HRT.	ERT/HRT for most women questionable, not needed and may be harmful.
2. Menopausal women should consult a physician and/or find the "right" one.	No specialized medical care needed; good general care recommended.
3. Lifestyle changes not advocated.	Lifestyle changes advocated.
4. Alternative therapies not recommended.	Alternative therapies recommended.

experience for all women. Commonality of female organs, hormones, and physiological processes determines the quality of menopausal experience rather than cultural or individual differences. Therefore, the first indicator of this position is an assumption that hot flashes are a uniformly negative experience. The second indicator is the view that menopause represents the loss of femininity and womanhood when fertility ends.

Consequently, the third indicator of the theme of universality in the pathology model is that the authors view the climacteric with apprehension. Fourth, they regard this period of a woman's life as a time of crisis and potential catastrophe.

The feminist model, on the other hand, sees menopause as a normal biological process mediated by individual and cultural differences and therefore unique for each woman. The four corresponding indicators for the theme of universality versus individuality in the woman-centered model reflect a view consistent with this position. First, feminist writers acknowledge that hot flashes can be a negative, positive, or neutral experience. Second, in the feminist model, menopause represents a new life stage of intellectual, sexual, emotional, and spiritual possibilities for many women. The third indicator of the feminist paradigm for this theme therefore posits menopause as a period of a woman's life which may offer an opportunity for growth and new zest. Fourth, the woman-centered authors view the climacteric not as a crisis but as a time of transition.

Theme II: Reductionistic versus Holistic Emphasis and Interpretation

The second theme contains three corresponding pairs of indicators. The biomedical model tends toward a reductionistic position, concentrating its focus not only on the body but even more narrowly on the reproductive organs, particularly the ovaries. Since "women's potential and function are biologically destined" (McCrea 111), the first indicator of this model is a negative view of the loss of reproductive function, the primary duty of women in patriarchal society. The second indicator of a reductionistic bias is that the author stresses a decrease in middle-aged women's attractiveness caused by wrinkles,

sagging flesh, redistribution of fat, and other bodily evidence of advancing years. The third indicator that evinces a reductionistic biomedical paradigm is the depiction of waning sexuality in midlife women caused by body changes.

The feminist paradigm, on the other hand, is characterized by a more holistic emphasis and interpretation of the climacteric transition. The woman-centered model regards the person as primary, with the body as merely a part of the whole individual. The first indicator of this theme is an emphasis on the beginning of freedom from menstruation, and from worries about contraception and pregnancy. In accordance with the more holistic approach, the second indicator of the feminist model is a view of a middle-aged woman's attractiveness as based on factors such as mature physicality, wisdom, and spirituality and therefore not dependent on conventionally-defined standards of youthful physical beauty. The third indicator of the feminist holistic emphasis is the view that women's sexuality need not end when reproductivity ceases at menopause but may continue and may even be enhanced.

Theme III: Interpretation of Physical Changes of the Climacteric

The third theme further reflects the differences between the "disease" and transition paradigms. The biomedical model regards the menopausal female body as decaying and declining, whereas the feminist model views bodily changes as the results of normal processes of aging. There are five pairs of indicators in this theme which are all based on the language used to describe somatic transformations that accompany the menopause. The negative descriptive language of the pathology model includes

references to ovarian/gonadal "failure," "atrophy," or "decline;" to estrogen/hormonal "deprivation," "starvation," or "deficiency;" hormonal "imbalance" or "endocrinopathy;" genital/urinary "atrophy;" and allusions to hot flashes or flushes as vasomotor "instability."

The corresponding language of the women-centered model describes the same changes in a more neutral or positive manner: referring to "cessation of ovulation," regarding lower levels of estrogen in postmenopausal women as normal and sufficient for their nonreproductive state, mentioning a "new" or "different" balance in hormonal relationships, and alluding to genital or urinary "changes."

Theme IV: Perceptions of Menopause as Pathological or Nonpathological

I designed the fourth theme to demonstrate that the writers who more closely fit the biomedical paradigm conceive of the menopause either as a disease, as disease-causing or as a biological marker of pathological states. There are seven pairs of indicators for this disease-orientation to the climacteric. The authors who give voice to the ideology of the pathology model name menopause as the major cause of osteoporosis. They consistently use the term "symptoms" to indicate the physical changes that accompany menopause, and they discuss menopause in terms of its "epidemiology." They assert that genitourinary atrophy, vaginitis, urethritis, and urinary incontinence are chiefly caused by lower levels of estrogen following menopause. They view the climacteric as the primary source of blood lipid changes associated with atherosclerotic cardiovascular disease. They regard insomnia in menopausal women as mainly a result

of hot flashes and night sweats, and they aver that menopause causes psychological problems and depression.

Because the woman-centered model characterizes menopause as a natural and normal, although sometimes problematic, transition period in women's lives, feminist writers on the subject tend to present a more complex view of the above issues. They regard osteoporosis as a multifactorial disease resulting from aging, heredity, and lifestyle components such as diet, lack of exercise, smoking, and caffeine and alcohol consumption. They assert that use of the term "symptoms" is inappropriate in discussions of a normal process and use the term "signs" instead. Moreover, feminist writers couch their discussions of the population of menopausal women in more neutral terms of demographics since "epidemiology" denotes the presence of disease. The feminist orientation toward the menopause as a natural phase also prompts these authors to point out that aging, childbirth history, toilet habits, and muscle tone are factors to be considered along with menopause in problems such as vaginitis, urinary infections, and incontinence. In the same vein, another indicator of the feminist model is that writers assert that cardiovascular disease may occur postmenopausally but is not necessarily directly attributable to it. As with osteoporosis, heredity and lifestyle factors are also important. Insomnia is likewise considered multifactorial with family problems, work, and other causes considered in addition to hot flashes and night sweats. Similarly, the feminist model views midlife as a complex period of women's lives, during which depression and other psychological problems are often precipitated by other events and conditions besides menopause.

Theme V: Views Regarding Treatment or Therapy

The fifth major motif which I discovered in the literature of menopause pertains to treatment and therapy. Because the biomedical model views the change of life as a process of disease and decay, writers who espouse this mind-set regard medical intervention as necessary for the health of perimenopausal and postmenopausal women. On the other hand, feminists aver that most menopausal women do not need specialized medical care or intervention in the form of hormones. They also often recommend a wide variety of alternative or nonmedical therapies. On this issue, the differences between the two ideologies of menopause were apparent in four pairs of indicators.

The pathology model concentrates on the medicalization of menopause and posits that the majority of menopausal women need hormone replacement therapy (estrogen or a combination of estrogen and progestin). Another assertion frequently found in this paradigm is the claim that it is very important for menopausal women to consult a physician, particularly a gynecologist, to help them through this period of crisis and that women should search until they find the "right" one. Lifestyle changes are not strongly advocated in this model, and nonpharmaceutical therapies (other than surgery) are rarely recommended.

In the feminist paradigm, writers frequently question the necessity, safety, and efficacy of hormone replacement therapy and cite contradictory findings and faulty research methods used in many studies on the climacteric. They also challenge the motives and the influence of the powerful multinational pharmaceutical corporations

which fund much of the medical research on menopause. Feminist writers do not stress the need for special medical care after menopause, although most of them advocate good general, routine care. A hallmark of the feminist model is the inclusion of detailed information and recommendations on a healthy lifestyle such as dietary modifications, exercise, rest, smoking cessation, and moderation in caffeine and alcohol consumption. Many of the works by feminist authors also contain sections on nonpharmaceutical, nonsurgical remedies such as herbs, vitamins, relaxation techniques, Kegel exercises, and vaginal lubricants for discomforts and problems that may accompany the climacteric.

Analysis

I have employed two types of measures in the quantitative content analysis of this study in order to evaluate the underlying ideologies of the gynecology textbooks, popular advice literature and women's accounts of menopause. First, I counted and tallied the number of mentions for each of the 23 indicators as I carefully read each source of the sample to determine whether or not its author paid attention to the particular topics for which I coded. Second, I calculated the page space devoted to each topic in each source to ascertain the depth and amount of attention that the writer gave to the subject whenever a mention occurred. I estimated page space using whole numbers and the following fractions: .05 (1/20), .10 (1/10), .13 (1/8), .17 (1/6) .20 (1/5), .25 (1/4), .33 (1/3), .40 (2/5), .50 (½), .66 (2/3), .75 (3/4), and .90 (9/10). I counted a single sentence as a minimum of .05 of a page. In the case of the second indicator in the fourth theme, the use of the terms "symptom" and "sign," I did not calculate page space but simply counted the

number of mentions. Therefore, the number of mentions for that indicator are not included in the totals for mentions in the theme on the pathological/nonpathological nature of menopause.

In each category of menopause literature, I added the sums of the mentions and page space from each source to obtain the total numbers of mentions and amount of page space for each indicator. I then added the totals of the indicators to obtain a total for each theme. I combined the theme totals to obtain the grand totals for each model in the sample. I calculated a mean value for each indicator and theme by dividing the amount of page space by the number of mentions. The mean values for the indicators and theme totals represent an average of the page space given to each topic and theme. The grand totals and their means represent a summary of the number of mentions and amount of page space given to the two paradigms of menopause in each of the three groups of sources. By comparing the total mentions, amounts of page space, and means for the opposing models in samples of each category of menopause literature, I have attempted to ascertain the extent and salience of each paradigm in the three types of recent writings on the change of life.

I also employed qualitative content analysis in studying the three types of writings on menopause, paying close attention as I read to the nature and tone of the language used by the authors in their characterization of menopausal women and the processes and experiences of the climacteric. I took thorough notes on each source to record textual patterns, nuances, and details that contributed to the overall impression of menopause each work conveyed. In addition, I noted what topics the writers left out of their texts as

well as what they included. By utilizing both quantitative and qualitative content analysis in this study, I have attempted to expose the socially constructed nature of this literature and the "truths" it contains.

As previously noted, I gathered data only from the nine chapters specifically devoted to menopause in the gynecology texts, but in the popular advice and women's writings samples I evaluated the books in their entirety, with the exception of a few nonpertinent chapters in the Doress and Siegal volume. The resulting disparity in the total amounts of material among the three categories of literature imposes limitations on making valid comparisons across the samples. Within each sample, I can legitimately make comparisons at the indicator and thematic levels of the number of mentions and the amount of page space. However, the different sizes of the samples means that comparisons across the samples are limited to only the general patterns of paradigm dominance.

These writings about, for, and by women shape, reinforce, and provide a record of patriarchal, sexist, and agist cultural attitudes, stereotypes, and norms that have contributed to the medicalization of menopause. They also provide a forum in which feminists may bring about positive changes in these socially constructed attitudes, stereotypes, and norms.

CHAPTER III

FINDINGS FROM ANALYSIS OF GYNECOLOGICAL TEXTBOOKS

The information included in gynecological textbooks, as well as that which is omitted, adheres, as expected, to the tenets of the biomedical model with few exceptions. The authors of these texts are considered by the culture to be the experts on women's bodies. Their authoritative position helps to establish their view of menopause--a biological event that is pathological and demands medical attention--as the dominant one in society. The language of the texts defines as "normal" the cyclic physiology of the reproductive system during the period of a woman's life between menarche and menopause. For example, Judd, referring to estrogen levels, states, "The estradiol levels in normal, cycling young women do not overlap those observed in postmenopausal subjects" (971). By implication, therefore, menopause is deemed "abnormal." In addition to viewing menopause as pathological, many of these writings portray the climacteric and the women experiencing it in a negative, condescending, and paternalistic fashion. In four of the five themes I examined, Universality versus Individuality of Menopausal Experience, Reductionistic versus Holistic Emphasis and Interpretation, Interpretation of Physical Changes, and Perceptions of Menopause as Pathological or Nonpathological, the data from the gynecological texts indicated agreement with the biomedical model. Please see Table 3.1 for a summary of the data from the gynecology texts.

Physicians' descriptions of menopausal processes were in accord with the feminist

Table 3.1: Findings from Gynecology Textbooks

	Biomedical Model			Feminist Model		
Themes & Indicators	**#**	**pg sp**	**mean**	**#**	**pg sp**	**mean**
Universality						
I-1 Hot Flashes -/+	17	2.19	.13	1	.10	.10
I-2 Femininity	13	1.25	.10	2	.10	.05
I-3 Apprehension/Zest	6	.53	.09	0	0	0
I-4 Crisis/Transition	4	1.60	.40	4	.25	.06
Totals	40	5.57	.14	7	.45	.06
Reductionism						
II-1 Reproductivity	21	1.35	.06	4	.30	.08
II-2 Attractiveness	6	1.21	.20	0	0	0
II-3 Sexuality	4	.60	.15	7	.83	.12
Totals	31	3.16	.10	11	1.13	.10
Interpretation						
III-1 Ovarian Changes	21	1.52	.07	1	.10	.10
III-2 Hormone Levels	38	2.96	.08	1	.05	.05
III-3 Hormone Balance	6	3.85	.64	9	4.77	.53
III-4 Genitourinary	22	1.70	.07	0	0	0
III-5 Vasomotor	17	4.49	.21	1	.10	.10
Totals	104	13.52	.13	12	5.02	.42
Pathology						
IV-1 Osteoporosis	31	7.99	.26	16	2.19	.14
IV-2 Symptoms/Signs*	198	na	na	24	na	na
IV-3 Epidemiology	7	.96	.14	6	.57	.10
IV-4 Genital Changes	16	3.81	.24	1	.05	.05
IV-5 Cardiovascular	16	5.33	.33	9	2.22	.25
IV-6 Insomnia	11	1.52	.14	0	0	0
IV-7 Depression	7	.50	.06	11	1.42	.13
Totals (*not included)	88	20.11	.23	43	6.45	.15
Treatment						
V-1 HRT	64	19.65	.31	3	.28	.09
V-2 Medical Care	3	.43	.14	0	0	0
V-3 Lifestyle Changes	0	0	0	12	2.27	.19
V-4 Alternatives	0	0	0	9	.70	.08
Totals	67	20.08	.30	21	2.97	.14
Grand Totals	**330**	**62.44**	**.19**	**97**	**16.30**	**.17**

model in only three of the 23 indicators I analyzed, and even in these areas the margin of agreement was small. In the area of Views Regarding Treatment and Therapy, the totals superficially appear to support further alignment with the feminist model. However, in this theme the subjects that are omitted from the texts or treated cursorily confirm that in this area gynecology texts also conform more closely to the pathology model.

Gynecologists overwhelmingly advocate hormone replacement therapy for most menopausal women and endorse specialized medical treatment for women during and after the climacteric. The emphasis in these texts, as expected, is definitely on the medicalization of menopause with specialized medical treatment and hormone replacement therapy rather than on lifestyle modifications and alternative treatments. See Table 2.1 for a summary of the data from gynecology textbooks.

Theme I: Universality of Menopausal Experience

The biomedical model posits physical manifestations as the primary factor in menopausal processes and experience and therefore tends to link commonality of body parts and processes with a similarity of experience for all women. In addition, physicians interact mainly with a clinical population of women who are experiencing difficulties in the perimenopause. Therefore, doctors routinely view the climacteric as problematic. Conversely, the feminist model sees menopause as a biological phenomenon mediated by cultural differences and individual variations in women's physical, emotional, intellectual, and spiritual reactions to the change of life. As expected, the data from the four indicators of the theme of universality of menopausal experience all show the

gynecology texts to fit the biomedical paradigm more closely than the feminist one. The results are more readily apparent in the first two indicators than in the latter two.

The first indicator in this theme deals with the treatment of hot flashes, which gynecologists assume to be a uniformly unpleasant experience. In the feminist model, hot flashes are acknowledged to be viewed by individual women as negative, positive, or neutral. Gynecology texts were consistently adverse in their discussions of hot flashes with 19 mentions and almost three pages of a total of 192 devoted to descriptions of the difficult and stressful nature of this physical phenomenon. Droegemueller et al. characterize the hot flash as "a sudden, explosive . . . phenomenon" (1088) which is the "pathognomonic symptom of the menopause" (1082). Only one text mentioned briefly that hot flashes in most women were mild and interfered little with activities (Willson 621). None mention that hot flashes might be perceived as a positive experience by women, a point that is indicative of the feminist paradigm.

The second indicator of the theme of universality assesses the authors' perception of the relationship between menopause and the loss of femininity or womanhood. The biomedical paradigm, true to its nineteenth century roots, links femininity with fertility; menopause, the transition to a nonreproductive state, therefore represents the loss of femininity and womanhood. On the other hand, in the feminist model, the climacteric represents not a loss of feminine identity but a new life stage of emotional, intellectual, and career possibilities for many women.

As expected, data from this indicator again show the gynecology texts overwhelmingly adhering to the biomedical model. Discussions in this area often

centered around changing patterns of facial and body hair. One writer attributes the "defeminization, hirsutism, and even virilism occasionally seen in older women" to the ovaries' decreasing production of estrogen and "increased . . . testosterone secretion." The same author also uses the term "femininity index" in referring to an assessment of the condition of the vaginal epithelial cells and its use in determining menopausal status (Judd 961). Two of the gynecology textbook writers did devote one sentence each to the assertion that the postreproductive period might represent a time when a woman could, in the words of Willson, "turn her resources and energies to new pursuits" (624).

Data from the indicator for attitudes toward the climacteric as a period to be viewed with apprehension or to be regarded as an opportunity for growth and new zest are not as clear-cut, and data from the indicator for viewing menopause as a crisis or as a time of transition are also mixed. These two indicators are similar in intent because a time of crisis and catastrophe would naturally be regarded with apprehension, and a time of change could be anticipated as a period of growth and new zest. I found only six definite statements which fit this topic of apprehension versus zest. However, the attitude that the indicator was designed to show was abundantly evident throughout the gynecology texts. It was imbedded in the "disease" orientation to menopause and the very negative approach to women's aging in general. I did not find a single statement indicating that the climacteric might be a period that women could look forward to as one of growth and new zest.

The fourth indicator was also largely imbedded, and again I found few direct statements which could be counted with this indicator. Of nine mentions, I found that

five were in accord with the change/transition feminist model, but four times as much page space was devoted to delineating potential crisis/catastrophe, a feature of the biomedical model. In this regard, Judd strikes an ominous note in his section on "Prevention," stating that "[n]othing can prevent the physiologic menopause (ie, ovarian function cannot be prolonged indefinitely), and nothing can be done to postpone its onset or slow its progress" (973).

Theme II: Reductionistic vs. Holistic Emphasis and Interpretation

The biomedical paradigm focuses on the body, with emphasis on the negative consequences of menopause. In the feminist model, the focus is on the whole person (body, mind, emotions, and spirit) with attention given to both positive and negative effects of menopause. Again, as expected, the gynecology texts fit more closely with the biomedical model in two of the three indexes with more mentions and a larger amount of page space devoted to loss of reproductive capacity than to freedom from menses, contraception, and fear of pregnancy. Many authors, moreover, focus not only on the reproductive system, but even more narrowly on a particular organ, the ovary.

Likewise, the writers paid more attention to a decrease in menopausal women's attractiveness caused by wrinkles, sagging, and redistribution of body fat. In fact, I found no indication in these books that a woman's beauty could depend on any facet of her being besides her physical body. In general, these authors devoted very little of their discussion to the topic of attractiveness, and five of them did not mention it at all. The attractiveness factor is implied rather than overtly stated. This is what I would expect in

"scientific" discussions of menopause, where value judgments regarding allure would be out of place. Curiously, one of the texts depicted a young woman's face in low relief on its cover (Moore et al.). This idealized, conventionally pretty "cover girl" had long tendrils of hair curling around her face, a pouty mouth, and half-closed eyes. The overall effect was one of dreamy lassitude. This portrait of a woman spoke wordless volumes about the conventional standards of beauty and sexuality by which women are judged in our society.

Findings were mixed regarding the reduction or continuation of women's sexuality following the menopause, with physicians giving slightly more mentions and page space to the feminist model, that women's sexuality continues and may even be enhanced after the climacteric. However, two of the authors of the gynecology texts do not mention sexuality at all, and the others treat it very briefly. Almost all the texts demonstrate an exclusively heterosexual orientation with only one of the nine sources mentioning lesbian sexuality. That text, written by a female gynecologist, is also unique in mentioning masturbation as an alternative for women who have no sexual partners (Gass 894).

Theme III: Interpretation of Physical Changes

In the biomedical or pathology model, the body of the menopausal woman is seen as decaying and declining while the feminist or transition paradigm views the body as undergoing the normal changes of aging. Four of the five indicators in this theme demonstrate widespread usage of negative, disease-oriented terminology in gynecology

texts. Terms that are widely used include ovarian/gonadal "failure," "atrophy," and "decline;" estrogen "deprivation," "starvation," and "deficiency;" genital/urinary "atrophy;" and vasomotor "instability." These findings show the gynecology texts definitely aligned with the pathology model.

Findings on hormone "imbalance" or "endocrinopathy" reveal more mentions and page space devoted to the feminist model--a new and different but normal balance of hormones consistent with a nonreproductive state. Most of the books contained fairly straightforward expositions of the changes in the endocrine system after menopause. Although most of the authors do not specifically refer to hormone imbalance, their concentration on estrogen "deprivation" and its perceived manifestations as seen in all indicators of Theme IV indicate that they view menopause, as one writer states, as "a hormone deficient state" (Dawood 620). The authors of one book placed the chapter on menopause in the "Endocrinology and Infertility" section of their book (Droegemueller et al. 1084). Moreover, the author of another text refers to postmenopausal individuals as "hypogonadal women" (Willson 620). Therefore, while the data in the indicators for estrogen "deprivation" and hormone "imbalance" seem contradictory, I surmise that these results are a function of the objective writing style used in the highly technical sections of the texts that cover hormonal changes and relationships. Totals for this theme indicate almost seven times as many mentions of terms fitting the pathology model than of those consistent with the transition model with more than twice as much page space given to material that conforms to the constructs of the former paradigm.

I found the language used by gynecologists describing ovarian "failure" in the

perimenopause to be of particular interest because it epitomizes the biomedical paradigm. As London and Hammond state, "Physicians have been unable to accept [ovarian] involution and the symptoms aging produces as a natural and inevitable phase of life" (906). Willson lists "[d]escrib[ing] the pathologic results of reproductive hormone depletion" as a major objective of his chapter on menopause (616). He also notes that as ovulation occurs more sporadically after age 40, "[t]he relatively few remaining [ovarian] follicles are less likely to respond appropriately to gonadotropin stimulation." This, he theorizes, is "because the most responsive follicles have already been used" (617) (emphasis added). Dawood states that at this time "recruitment and stimulation of follicles to full maturity become increasingly difficult" (emphasis added). He further implies that the ovaries are inherently defective since the "failure" of many follicles to develop is "probably determined by the intrinsic genetic program of the ovary" (621).

In his discussion of the "Etiology and Pathogenesis" (emphasis added) of menopause, Judd, who is mentioned in another text for his "continuing contributions . . . to our understanding of the hormonal dynamics" of menopause (Kase 339), states that "[a]t birth, there are approximately 2 million oocytes, and by puberty this number has been reduced to 300,000." Since "only 400-500" of these are released from the ovary by ovulation, he asserts that "[n]early all oocytes vanish by atresia," which is the absence of a normal body opening (959). This entire argument appears to be a contradiction in terms because if only 400 to 500 eggs are ovulated out of a potential two million oocytes, then ovulation is the exception and not the rule. Therefore, use of the term "atresia" is inappropriate because it is 4,000 to 5,000 times more likely that any particular oocyte will

disappear by an unknown process than that it will develop into an egg and be released by ovulation.

Theme IV: Perceptions of Menopause as Pathological or Nonpathological

In the biomedical model, the climacteric is regarded as a disease, as disease-causing, or as a biological marker for pathological states. The feminist model views menopause as a natural, normal transition from a fertile to a nonreproductive state. Overall totals for the seven indicators in this theme show more than twice as many mentions and three times as much page space devoted to material which fits the biomedical paradigm. Only in the indicator that assesses the authors' views regarding the relationship (if any) between menopause, psychological problems, and depression do the gynecological texts tend to be more in accord with the feminist position, and even there, some of the material is quite misogynistic.

The indicator concerning osteoporosis shows that the writers of gynecology textbooks devote almost twice as many mentions and four times as much page space to menopause as a causative factor in this disease as they do to other factors such as heredity, aging, diet, lack of exercise, caffeine and alcohol consumption, and smoking. These results are consistent with the pathology model. Walsh and Schiff state, "Primary osteoporosis results from estrogen deficiency and constitutes 95% of all cases" (458).

The authors of the gynecology texts in this sample use the term "symptom," implying the presence of a disease or an abnormal condition, more than nine times as often as the term "sign," a more neutral word preferred in the feminist paradigm. Since I

simply counted the number of times the two terms were used and did not tabulate any page space, I have not included the numbers for this indicator in the totals for the theme.

Three of the nine gynecology texts included the term "epidemiology" (implying disease) in their discussions regarding the population dynamics of menopause, either as subject headings or in the body of the text. Dawood's treatment is typical of the pathology model. In his section titled "Epidemiology," he states that "the average woman undergoing natural menopause will spend at least 30 years, or more than one third of her life, in the hypoestrogenic state" (620). Judd and Kase do not use the term "epidemiology," but their treatments of the topic center around the pathological implications of the growing numbers of postmenopausal women in the population. I found no mention of the more neutral term "demographics" that is more in accord with the feminist model. However, I coded text using neither term according to the tone of the material and the degree to which the authors evinced a disease orientation. For example, I coded Benjamin and Seltzer's treatment as closer to the transition model because they discuss the increasing numbers of postmenopausal women in the population in a straightforward paragraph without an emphasis on pathology (166). As a rule, the authors devoted little attention to this topic, and some of them did not discuss it at all. However, almost twice as much page space was given to material agreeing with the biomedical model than to the feminist model by those authors who did include the subject. The following statement by Droegmueller et al. is representative of the "disease" model: "Thus a large portion of all physicians' time (gynecologists, internists, and family practitioners) will be spent taking care of postmenopausal women" (1082).

The indicator concerning menopause as the primary cause of genitourinary "atrophy," vaginitis, urethritis and incontinence showed a very clear adherence to the biomedical model with 17 times as many mentions and nearly 83 times as much page space devoted to this topic than to the feminist stance that aging, childbirth, muscle tone, and other factors may play a part in these problems.

The indicator that assesses the authors' orientation on the subject of the relationship (if any) between the climacteric and cardiovascular disease shows that gynecologists also tend to view menopause as the primary source of blood lipid changes associated with cardiovascular disease in postmenopausal women. I found 70 percent more mentions and more than twice as much page space devoted to menopause as a causative factor than heredity, diet, lack of exercise, and smoking--indicating strong adherence to the biomedical model.

In the indicator regarding insomnia, not even one writer mentioned that sleeplessness suffered by women during and after the perimenopause might be caused by any factor other than hot flashes or night sweats. Women in midlife might lose sleep over their jobs, family problems, relationship difficulties, separate health issues, and a host of other reasons. However, all the gynecology texts omitted these causes of sleeplessness and attributed insomnia solely to menopause. This stance is clearly consistent with the pathology model.

The index concerning causative factors of depression was the only one in this theme in which more mentions and page space were given to the feminist model than the biomedical one. Although some authors saw menopause as a cause of psychological

problems and depression, many mentioned that these could be produced by other factors in a woman's life. More than twice as much space was given to discussions which more closely agree with the feminist paradigm. However, the tone of some of this material seems quite misogynistic. Dawood, for example, describes the postmenopausal woman as "biochemically predisposed" to depression which can then be triggered by an empty nest or "the successful spouse devoting less time to the family" (626). Note that the "successful spouse" is assumed to be male. In a passage that brings to mind nineteenth century physician E. J. Tilt, Willson urges his colleagues to provide "authoritative guidance and assurance" to midlife women who "now have less and less to do." He further states that "too few [of these women] know how to make use of the many free hours available to them" and that "[t]hose who are working may realize that there is no hope of advancing to more interesting or responsible positions" (622). Although most of the authors do not state specifically that menopause causes depression, some state that estrogen therapy can help alleviate it. Several physicians also write that estrogen has a strong placebo effect on the relief of depression in many menopausal women.

Theme V: Views Regarding Treatment/Therapy

The biomedical paradigm views medical intervention, usually in the form of hormone replacement therapy, as necessary for the continued health of perimenopausal and postmenopausal women. The authors of the gynecology texts also frequently write about the necessity of "managing" menopause. The feminist model generally sees no need for specialized medical intervention during and after menopause, and often

recommends alternative or nonmedical therapies. I found the totals for this theme to favor the biomedical model by more than three to one in mentions and by a margin of almost seven to one in page space. In regard to hormone replacement therapy and specialized medical care such as bone density scans, the gynecology texts overwhelmingly adhere to the biomedical model. However, data for the indicators regarding lifestyle changes and alternative therapies may be interpreted as fitting the feminist paradigm more closely.

Authors of the texts I examined overwhelmingly assert that most menopausal women can benefit from HRT with 67 mentions compared to three which fit the feminist model that HRT is questionable for many women. Almost 20 pages of space are allotted to the biomedical position. Conversely, the writers give only slightly more than a quarter of a page to the feminist stance. Several authors include statements similar to Willson's that the "overall mortality in postmenopausal women who are taking estrogen is lower than in those who are not" (624). However, none of them consider the socioeconomic status of women taking HRT or acknowledge that the great majority of these patients are in the middle or upper classes and thus have access to better general health care and living conditions.

Many gynecologists are in agreement with Droegemueller et al., who assert that "the risks of estrogen replacement therapy are minimal" (1096). They also cavalierly note that "endometrial cancer that develops in estrogen users is always well differentiated and is usually cured by performing a simple hysterectomy" (1102). The gynecology texts therefore imply that they prefer that women risk cancer rather than refuse HRT. These

authors fail to mention the obvious fact that the major surgery that they refer to as "simple hysterectomy" represents a further source of income for the physician. Furthermore, while a hysterectomy may seem "simple" to the physician, it is no doubt much more difficult for the woman who undergoes it. These authors conclude their chapter on menopause with the following statement: ". . . estrogen replacement therapy is indicated for nearly all postmenopausal women" (1104).

Several gynecologists advise that women should continue HRT indefinitely, and Dawood recommends "continuous combined estrogen and progestin therapy" to avoid withdrawal bleeding [a common result of sequential therapy] and, therefore, to increase patient compliance" (emphasis added) (636). The number of mentions advising use of HRT is second only to the use of the term "symptoms" among the indicators I examined, and the amount of page space devoted to this topic is the largest by far among all indicators.

Predictably, the material in these texts concerning specialized medical care implies that menopausal women should consult a physician and/or find the "right" one to help them "manage" their menopause. However, I found the specific indicator in only three of the texts in this category. I believe this is because the doctors' "disease" orientation toward menopause assumes that women will seek medical care during the perimenopause, and so they do not state the "obvious."

Most of the texts contain some material advocating changes in diet, exercise, and smoking cessation for menopausal women. However, the texts' inclusion of recommendations for a healthier lifestyle probably reflects the increased popular interest

in health and fitness that developed in the 1980s. In the nine chapters on menopause, I found only 12 mentions and slightly more than two pages of material advocating lifestyle changes. These findings could therefore be construed to be in accord with the pathology model since that paradigm does not stress such treatments but concentrates on medical remedies.

There are only nine references to alternative and nonpharmaceutical therapies and less than one page of information favoring these treatments. Moreover, when these are mentioned, those most often recommended are Kegel exercises (invented by a physician), vitamins, and vaginal lubricants. As expected, therapies such as acupuncture, herbal treatments, and relaxation techniques were not mentioned. Again, the numbers for this indicator superficially seem to be in accord with the feminist model. However, on closer examination they may be construed to be more in agreement with the biomedical paradigm.

The gynecology text in this sample that offers the most balanced overall approach is the most recently published one (1993), written by Margery L. S. Gass. She writes, "Menopause can be viewed both as a normal physiologic event and as a hormone deficiency state." This dualistic approach to her subject is also exemplified by her title, "Physiology and Pathophysiology of the Postmenopausal Years" (883). However, Gass is unique among her colleagues in stating that "[m]enopause is a physiologic event that all women experience in due time and should not be considered a disease state." She is also the only physician to mention that ". . . HRT may be unacceptable to some women. The objection can be as basic as not wanting to use a medication every day for the rest of

her life" (895). Nevertheless, Gass uses much of the negative language typical of the other texts, making her material seem self-contradictory. In her discussion of transvaginal sonography, for example, she states that endometrial thicknesses of less than 5 millimeters in a menopausal woman indicate "atrophic or hypoestrogenic states." However, measurements of greater than 5 millimeters can represent a "proliferative endometrium, hyperplasia, polyps, fibroids, or cancer" (893). Logically, therefore, regardless of its measurement, the endometrium of a menopausal woman may be viewed as "abnormal" or diseased.

In summary, grand totals for sources G01-G09 show the gynecology texts as a group adhering to the biomedical model by a ratio of more than three to one in both mentions and page space. Gynecologists' longstanding orientation to menopause as a pathological physical state is clearly evident in the nine recently published medical textbooks I examined; their reductionistic focus is understandable, perhaps inevitable, given the fact of their medical specialization. The objectivity of their highly technical scientific writing style and their authoritative tone reflect their authors' position as late-twentieth century "experts" on the subject of women's bodies and menopause.

These texts re-establish, reinforce, and transmit the long-standing "disease" construct of menopause to each new generation of physicians who study these texts as part of their medical school curriculum. Practicing physicians, in turn, pass on their orientation to the climacteric as pathological to their female patients. Thus, the medicalization of menopause continues to increase with the large numbers of women of the baby boom generation who are now entering or approaching the climacteric and

seeking sources of information on menopause. One of the major ways in which the "disease" approach is conveyed to women in midlife is through popular advice books on the menopause written by physicians.

CHAPTER IV

FINDINGS FROM POPULAR ADVICE BOOKS WRITTEN BY PHYSICIANS

The eight popular advice books I examined are quite diverse and evince a wide variety of medical opinions and recommendations about the climacteric. Taken individually, they represent both extremes as well as the middle range of the ideological continuum of menopause as pathology versus normal transition. Not only do the works in this category contradict one another, but some of them contradict themselves and convey mixed messages about the nature of menopause. Although all of them at some point give lip service to the view that menopause is not a disease, nearly all of them portray it as such by the negative language they use to describe the process. In addition, almost all of these authors indicate that they regard the climacteric as a condition that requires medical care and treatment.

I found that each author's position on one issue, the nature of hot flashes, appears to be influenced by his or her gender; on the remainder of questions, however, the writer's stance seems to be more affected by his or her medical specialty and training. In general, gynecologists and endocrinologists tend to offer more advice based on the pathology construct; family practitioners and gynecological oncologists are inclined to take a more centrist or feminist stance. See Table 4.1 for a summary of the data from the popular advice literature.

Table 4.1: Findings from Popular Advice Books

	Biomedical Model			Feminist Model		
Themes & Indicators	**#**	**pg sp**	**mean**	**#**	**pg sp**	**mean**
Universality						
I-1 Hot Flashes +/-	20	6.14	.31	3	2.00	.67
I-2 Femininity	6	1.40	.23	12	7.29	.61
I-3 Apprehension/Zest	32	11.64	.36	11	8.42	.77
I-4 Crisis/Transition	7	1.18	.17	22	5.48	.25
Totals	65	20.36	.31	48	23.19	.48
Reductionism						
II-1 Reproductivity	15	9.45	.63	18	2.78	.15
II-2 Attractiveness	26	28.95	1.11	5	1.58	.32
II-3 Sexuality	40	12.61	.32	30	16.38	.55
Totals	81	51.01	.63	53	20.74	.39
Interpretation						
III-1 Ovarian Changes	28	10.11	.36	7	3.73	.53
III-2 Hormone Levels	33	3.53	.11	2	.25	.13
III-3 Hormone Balance	9	3.29	.37	3	2.16	.72
III-4 Genitourinary	25	2.06	.08	1	.13	.13
III-5 Vasomotor	15	4.18	.28	2	.88	.44
Totals	110	23.17	.21	15	7.15	.48
Pathology						
IV-1 Osteoporosis	51	8.27	.16	26	19.91	.77
IV-2 Symptoms/Signs*	363	na	na	24	na	na
IV-3 Epidemiology	1	.50	.50	6	1.26	.21
IV-4 Genital Changes	39	13.45	.34	14	7.67	.55
IV-5 Cardiovascular	31	8.16	.26	19	8.44	.44
IV-6 Insomnia	18	3.63	.20	4	.55	.14
IV-7 Depression	23	5.30	.23	14	10.65	.76
Totals (*not included)	163	39.31	.24	83	48.48	.58
Treatment						
V-1 HRT	123	50.77	.41	17	8.59	.51
V-2 Medical Care	49	45.96	.94	1	1.55	1.55
V-3 Lifestyle Changes	0	0	0	91	365.26	4.01
V-4 Alternatives	0	0	0	47	38.72	.82
Totals	172	96.73	.56	138	403.98	2.93
Grand Totals	**591**	**230.58**	**.39**	**355**	**513.68**	**1.45**

Theme I: Universality of Menopause Experience

Data for the theme of universality are mixed in this group of sources. Results for the indicators for hot flashes and apprehensive attitude are more representative of the pathology model. However, on the issues of loss of femininity and the climacteric as a period of crisis versus one of normal transition, the totals for both mentions and page space are more aligned with the feminist model.

On the question of the nature and experience of hot flashes, I found only three instances in these books where these phenomena were portrayed as neutral or positive experiences. All three of these mentions, evidence of agreement with the feminist model of menopause, were written by female physicians: Sadja Greenwood, Penny Wise Budoff, and Lila Nachtigall. However, Budoff's and Nachtigall's portrayals remain largely negative. Budoff, whose attitude is clearly reflected in the title of her book, No More Hot Flashes and Other Good News, devotes more than a page to the negative aspects of the hot flash, with merely a single sentence stating that "[t]he only advantage of the hot flush, as I see it, may be to those women who are forever cold and who wear socks to bed even in summer" (26). (Many physicians use the term "hot flush" interchangeably with hot flash.) Likewise, Nachtigall mentions the disagreeable nature of hot flashes five times in more than a page and a half of text, while acknowledging briefly that hot flashes "may not bother [some women] in the slightest but may be simply interesting to observe" (57). Of these three authors, only Greenwood treats the subject evenhandedly, commenting that "[s]ome women enjoy their hot flashes, feeling the heat as energy traveling through the body." She also urges "each person to be a student of her

own responses, and not to automatically expect a negative experience just because others might" (32). The male physicians were unanimous on this subject, covering only the unpleasant aspects of hot flashes. Utian's "disease" orientation is evident as he asserts, "Hot flashes are one of the most disabling symptoms of menopause. They can interfere with the quality of a woman's life and even with her ability to function" (80).

On the representation of menopause as the beginning of the loss of femininity and womanhood or as a new life stage of possibilities for women, the popular advice authors devote twice as many mentions and more than five times as much page space to the feminist transition interpretation than to the more negative biomedical position. Again, Greenwood's portrayal is the most positive. She concludes her book by citing female leaders from many nations as role models for women in midlife and asserting that "[a]ll these women have used the special wisdom and experience of being female to inspire their action in the world" (203-204). Clark Gillespie's position on this issue is more typical of the biomedical model as he relates how the relative increase of male hormones in postmenopausal women "produces masculine-like tendencies in some older women--facial hair growth and breast atrophy--and even increased sex drive" (34).

As to whether women should regard menopause with apprehension or look upon it as a period of personal growth and new zest, the popular advice books contain three times more mentions and nearly forty percent more pages of material that fits the pathology paradigm. Notelovitz, for example, points out that "it's important to make a distinction between normal aging and menopause" since "menopause can have a major impact on your health, your looks, and your sense of well-being" (11). Some of the

portrayals in these texts may fairly be characterized as "horror" stories--hair-raising accounts of the "terrible" fate of women who have suffered through menopause without the benefit of HRT. Wulf Utian's and Clark Gillespie's narratives are the most egregious in this regard.

Utian begins his first chapter with the story of college sorority sisters, Nancy and Susan, who had been nicknamed "'the twins'" because of their close resemblance to each other. He describes the women as having been ". . . blond, blue eyed . . ." with ". . . ample breasts, tiny waists . . ." and "perky personalities" (1). However, when Nancy and Susan returned to their alma mater for their thirty-fifth class reunion, their former classmates were shocked at the difference in "the twins'" appearance. Utian continues, "It was as if the years had stood still for Susan." Nancy, however, "now looked approximately twenty years older than Susan. She was three inches shorter in height and was slightly stooped; she was much heavier in weight; her skin was very wrinkled." Utian concludes that Susan and Nancy "represented the extremes of ovarian function and ovarian failure" (2). Susan had followed the "Utian Menopause Management Program (MMP)," the cornerstone of which is hormone replacement therapy; unfortunate Nancy, on the other hand, had "experienced nineteen years of estrogen deprivation" and therefore looked much older, suffered from osteoporosis, and had a shrunken vagina and no sex life (5). This physician's position seems to be that midlife and beyond can be a rewarding and enjoyable stage of life for women only if they take care of themselves and adopt the Utian MMP, which involves extensive visits to a gynecologist and HRT.

Gillespie, who proudly states that he is a founding member of the North American

Menopause Society, employs a very paternalistic writing style. His portrayal of untreated menopause is a very bleak one. He begins his chapter on the relationship between the premenstrual syndrome (PMS) and the perimenopause by advising readers to "Start by reading in your Bible--Hebrews, 13:8" (21). The Revised Standard Version of this scripture states that "Jesus Christ is the same yesterday and today and forever"--as opposed, one infers, to women, who are not. A reader could surmise from his Menopause Survival Guide that the only way to endure the climacteric is with the help of a higher power and a gynecologist. Gillespie's book is replete with phrases that evoke the deleterious nature of the climacteric. He describes it as "insidious" (26) and a "continuum of insults" (32) with "profound and destructive effects on women's health" (118). His extreme disease-orientation is perhaps best evinced by his phrase "full blown acute menopause" (20). This condition, he asserts, leads to a "continuous gradual decline in physical and emotional function" (4). A woman who relied only on Gillespie's book for information on menopause would indeed dread the onset of this extremely "pathological" condition.

The popular advice books characterize menopause as a transition period more than one of crisis, with three times more mentions and approximately four and one-half times as much page space given to the feminist transition model. Greenwood and Budoff treat the subject very briefly. Jovanovic, Notelovitz, and Cherry and Runowicz, take a positive stance on this issue; but Nachtigall's treatment is mixed. She deems menopause a "natural and normal life event" (38) that is "a particularly difficult time for many women" (41). Utian indicates that the climacteric need not be viewed as a crisis because its

ravages can be prevented by medical "management" (21). Gillespie's treatment of this question is also mixed. He states in one passage that menopause does not "represent an abrupt change . . . or a sudden decline in body function" (33). However in a later section titled "Gentleman's Quarters," he contradicts himself, stating that "at the menopause, women's estrogen production ceases very abruptly and causes profound destructive changes."

This segment of his book begins with an epigraph, Professor Henry Higgins' query from My Fair Lady, "Why can't a woman be like me?" Here, Gillespie fatuously attempts to help men understand "the wondrous women (created for [men] by [their] Maker from one of [their] lesser ribs)." He recommends that a woman "ask the man in [her] life to read this section" in which he explains "the difficult bridgeheads that beset [her] body and soul as [she] pass[es] through the menopause and beyond." Thus, the man will be able to "support and ease [her] through the critical times when everything is flashing 'TILT' before [her] eyes" (114-115). Gillespie's metaphorical use of the word "tilt" here is ironic. He probably means to suggest the frenetic, flashing warning lights of a pinball machine, but his tone is more evocative of nineteenth-century physician E. J. Tilt.

Utian also includes a chapter titled "Men and Menopause" which he suggests that women get their spouses to read (154). In essence, this section is an explanation of the male midlife crisis and how it may influence men to leave their menopausal wives for younger women. Utian also offers advice on how the perimenopausal woman may "help keep her relationship strong" (160). In a similar vein, Gillespie writes, "In our middle

years, we men often face multiple social, personal, medical, sexual and career goal conflicts that bring us--often abruptly--to a confrontation with our own mortal nature." He maintains that "[t]his stress--added to the daily stress of our world--often produces . . . menopausal-like symptoms" such as "depression, irritability, insomnia, anxiety and angst" (116).

It is particularly telling that this physician attributes the very same "symptoms" to midlife stress in men but to menopause in women, who also have comparable midlife stressors. Even more ironic is his "hope that some hormone therapy could eventually become safe and accessible to men." He notes that testosterone is "a controlled substance--like morphine!" Alas, he relates, this is an area in which "much more study has been given to women's needs" (116).

Theme II: Reductionistic versus Holistic Emphasis and Interpretation

Overall totals for data on the theme of reductivity reveal the popular advice texts tending toward the biomedical model in both number of mentions and amount of page space. Nearly thirty more mentions and two and one-half times as much page space are given to material consistent with the pathology model.

The first pair of indicators in this theme assesses whether the authors take a negative view of the loss of fertility that accompanies menopause, or whether they emphasize instead the fact that menopause brings with it freedom from menstruation, contraception, and fear of pregnancy. The former stance is consistent with the biomedical model, and the latter indicates a more feminist stance. On this question, the feminist

position is mentioned more frequently, but it is given less page space. Authors of the popular advice books devote more than nine pages of text to discussions lamenting the loss of fertility at menopause, whereas material stressing the benefits of the end of fecundity total less than three pages. Utian mentions in two sentences that freedom from pregnancy and from the necessity of birth control are benefits of menopause (138 and 144). However, he then includes a two-page section on how recent increases in medical technology can enable aging women to bear children (151-153). Nachtigall also discusses modern in-vitro procedures that have "resulted in many successful pregnancies for women who thought their childbearing days were over" (55-56). Notelovitz devotes five pages to material on "declining fertility" in midlife women and new technologies that facilitate pregnancy in postmenopausal women; he concludes the section with a reference to "a postmenopausal woman [who] gave birth to her own grandchild" (200-204). Gillespie titles his chapter on "human menstrual life" "The Fruitful Years" (1). Greenwood, on the other hand, implies that women's postmenopausal years may also be fruitful when she states, "Anthropologists have suggested that the menopause has benefited our species during evolution, by releasing women from the stresses and dangers of childbearing to raise their late-born children and transmit cultural knowledge" (4).

On the question of a woman's attractiveness, all but three of the popular advice books overwhelmingly stress the need for postmenopausal women to reduce wrinkles, sagging flesh, "excess" weight, and redistribution of body fat. Only Greenwood asserts that a woman's beauty need not depend on the conventional physical standards of youth and slimness. One of her chapters is titled "Age Is Becoming," and she writes in another

section about the potential health benefits of having a few extra pounds after menopause. Cherry and Runowicz briefly mention that our culture values youth, and Budoff does not address this subject at all. The other authors devoted from less than one page to more than 15 pages to discussions of wrinkles, sagging and "withering" breasts (Gillespie 6), liver spots, changes in body shape, thinning and graying hair, and even snoring. While Utian mentions briefly that aging skin can show "inner character" (166) and cites artist Georgia O'Keeffe as an example of a woman "whose face grew more beautiful with age" (167), he puts much more emphasis on wrinkle remedies such as estrogen, Retin-A, and cosmetic surgery (166-167, 171). Jovanovic, and Notelovitz also include a large section in their texts stressing the maintenance of youthful looks with advice on skin, hair, clothing, cosmetics, and plastic surgery. As a group, the popular advice authors gave more than five times as many mentions and more than 18 times as much page space to the "negative" effects of menopause on female beauty.

Regarding the topic of women's sexuality during and after the climacteric, the writers in this sample again present mixed messages. They mention more often that sexuality is reduced because of body changes; however, they devote more page space to the view that sexuality continues and may even be enhanced after the menopause. Greenwood exemplifies the more holistic view that ". . . the most important sexual organ is the mind." She asserts, "[i]f you are interested in sexuality, you can be sure the menopause will not create a sudden end to your sex appeal" (59).

Many physicians state that continued enjoyment of sex is possible but contingent upon the use of HRT. Nachtigall, for instance, states that ". . . virtually every woman will

eventually have to give up sexual intercourse unless she starts taking estrogen" (84). Indeed, she deems refusal to take HRT "sexual suicide" (90). Clearly, her definition of sexual intercourse is limited to the heterosexual, penis-in-vagina variety. Cherry and Runowicz present a broader view: "Menopause is only the end of the menstrual phase of your life; it is not the end of your libido or sexual needs" (37). In addition, their extensive treatment of the continued sexuality of older women includes the statement that "[h]omosexuality is also part of the normal range of human sexual behavior, and the stigma associated with lesbianism is also diminishing" (38). On this issue, the popular advice authors present a wide range of divergent views.

Theme III: Interpretation of Physical Changes

The third theme addresses the language the authors of popular advice books use to describe five facets of physical change that accompany menopause. The tone of the language the physicians use is an indication of whether their discussions are based on the "disease" model or the transition model. I specifically looked at the writers' treatment of ovarian changes, estrogen/hormone levels, the relationship between hormones, genital and urinary changes, and vasomotor fluctuations (hot flashes).

The language employed by the physicians writing popular advice books in this sample definitely perpetuates the construct of menopause as pathological. I found 110 references to terms consistent with the portrayal of the climacteric as a disease and only 15 references that fit the transition paradigm. In addition, the authors allotted three times as much page space to negative descriptions of the physical changes that accompany

menopause.

All the authors but Greenwood and Notelovitz use the terms ovarian "failure," "atrophy," and/or "decline"--with Utian, Jovanovic, and Gillespie employing it most frequently. The differences between Utian's and Greenwood's treatment of the subject are particularly revealing. Utian titles the first section of his first chapter "Outwitting the Powerful Ovary" (1), and in the second chapter he refers to "the all-powerful ovary." Thus, his entire text is concerned with what happens when "the most powerful gland in a woman's body" (25) "fails" to produce eggs and estrogen and how the calamitous effects of "ovarian failure" may be remedied with HRT. In contrast, Greenwood titles her third chapter "The Ovaries--Hidden Sources of Well-Being." Declining to concentrate on ovarian "failure," she contends that after menopause the ovaries continue to produce androgens, "hormones similar to male hormones" which are "converted to estrogen in the body's fat cells" and aid in "maintaining muscular strength, sex drive, and the elasticity of the vagina." She further asserts, "The various hormones secreted by the ovaries in middle and old age contribute to well-being in many ways, and cannot always be duplicated by pills" (21-24). Cherry and Runowicz use the more active and positive term "ovarian shutdown" instead of "failure" (24).

Predictably, most of the popular advice books follow their discussions of ovarian "failure" with material on estrogen or hormonal "deprivation," "starvation," or "deficiency." Gillespie's statement is typical of the majority of his colleagues: ". . . menopause and the years that follow have been clearly established as an endocrine deficiency state--a disorder worthy of, and indeed, almost always requiring,

comprehensive treatment" (xvii). Greenwood and Notelovitz are again exceptions to this rule. Both write that low levels of estrogen are normal for women in the post-reproductive years. In addition, Greenwood deplores the "disease" orientation to menopause common among physicians and states, "Such attitudes on the part of the doctor can be more painful than the vaginal problem itself" (198).

Six of the authors of the popular advice books write little or nothing on the question of the relationships among hormones following menopause. Jovanovic, whose specialty is endocrinology, writes the most on this subject; her treatment is typical of the "disease" model. She refers to "the imbalance between female and male hormones" (118) and states that the menopausal woman's ". . . body's hormonal system is out of whack due to the loss of estrogen and progesterone" (122). Cherry and Runowicz give a much more straightforward version of postmenopausal hormone relationships and conclude that "[t]he adrenal glands and other tissues in the body may produce estrogens for many years" (25-27).

All the writers except Greenwood make references to postmenopausal genital and/or urinary "atrophy." Nachtigall, for instance, includes this ominous statement in her discussion: "In addition to providing a happy home for infectious organisms, the thin, dry [vaginal] lining sometimes develops a chronic noninfectious inflammation called atrophic vaginitis" (88). Greenwood avoids this negative medical terminology while describing simply and accurately what happens to the vagina after menopause: ". . . the vaginal walls become thinner and drier. The cervix no longer secretes the quantities of mucous it did during the fertile years. [And] [t]he entrance to the vagina becomes smaller

. . ." (42).

Of the nine popular advice authors, only two write briefly of hot flashes as normal (Notelovitz 240) and possibly beneficial (Greenwood 34) phenomena experienced by most women during the climacteric. The other writers are unanimous in portraying hot flashes in terms of vasomotor instability and malfunction. Utian states that flashes may make women feel as though their "personal thermostat has gone awry" (59). Nachtigall writes that the "vasomotor disturbance" is caused by the fact that the "temperature-control mechanism has temporarily gone haywire" (62). Budoff refers to the hot flash as a "temperature-regulating dysfunction" after which the body may require "nearly a half-hour to regain 'normality'" (27).

Theme IV: Perceptions of Menopause as Pathological or Nonpathological

Data in this sample is mixed as to whether these authors view menopause as pathological or not. As a group, the physicians mention menopause twice as often as other causative factors for osteoporosis, genital atrophy, cardiovascular disease, insomnia, and depression. However, they devote 23 percent more page space to their discourse on other causes for these conditions. They overwhelmingly favor the term "symptom" over the term "sign." However, none of them uses the term "epidemiology" in their discussions on the population of menopausal women, and only one of them couches his discussion on that subject in terms of disease. Conflicting views and wide-ranging opinions seem to be characteristic of these authors on the subject of menopause

as a pathological condition.

Utian, Budoff, Gillespie, and Notelovitz take the position that the decrease of estrogen following menopause is the primary cause of osteoporosis. All these physicians briefly mention other factors that contribute to this malady, but they clearly emphasize "loss of ovarian function" as "the culprit" (Utian 36-37). Gillespie states that one of the "profound and destructive effects on women's health" that results from menopause is that "[b]one loss accelerates at a tremendous pace . . ." (118). Similarly, Budoff asserts, "[o]steoporosis is the most important problem associated with menopause" (56). Jovanovic's and Nachtigall's treatments of the subject are more equivocal. Both devote more than three pages to other factors which contribute to bone loss, but Jovanovic lists it as a "long term complication of menopause" (33). Nachtigall asserts that ". . . it is primarily the direct result of diminishing female hormones" (116). On the other hand, Greenwood and Cherry and Runowicz are more in agreement with the position that osteoporosis is a multifactorial condition. These authors give much more of their attention to the many causes for bone loss other than menopause. Cherry and Runowicz also comment that bone fractures in postmenopausal women are not always the result of osteoporosis and that it is not as severe a problem as many physicians, the pharmaceutical companies, and the media would have women believe. Furthermore, they advocate nonhormonal ways of preventing bone loss and assert that "the idea of the entire female population of the world taking estrogen to prevent osteoporosis simply is not warranted at this time" (52-54).

All the authors of the popular advice books use the term "symptom" much more

frequently than the more neutral term "sign" in their discourse on the climacteric. I tallied 363 "symptoms" and only 24 "signs" in these works. Utian defines "symptom" in his glossary as "the feeling that alerts the body to something wrong" (214). Even in two cases where he uses the more neutral term, he qualifies it with the adjective "warning," suggesting a more menacing meaning than "sign" alone. The overwhelming preponderance of the word "symptoms" to categorize the physical signs of the climacteric indicates the degree to which this normal transition has been pathologized. Even Greenwood, whose commentary and advice is generally much closer to the feminist paradigm than that of other physicians in this group, utilizes "symptom" more often. And Cherry and Runowicz, who emphatically state, "We object to the notion that menopause is a disease" (xiv), use the word that connotes a pathological condition exclusively, sometimes as many as five times on a single page. Obviously, these physicians' medical training has influenced their choice of language in describing the physical manifestations of the climacteric, but perhaps those who assert that they do not regard this transition as a disease might wish to look more closely at why their terminology nevertheless continues to imply "something wrong."

None of the popular advice writers uses the term "epidemiology" with regard to the increase of the menopausal population resulting from the aging of the Baby Boom generation. Notelovitz does not mention the subject, and most of the other physicians treat it quite briefly and in an equitable manner. Utian, however, notes in his discussion of "the 'graying of America'" that "[m]enopause . . . correlates frequently with an increase in the incidence of . . . osteoporosis and coronary heart disease" and warns that

"the increased cost of medical care for this greater number of [older] individuals will be foisted upon an already dangerously overburdened medical industry . . . very likely to the detriment of the women needing it most" (10-11). Thus, he implies that he expects a menopause "epidemic" even though he never uses the term "epidemiology."

The popular advice authors again differ on the degree to which menopause is responsible for genitourinary changes, vaginitis, urethritis, and incontinence. As a group, they give nearly three times more mentions and almost twice as much page space to material consistent with the medical model, citing menopause as the chief cause. Utian, Budoff, Jovanovic, Gillespie, and Notelovitz briefly mention other factors that contribute to the above problems. However, they devote most of their discourse to the premise that lower levels of estrogen directly account for or contribute to the majority of urogenital problems in postmenopausal women. Utian, for example, lists "symptoms caused by a deficiency of estrogen/progesterone," including vulvar or vaginal "[s]hrinkage, itching, . . . infection, [and] blood-stained discharge; uterine/pelvic "prolapse;" and urinary "infection, . . . frequency and/or urgency" and incontinence (39).

On this issue Greenwood, Nachtigall, and Cherry and Runowicz present a more complex and balanced view, citing factors in addition to lowered hormone levels that may cause or exacerbate these problems. Greenwood comments that strong soaps and hot water can irritate the "thinner and drier" postmenopausal vagina. She also notes that "[v]aginal infections may occur after intercourse, especially with new partners . . ." (47). Nachtigall stresses that fatigue, malnourishment, poor toilet habits, douching, synthetic underwear, a diet high in sugar, hot tubs, and antibiotic medications may also encourage

vaginal infections (103-105). Cherry and Runowicz point out that aging, "a difficult delivery, . . . multiple pregnancies, . . . [and] genetic predisposition" may contribute to weakening of the supporting muscles and ligaments of the pelvis and consequently to problems such as cystocele, rectocele, and uterine prolapse (194-196). They also include a very thorough discussion of urinary incontinence in which they stress that it primarily results from aging and may be caused or made worse by certain medications; conditions such as stroke, dementia, and arthritis; and diseases such as diabetes, multiple sclerosis, Parkinson's disease, and cancer (225-226).

All the physician-authors of popular advice books in my sample except Greenwood mention menopause as a source of blood lipid changes that contribute to cardiovascular disease. Cherry and Runowicz flatly assert, "Menopause does not cause heart disease." Nevertheless, they also write, "If you are a postmenopausal woman, you must recognize that you are at risk for heart disease" (43). They then proceed to discuss many other risk factors for cardiovascular disease in addition to menopause. These include genetic history, "age, . . . diet . . ., cigarette smoking," hypertension, "diabetes, obesity, stress, and a sedentary lifestyle" (45-48). Utian, Jovanovic, Gillespie, and Notelovitz also present a fairly balanced treatment of heart disease factors, but they tend to give more weight to the position that "[w]ithout estrogen, arteriosclerosis hastens to clog important arteries" (Gillespie 6). The extreme version of this position is represented by Nachtigall, who never mentions any other causative factors of cardiovascular disease, and Budoff, who equivocates that the course of heart disease "probably depends" on a number of other factors. However, she confines her discussion of these to a single

sentence (37). In sum, the popular advice writers mentioned decreased estrogen as a cause of cardiovascular disease more than they mentioned other causes, but they gave slightly more page space to the other factors. The most obvious reason for this may simply be that there are so many other factors.

The authors of these popular advice books much more readily attribute insomnia affecting women in midlife to menopausal manifestations than to other causes. In fact, Greenwood, Cherry and Runowicz, and Notelovitz were the only physicians who mentioned other possible factors. More than six and one-half times more page space was devoted to sleep loss resulting from hot flashes and night sweats than to excessive caffeine consumption (Greenwood 31), nervous tension and anxiety (Cherry and Runowicz 31), hypothyroidism (Cherry and Runowicz 82), and depression (Notelovitz 246).

As to whether menopause causes depression and psychological problems or whether these problems are attributable to other factors in the lives of midlife women, the findings from this sample are again mixed. The popular advice authors mention the former opinion more frequently but devote twice as much page space to the latter belief. Although not specifically stating that menopause causes psychological problems, Utian implies this idea by including a paragraph on short term memory loss associated with the climacteric. He also discusses his 1972 study that "showed conclusively" the "mood-enhancing effects of estrogens on women who had lost ovarian function" (93-94). Budoff cites Utian's study in her section "No More Postmenopausal Blues" advocating HRT (40-42). Nachtigall concurs that emotional difficulties during menopause are hormone-

related. She writes, "If your emotions seem out of whack around the time of menopause, consider yourself a member of the club" (65). Gillespie's exhaustive "list of the commonest emotional symptoms found in the menopause" includes "depression, irritability, anxiety, insomnia, tension, antisocial behavior, headaches, inability to concentrate, loss of sex drive, nervousness, and aggressiveness" (39).

The other side of this debate is presented by Greenwood, who asserts, "Perhaps emotional upset during the menopause is caused by important coincidental changes in women's lives and the way middle age is viewed in our culture, rather than by hormonal changes." She notes that the "two views of the psychology of menopause have been debated for some time, and the issues are complex and interrelated." In her chapter "Hormones and Psychology: Is Menopause a Time of Emotional Imbalance?" she examines both sides of the issue, with sections on cultural and hormonal factors, and "synthesize[s] what is valuable in the two viewpoints" (79-88). Jovanovic, Cherry and Runowicz, and Notelovitz also treat this subject in a balanced manner. Cherry and Runowitz comment that depression in the climacteric could "be related to events that are common in midlife: divorce, death of a spouse or parent, empty nest syndrome, or midcareer crises" (34). Notelovitz cites his own study, funded by the National Institute on Aging, of 145 women between 36 and 75 years old. The study assessed "the emotional and physical effects of menopause and aging on women in midlife" and found "no increased incidence of depression." He avers that "[f]or a majority of women, menopause will mark the beginning of the best years of their lives" (5-6).

Clearly, the popular advice authors are divided as to whether hormonal changes at

menopause produce depression and other psychological difficulties or not. A woman seeking information and counsel in this area would receive dramatically divergent impressions from Gillespie's narrative than she would from Greenwood's. Some of the physicians in this sample obviously regard menopause as abnormal and/or pathological and others do not. Each author's position is clearly reflected in his or her advice regarding what women should do to keep, attain, or regain good health in the years during and after the climacteric.

Theme V: Views Regarding Treatment/Therapy

Findings for this theme are critically important since it is in this area that the physicians/authors of the popular advice books actually recommend specific courses of action, treatment, or therapy for their readers that they believe will help them to be healthy for the rest of their lives. The recommendations in this area fall into four general categories: the advisability of hormone replacement therapy, the type and amount of medical care needed, appropriate lifestyle changes, and suggestions regarding alternative treatments. In their writings on this theme, I discovered differences of opinion among the popular advice authors which coordinate closely with their stances on the other themes. As a group, these writers strongly advocate ERT/HRT for menopausal and postmenopausal women. Consequently, the majority of them definitely urge women to seek specialized health care at this period of life. Most of them also stress the importance of a healthy lifestyle and recommend a number of nonpharmaceutical, alternative therapies.

My findings indicate that hormone replacement therapy is unquestionably the core and mainstay of treatment methods recommended by the popular advice authors. All of them suggest it for some women, and some of them endorse it for virtually all women. Those who are strong proponents of HRT also suggest that it should be continued indefinitely. Those who recommend it most forcefully are Utian, Budoff, Nachtigall, Jovanovic, and Gillespie. Utian, in his section titled "What do female sex hormones do for the female body?" metaphorically compares estrogen to a "builder" and progesterone to an "interior decorator" (32). He states that decreased levels of these hormones after menopause "ultimately affect all of your tissues" (30).

Utian's position is that midlife and beyond can be good for women only if they "outwit" the "all-powerful ovary" (25) and learn to "manage" their menopause by cooperating with their physician and taking HRT. The benefits of HRT, he asserts, include "improved quality of life," "relief of hot flashes," "improved mental outlook," "improved short-term memory," "disease prevention," "enhanced sexuality," "slowing down the aging process," "strengthening the bladder/pelvic floor," "breast firmness," and "longer life" (92-97). He concludes that "for those women without strict contraindications, there appears to be little doubt that the potential value of HRT outweighs its potential risks" (98).

Nachtigall is another enthusiastic advocate of HRT. Her book, aptly titled Estrogen, is a paean to that hormone and contains 45 mentions and more than 24 pages citing estrogen as a panacea for every ill from osteoporosis to nosebleeds. She proclaims HRT "safe for virtually every woman today" (60) and contends that "[e]very woman's

vagina can be restored to mint condition with enough estrogen" (93). She further states that "it's never too late" for HRT, even for women in their nineties (184). Despite all this evidence to the contrary, she also avers that "[t]his book is not an argument for taking estrogen . . ." (15)!

In a statement that epitomizes the biomedical model, Gillespie deems HRT "the centerpiece of [menopause] management." He authoritatively continues, "Most gynecologists now feel that [HRT] should be offered to every menopausal woman who has no insurmountable contraindication. The present methods of administration have been proven to be so safe and so effective that there is really little argument remaining against its regular use" (53-54).

Jovanovic, like several other popular advice authors, rationalizes her enthusiasm for HRT by equating menopause to diabetes: "Unlike most medications, HRT is not adding foreign substances to the body, but is rather replacing essential substances that your body can no longer produce naturally, much like insulin in the body of a diabetic" (emphasis in the original) (69). She attempts to present both sides of the HRT debate but clearly favors hormone therapy. Jovanovic makes extensive use of the adjective "healthy" in her section on the benefits of HRT, implying that postmenopausal life without HRT would not be healthy (84-87). She concludes, "only if you suffer from certain conditions that may prevent you from taking hormones . . . should you refrain from obtaining a prescription for HRT right away" (88).

Like Jovanovic, Greenwood also expounds on both sides of the hormone replacement dilemma, but her presentation is much more even-handed and her emphasis

is on enabling each woman to make her own individual, informed decision as to whether or not to pursue HRT. She includes a helpful self-rating scale with the advantages and disadvantages of HRT as a tool for intelligent decision-making, and she presents hormones as an option but never promotes them as aggressively as the above-mentioned writers do.

Cherry and Runowicz take an even more conservative stance on HRT. They declare that "many women are taking hormones that have not been proven safe or effective. While these drugs may be helpful for some women, they are not warranted in every case" (xiv). Far from pushing menopausal women toward hormone drugs, this medical duo (who are, incidentally, husband and wife) question the practices of their colleagues and the drug companies which have popularized estrogen as a magic elixir for women in midlife. In a section of their text titled "Hormone Replacement: Risky Business?" they state, "Hormones have been promoted as a cure for all the symptoms of menopause, yet many of the symptoms commonly associated with the change of life have little to do with menopause." They continue, "The tendency is for menopause to get mixed up with--and blamed for--all the normal changes of midlife" (4-5). They conclude that "[t]he idea of menopause as a disease . . . is a negative stereotype that lays the ground for unnecessary treatment . . . that may, in the long run, do women more harm than good." These physicians also disagree with the premise that menopause produces aging, asserting instead that "[i]t is [merely] part of the aging process" (6). In addition, they decry our culture's "preoccupation with youth" and declare that the notion "that hormone therapy can keep a woman young indefinitely" is simply not true (7).

Cherry and Runowicz, in disagreement with many of their colleagues, opine that data concerning the "safety and effectiveness" of HRT is "poor and conflicting" (68) and "advise caution," especially in the long-term use of HRT, for three reasons: "(1) the unknown effects of long-term estrogen replacement on the breasts, (2) the alternatives to hormone therapy for prevention of osteoporosis, and (3) the diminished cardiovascular effects of estrogen when progesterone is added" (76). They further maintain, "the current thinking is that taking estrogen for fifteen years or more increases breast cancer risk by 30 percent" (77). Dr. Cherry is a long-time opponent of widespread hormone therapy. In the 1970s, he wrote The Menopause Myth warning of the connection between estrogen therapy and cancer of the endometrium. I surmise that Dr. Runowicz's experience in her specialty, gynecological oncology, may have led her to concur with Cherry in opposing the indiscriminate use of HRT.

Notelovitz is another gynecologist who does not urge HRT for virtually all menopausal women. He asserts that the term hormone replacement therapy is "misleading because it suggests that hormones that should be there are being replaced." The term HRT, he feels, "has become symbolic of a mind-set that has led to the medicalization of menopause." He suggests the use of an alternative term, "hormone additive therapy," since "[t]echnically . . . hormones are not being replaced; they're being added" (emphasis in the original) (437-438). Like Cherry and Runowicz, Notelovitz represents the viewpoint of the feminist paradigm because he resists the idea that all menopausal women should be treated with hormone drugs. He argues that "diet and exercise provide ample protection against heart disease." And that "[a] lifetime of

exercise and good eating habits protects against osteoporosis, as well." He advises, ". . . learn the facts [and] . . . make up your own mind. Your doctor may recommend hormone-additive therapy, but the final decision rests with you" (449).

While the popular advice authors are by no means unanimous in their opinions about HRT, they are nearly united in agreement that midlife and older women should consult a medical specialist regularly. Furthermore, many advise women not to see just any doctor, but to search until they find the "right" one. For most of these writers, the "right" one means a gynecologist who can prescribe the "proper" regimen of HRT. Greenwood is the only voice of dissent, stressing health care for "yearly checkups and for illness" and recommending a variety of practitioners, including a physician's assistant or nurse practitioner. She also suggests that menopausal women's health needs are better served by "[d]octors who take a positive view of the menopause, and do not . . . view ill health and pain as inevitable parts of aging" (197-198).

The stance of the biomedical model on the issue of health care is well represented by Dr. Utian, whose book contains a whole chapter on "Finding Dr. Right" (20). He avers that "your physician is the number one tool in your armamentarium [against menopause]" (15). Notelovitz agrees, incorporating a detailed passage elaborating on "First Things First: Finding the Right Physician" (21). Nachtigall also includes sections titled "It's Time to Go to the Doctor!" (46), "Finding the Right Doctor" (194), and "Do You Need a Gynecologist?" (196). She recommends "a gynecological checkup every six months, whether or not you have questions or problems" (97). Gillespie concurs, adding that "[s]eemingly trifling problems that may arise at this time can, if neglected, ignite into

crippling disorders in later years" (27). He also counsels, "Comply with your doctor's recommendations. Compliance is one of your major responsibilities" (49). The popular advice authors in this sample mention the need for the "right" specialist to usher women safely through the climacteric 49 times, allotting nearly 46 pages to this topic. In contrast, they give only one mention and less than two pages to the premise that most women need no specialized medical care during the menopause.

All the physicians in this sample of popular advice books advocate, to some degree, changes in lifestyle which can make the menopausal transition more pleasant for women and aid in achieving and maintaining good health to the end of life. Most of the authors deal with this subject quite extensively, devoting several chapters to information and encouragement on healthful modifications in diet and exercise, moderation in the use of alcohol and caffeine, and smoking cessation. Notelovitz' treatment of these topics was the most comprehensive and totaled nearly 135 pages. (His book is also the longest, 512 pages.) Budoff and Nachtigall allotted the least amount of space to lifestyle issues, slightly more than four and three and one-half pages respectively. This is not surprising, given their enthusiasm for hormone therapy. The remaining five authors, Utian, Greenwood, Jovanovic, Cherry and Runowicz, and Gillespie included an approximate average of 45 pages each on ways in which menopausal women can improve their health and the quality of their life through nonmedical behavioral modifications. Jovanovic takes this one step further by recommending dietary changes and exercise as a remedy for fluid retention and other disagreeable side effects of hormone therapy (77).

The health and fitness movement that became popular in the 1980s and continues

to the present day has undoubtedly contributed to general awareness of the importance of diet and exercise and the dangers of stress, cigarette smoking, and alcohol abuse. The public has become more conscious of self-help measures that all individuals can employ to improve their health and fitness, and there is also a focus on persons being more informed and taking more responsibility for their own well-being. This trend has assuredly influenced many physicians writing popular advice books to include material on a healthy lifestyle in their books. Suggestions of this type are more representative of the holistic feminist model than of the biomedical model, which tends to concentrate on drugs and surgery as methods of treatment. However, the trend may also be a result of the social doctrine that the ideal modern woman, regardless of her age, should be slim and physically fit. It is therefore difficult to assess how much of the diet and exercise recommendations in the popular advice books has been influenced by feminism, by social standards of wellness, and by agism and sexism. I am inclined to believe that all these factors have affected this advice to some degree.

Another current trend in personal health has been the rise in popularity of alternative therapies such as homeopathy, acupuncture, herbal medicine, and relaxation techniques. Vitamins, Kegel exercises to improve the muscle tone of the pelvic floor, and vaginal lubricants are other measures women can use to help remedy the signs of aging and menopause without the supervision of a physician.

All the doctors in this sample mention some alternative self-help therapies and preventive measures that are available to women in lieu of HRT. The most frequently recommended therapies are vitamin and/or mineral supplements, nonprescription vaginal

lubricants, and Kegel exercises. Nachtigall and Greenwood refer to the widest variety of alternative therapies and provide the most information on them, with 15 and 11 pages respectively. These two authors discuss therapies such as acupuncture and homeopathy as well as simple, inexpensive natural remedies like herbs for relief of hot flashes, and vinegar douches and yogurt to alleviate chronic vaginitis. These methods are ignored by the other physicians. Gillespie offers the briefest amount of advice on alternatives to HRT, approximately one-quarter of a page. This is consistent with his extreme "disease" orientation to menopause.

To summarize the general patterns for popular advice books, the grand totals for this sample of works on menopause authored by physicians show more mentions of opinions and topics in accord with the biomedical "disease" paradigm of menopause. However, the totals show a greater number of pages given to subject matter more aligned with the holistic feminist model. A closer look reveals that it is the large amount of information on healthy lifestyles included by these physicians that skews the data in a feminist direction.

Taken individually, none of these works represents an entirely feminist nor an exclusively biomedical ideology. The volumes differ widely in their approach and attitude toward the climacteric in particular and women's aging in general. Some authors, such as Utian, Notelovitz, and Cherry and Runowicz, adopt a more "scientific" style, with many charts, tables, and detailed illustrations. In contrast, Greenwood's book appears to be much more informal and accessible, with nontechnical language and whimsical drawings. Several of the male physicians, Gillespie and Utian in particular,

adopt an authoritarian, at times condescending, tone that is not found in the female doctors' prose.

Placing all these books on a relative scale with a biomedical model and a feminist model at either end, I consider Gillespie's work as closest to the biomedical paradigm and Greenwood's as most consistent by far with the feminist paradigm. Cherry and Runowicz' volume also evinces a strongly feminist attitude in its portrayal of menopause as a normal part of female aging and its refusal to advocate HRT for virtually all women. The other authors fall closer to the pathology model because of their orientation to menopause as a pathological process and their insistence on the need for medical care and intervention in the form of hormone drugs.

It is obvious that these physicians' medical education has shaped, to varying degrees, their perspective on menopause. This bias is evident in their tendency to universalize the experience of menopause; in their propensity to focus on the "all-powerful" but "failing" ovary as the source of all midlife ills; in the very negative language with which they portray the physical signs of menopause and aging; in their "disease" orientation toward the climacteric; and in their insistence on HRT as a panacea for nearly all afflictions of women in middle and old age. Even those individuals who protest that the climacteric is not a disease refer to its physical signs as "symptoms." This negative language, taken for granted by the medical community, the mass media, and the general public alike, colors the way many women view their own menopause experience. The characterization of menopause as a medical event influences women, even those who are otherwise healthy and are experiencing only mild menopausal problems, to submit to

unnecessary medical procedures and to take powerful, potentially dangerous hormones, resulting in millions of dollars of profit annually for the medical and pharmaceutical industries.

Many more women are writing publicly of their individual menopausal experiences. While many of these accounts differ dramatically from negative medical portrayals of the climacteric, other women have participated in the medicalization of menopause by adding their voices to the hegemonic chorus that continues to vilify the normal female transition from fecundity to old age. I do not wish to deny or minimize the suffering of those women who experience problems in menopause, nor to imply that they should not seek medical help. I do, however, believe that it is important to point out that women's accounts of difficulties with the climacteric are often incorporated in popular advice literature by physicians to buttress their claim that menopause necessitates medical intervention. The results of my investigation of women's writings on the menopause are delineated in the chapter that follows.

CHAPTER V

FINDINGS FROM WOMEN'S WRITINGS ON THE MENOPAUSE

The eight women's books in this sample portray a broader spectrum of experiences of and opinions on the menopause than either of the other two groups of writings on the subject. The style, tone, and literary form of these sources vary greatly as well. Four books have individual authors, and four are the work of multiple authors and an editor or editors. Of the latter group, two are anthologies of personal prose and poetry on menopause; one is a collection of essays selected from papers given at a 1989 multidisciplinary conference on menopause held at the University of Kentucky; and one is a cooperative effort in association with the Boston Women's Health Book Collective.

The individual authors and editors are also quite diverse. Germaine Greer is a well-known feminist writer; born in Australia, she now lives in England. Gail Sheehy is a renowned American author whose most famous work, Passages, chronicles the stages of adult life. Amber Coverdale Sumrall is a widely published editor and author of prose and poetry; Dena Taylor makes her living as a freelance writer and researcher. Elizabeth Claman writes poetry and fiction and edited her book while working on a Ph.D. in comparative literature. Paula Brown Doress is a coauthor of Our Bodies, Ourselves and a founding member of the Boston Women's Health Book Collective. Diana Laskin Siegal, a consumer advocate and activist, is a consultant and lecturer on older women's health issues. Gayle Sand is an author and lecturer who has been a columnist, restaurant critic, and editor-at-large for a Florida newspaper. Lonnie Barbach is a clinical-social

psychologist and author noted for her work on human sexuality. Joan Callahan, Associate Professor of Philosophy at the University of Kentucky, specializes in ethical and moral issues of human reproduction.

The works in this subsample predominantly reflect a feminist viewpoint but also demonstrate the extent to which the biomedical paradigm and the prevailing negative societal concepts of menopause and women's aging may adversely affect an individual's perception of her own menopausal experience. The data totals show the women's writings aligned more closely with the feminist model in the number of mentions in four of the themes and in the amount of page space in all five themes. Please see Table 5.1 for a summary of the data from the sample of women's accounts.

Theme I: Universality of Menopausal Experience

Data in the theme of universality conform to the feminist model of menopause by wide margins in both numbers of mentions and amounts of page space. Theme totals indicate that the women writers definitely view the climacteric as a biological phenomenon that is strongly influenced by individual and cultural differences. The opposing biomedical paradigm, which concentrates on biological aspects of menopause and tends to ignore or minimize the effects of societal norms and personal variations, receives less than a third of the amount of page space devoted to depictions consistent with the dominant feminist model. A look at the data for the four indicators of the universality theme reveals the details of these general findings.

Depictions of the experience of hot flashes in women's accounts run the gamut

Table 5.1: Findings from Women's Accounts

	Biomedical Model			Feminist Model		
Themes & Indicators	**#**	**pg sp**	**mean**	**#**	**pg sp**	**mean**
Universality						
I-1 Hot Flashes +/-	32	16.14	.50	33	24.25	.73
I-2 Femininity	6	2.38	.40	57	68.05	1.19
I-3 Apprehension/Zest	19	7.19	.38	33	14.37	.44
I-4 Crisis/Transition	13	7.26	.56	47	18.31	.39
Totals	70	32.97	.47	170	124.98	.74
Reductionism						
II-1 Reproductivity	23	11.44	.50	33	7.93	.24
II-2 Attractiveness	12	2.46	.21	21	35.24	1.68
II-3 Sexuality	35	16.96	.48	51	34.52	.62
Totals	70	30.86	.44	105	77.69	.74
Interpretation						
III-1 Ovarian Changes	8	.70	.09	8	2.18	.27
III-2 Hormone Levels	16	1.15	.07	14	3.48	.25
III-3 Hormone Balance	6	1.15	.19	8	2.60	.33
III-4 Genitourinary	4	.20	.05	10	1.20	.12
III-5 Vasomotor	6	.50	.08	4	1.10	.28
Totals	40	3.70	.09	44	10.56	.24
Pathology						
IV-1 Osteoporosis	14	3.94	.28	20	15.84	.79
IV-2 Symptoms/Signs*	341	na	na	26	na	na
IV-3 Epidemiology	1	.10	.10	10	1.79	.18
IV-4 Genital Changes	7	1.79	.26	5	3.20	.64
IV-5 Cardiovascular	7	2.17	.30	15	7.13	.48
IV-6 Insomnia	18	3.89	.22	3	2.05	.68
IV-7 Depression	21	14.94	.71	21	18.91	.90
Totals(*not included)	68	26.83	.39	74	48.92	.66
Treatment						
V-1 HRT	41	16.24	.40	44	32.71	.74
V-2 Medical Care	11	6.05	.55	13	9.13	.70
V-3 Lifestyle Changes	0	0	0	90	109.35	1.21
V-4 Alternatives	0	0	0	73	81.14	1.11
Totals	52	22.29	.43	220	232.33	1.05
Grand Totals	**300**	**116.65**	**.39**	**613**	**494.98**	**.81**

from celebratory to horrific. Data for this indicator show an almost equal number of mentions for both paradigms, but 50 percent more page space is devoted to the feminist model, asserting that women may experience this hallmark sign of menopause as either negative, positive, or neutral. Only two volumes in this subsample, Sheehy's and Sand's, portray hot flashes in a consistently negative manner. Sand states that she was "a hormonal hermit" who "no longer socialized for fear of the uncomfortable and embarrassing hot flash" (88). In contrast, Doress and Siegal and Barbach exemplify the feminist model, pointing out that every woman does not have flashes and that, among those who do, each person's reaction to them is unique. Barbach includes a discussion of cultural factors, noting that "the phenomenon is by no means universal" and that the hot flash "is so uncommon in Japan that there is no Japanese word for it." The diet of Japanese women, low in fats and high in vegetables and soybeans (a source of phystoestrogens), may play a part in the rarity of hot flashes among them. Barbach also states that hot flashes are reported by only 30 percent of Nigerian women. They are most commonly experienced, she asserts, by "more Western-acculturated city-dwellers" (88). The other four volumes contain mixed portrayals, with a greater portion of their text fitting the feminist paradigm.

The Taylor and Sumrall anthology includes the most extensive amount of material on hot flashes. They are portrayed therein with an amazing variety of descriptive terms, including "hellish" (74), "funny" (27), "intense and often pleasurable" (76), and "cleansing fire" (315). One of the most exuberant selections in this book is a short story

written by Sally Miller Gearhart and titled "Flossie's Flashes." It depicts hot flashes as very sensual, pleasant, and even sexual (240-244). The Taylor and Sumrall volume also has a cover illustration of the "Hot Flash Fan," a visual celebration of the many-faceted experiences of menopause. The fan is composed of twelve blades in the colors of the spectrum. Made of fabric and decorated with embroidery, beading, paint, and other embellishments, it is the work of Ann Stewart Anderson and 52 other artists. The "Hot Flash Fan" is also used as an introductory image on the first page of each of the book's chapters.

On the question as to whether menopause represents the loss of femininity and womanhood or a new life stage of possibilities for many women, the female writers almost unanimously support the latter, or feminist, position in both number of mentions and amount of page space. The ratio of mentions for the feminist model as compared to the biomedical paradigm is 57 to six, respectively. In terms of page space, the disparity in favor of the more positive feminist stance is even greater: 68 to two. Sand's account is again the most negative, containing three of the six mentions of loss of femininity and womanhood. Deeming herself an "estrogen junkie," she writes, "I can't function without it. It calms me down. It makes me feel good. It gives me sexual power. When I was on it I was on top of the world. I had it all--youth, fresh skin, a sex life, a period. But all that's changed. My supply has dried up" (106). Her view of herself, with a focus on youthful beauty, has clearly been shaped by cultural standards of womanhood. The other women's discourse in the sample presents a radically different view.

Jacquelyn N. Zita writes, ". . . we must challenge the metaphysical misogyny which defines 'woman' by her reproductive capacity, a misogyny which is everywhere present in women's obsessive concern with 'the youthful perfect body' . . . Womanhood does not stop at menopause" (in Callahan 75). Greer asserts that "femininity" is a social construct and a "charade," while "femaleness" is an inherent, although not necessarily definable, state which "the onset and retreat of [the] reproductive years cannot alter" (52).

Barbach, Sheehy, and Greer devote substantial portions of their texts to the argument that, having finished with the business of reproduction and constantly caring for the needs of others, postmenopausal women are ready "to take risks and pursue passions and allow ourselves adventures perhaps set aside way back at thirteen, when we accepted the cultural script for our gender that ordinarily denied those dreams" (Sheehy 40). Both the Taylor and Sumrall and the Claman anthologies contain short stories about menopausal women who literally run away from home to live out their fantasies. Again, Taylor and Sumrall's book has more material on this issue than any of the other volumes. Henrietta Bensussen's statement from her essay "Coming of Age" sums it up well: "The long view back helps light up possibilities for the future" (in Taylor and Sumrall 81). All the women's accounts except Sand's definitely present the climacteric as a time for development and departure rather than decay.

Most of the women writers also seem to regard the climacteric as a period of growth and new zest. They devote about two times as many mentions and twice the amount of page space to the feminist view. An attitude of apprehension is more typical

of the biomedical model. Sheehy briefly mentions that during the perimenopause a period of "panic" occurs that is similar to the onset of menarche when women feel "out of sync" with their bodies (66). Two essayists in Taylor and Sumrall's book, Connie Batten (15) and Elaine Goldman Gill (183), also liken the perimenopause to adolescence and assert that it is "threatening." However, none of the authors dwell on the negative aspect of this subject as much as Greer and Sand.

In her eleventh chapter, "Misery," Greer asserts that the afflictions of menopause have "two sources, from without and from within." She states that "the external cause of misery is to be found in the attitudes of others. The internal source is the awareness of the stigma, which persists despite . . . the denial that one is a menopausal woman or, worse, an old woman" (235). Sand, a resident of Los Angeles, California, who "panicked" at the notion that she might be entering the climacteric, conveys the same ideas with more humor: "In L.A. nobody experiences menopause. In L.A. menopause is considered a terminal illness." She continues, "Here they appreciate vintage wine, respect old money, collect antique cars, and trade in menopausal women" (4). Sand, too, likens menopause to adolescence, stating that "[b]oth are very confusing times, filled with fear, anxiety, guilt, grief, and anger . . .. As a teenager I was uncomfortable, insecure, and isolated. I didn't know where I was headed and I feel the same now" (202). Curiously, she later tempers her angst over the climacteric with a more positive, though contradictory, assertion: "I want to be a new woman and I welcome the change. Menopause isn't the end of the road but the beginning of a new adventure" (203). Both

Greer and Sand maintain that the tribulations of menopause, significant in and of themselves, are greatly exacerbated by negative societal views of menopause and aging women. Both these accounts illustrate how women's negative or ambivalent attitudes toward and experiences of the climacteric may be products of internalized cultural misogyny and agism.

With few exceptions, most of the women writers agree with the feminist stance that menopause is a period of change and transition. Sand, once again, presents a dissenting opinion, as do a few of the essayists in the Taylor and Sumrall volume, recounting a time of crisis and catastrophe more in tune with the biomedical model. Nonetheless, portrayals representative of the feminist model outnumber more negative depictions by a factor of three in mentions and two-and-one-half in page space. However, the women who characterize menopause as fraught with crisis paint a quite dreadful picture.

Clare E. Wood, who describes her menopause as "devastating," writes, "I'm not the person I was three years ago. Menopause took that person and made her a hysterical, moody, angry, anxious, tired, forgetful, and depressed 'person.' Before, I was a together woman, juggling all life had to offer. Then, Menopause. I felt like a split atom--no longer in control" (in Taylor and Sumrall 196). Another author, Chris Karras, characterizes the climacteric as a "twilight zone," in which she encountered "severe migraines, hot flushes, abdominal bloat, stress-incontinence, heart palpitations, nausea, severe vertigo and . . . fainting." In addition, she suffered from "irritability, free-floating

anxiety, horrific nightmares, insomnia and a rapidly eroding self-confidence and self-esteem" (in Taylor and Sumrall 306).

Germaine Greer asserts, however, that it is predominantly male researchers and physicians who "remain attached to a view of menopause as catastrophe." She further opines that "women who have made the adaptation to male requirements will share the pessimistic view that men take of menopause and suffer more as a result" (17-18). However, Doress and Siegal stress that those women who do have severe difficulties during the climacteric should not be blamed for their own suffering or "told that their attitudes about themselves are the cause of their problems" (117).

Greer devotes an entire chapter of her book to the argument that women need a rite of passage to help them celebrate the menopausal transition. Sheehy, who dubs menopause a "transformation," urges women to "break the conspiracy of silence . . . by starting self-help groups and sending out educational messages in every way, shape, and form" (132). Barbach, too, is a strong advocate for menopause support groups and education (229-232).

All the women writers in this sample who describe menopause as a disaster period do so strictly within the context of their <u>own</u> personal experience. In contrast, every woman writing about the climacteric transition among women <u>in general</u> portrays it as an experience that is by no means universal, but unique for each individual. As she discusses the research she did while compiling her book, Claman states, "Everyone had a story, and what struck me most intensely was that each one was different; every woman I

read about or talked to approached and passed through menopause just as she did everything else: in her own way" (2). Influenced by their training and clinical practice, many physicians seem to extrapolate from the terrible experiences of a few menopausal women, such as Wood and Karras, to the general assumption that the change of life is calamitous for all women. The female writers in this sample definitely refute this conclusion.

Theme II: Reductionistic versus Holistic Emphasis and Interpretation

The women whose works I surveyed seem to take a predominantly holistic view of menopause, which is indicated by the data totals for this theme. These accounts agree more often with the feminist model in both number of mentions and in amount of page space. However, in two indicators, reproductivity and sexuality, the influence of the biomedical paradigm is readily apparent.

In the biomedical model, the loss of reproductive capability which occurs with menopause is lamented because bearing children is deemed to be women's chief function. The feminist paradigm holds that women should be valued for more than simply their capacity to produce children. Aging women are an important source of cultural wisdom. Feminist writers also tend to emphasize bonuses of the climacteric such as the cessation of menstruation, the end of the monthly dilemma of birth control, and the beginning of freedom from the fear of pregnancy. On the question of reproductivity, the female

authors mention more points consistent with the feminist model. However, they devote three-and-one-half more pages to discussions that fit the biomedical model.

Many menopausal women report a deep feeling of ambivalence about the loss of their menstrual periods and fertility. The works by Sand, Sheehy, Claman, and Taylor and Sumrall all contain a significant amount of material lamenting the loss of fecundity at menopause. Sand expresses her grief in her typically flippant style with a pun. "Now every time I see a pregnant woman I get mourning sickness" (42). Erica Lann Clark states the case more poignantly:

> Finally, the Grand Climacteric couldn't by denied. But what a misnomer! No climax here. There was nothing. No more monthly messages from Mama, no red thread, only a pause. A long, long pause. I was scared and sad and angry. No more eggs? How can you be a woman and not be fertile? How be fertile and not bleed? Life had passed me by without giving me enough babies. I never even had my daughter and now it was too late, the source of my power had gone dry. (in Taylor and Sumrall 207)

The most salient phrase here, I believe, is "the source of my power." Women, consciously or not, know that their capacity to bear children is a fount of great power as human beings. However, in patriarchal cultures in which men attempt to control female sexuality, a woman's fertility also represents her greatest vulnerability to oppression. Thus, while she may welcome the transition which brings an end to that vulnerability, a woman may simultaneously grieve because it also terminates the source of her power.

Women writers who address the issue of whether older women's attractiveness is diminished by wrinkled skin, graying hair, sagging flesh, and an increase or redistribution of body fat generally do not concur with this biomedical construct. They give nearly

twice as many mentions and fourteen times more page space to opinions in agreement with the feminist model that an aging woman's attractiveness is not dependent on conventional standards of youthful beauty. The anthology edited by Callahan does not mention this subject, and Sand's book contains only two brief sentences about it which are more aligned with the biomedical model: "I would never ask another woman about her menopause because it implies that she looks menopausal. Women find this very insulting because they all think they look twenty-two, including me" (107). The Doress and Siegal work treats it more extensively than the other books, with an entire chapter, "Who Needs Cosmetic Surgery? Reassessing Our Looks and Our Lives," discussing the personal, relational, and social implications of looking older in a society that considers aging women unattractive. These authors take a decidedly feminist stance, suggesting that women "make conscious efforts to change [their] own and others' ideas of beauty" by telling older friends "how fine and handsome are the visible signs of years, experiences, and character" (44-45).

The data for the indicator regarding sexuality show that female authors are more in agreement with the feminist stance that sexuality continues and may even be enhanced following menopause. However, a substantial number of mentions and amount of page space were also given to assertions more consistent with the biomedical model, that the body changes concurrent with the climacteric bring about decreased desire and diminished sexual experience for women. All eight works contain at least one sentence representing each of the paradigms. The Callahan volume treats the issue minimally,

with equal amounts of material representing both sides. The books portraying postmenopausal sex most positively are those by Greer, Taylor and Sumrall, Doress and Siegal, and Claman. A more pessimistic view is presented by Sheehy, Sand, and Barbach.

A large part of Sheehy's material on the "flagging of libido as the estrogen level drops and the tissues of the vaginal wall become thinner and drier" (85) is, in fact, about the experience of Gayle Sand, whom Sheehy describes as a "slinky, sexy-looking California woman with great black Diana Ross hair" (84). Furthermore, Sand's book is, once again, by far the most consistently negative about menopausal sexuality. Sheehy's book does contain some positive observations about sex after menopausal, such as the results of a Gallup poll which found that 70 percent of husbands and wives surveyed reported no decrease in women's interest in sex following menopause (92). Barbach discusses extensively the ways in which the climacteric "can directly affect sexual desire, lubrication, arousal, and orgasm" (121). However, she also relates the good news that some women experience increased desire (139-140), suggests many ways to enhance sexual pleasure in midlife (142-144), and concludes that "if you put a high priority on masturbation or sex with your partner, you can expect to maintain an active sex life for a long, long time" (145). Sand's portrayal of menopausal sexuality, on the other hand, is almost completely negative. Her book contains five pages of descriptions such as this: "Now sex has all the eroticism and pleasure of a full body wax. Except for the hot flashes there is absolutely no heat in our relationship. . . . Menopause has had a magical

effect on our sex life. It made it disappear" (151).

Greer, Taylor and Sumrall, Doress and Siegal, and Claman present sex after menopause in a markedly different, more feminist light. In two chapters, "Sex and the Single Crone" and "The Aged Wife," Greer asserts that "the options seem as varied as ever they were" (280) and that "there is more to lovemaking than insertion of the sacred phallus. There is also closeness, sleeping together, waking together, sight, smell and touch" (293). In essence, Greer avers that even if aging women lose their desire for heterosexual intercourse, this is not necessarily a problem. Laughter, closeness, and emotional intimacy are as important, if not more so.

The Taylor and Sumrall anthology contains nearly nine pages of writing by women who declare that menopause does not mean the end of sexuality. In the short story "A Welcome Change," Constance Mortenson's menopausal heroine Melanie states that she "had never had more fun between the sheets than now" (99). Sumrall, surprised by her "new-found sexuality," reports that "[l]ovemaking has never been so intensely pleasurable" (126). Kathy M. White's poem "Initiations" recounts the experience of a menopausal woman in Polynesia who provides instruction in the delights of sex for an adolescent boy (210). Lea Wood's essay "Unforeseen Blessings" includes an allusion to "wonderful sex in an affair that started when I was 62 and lasted until I was 70 (not because the sex deteriorated)" (316).

Claman describes herself as "in the thick of menopause, yet feeling fit, active, and sexually energized" (4); she includes five pages of material about and by sexually active

aging women in her anthology. The chapter "Sexuality in the Second Half of Life" in the Doress and Siegal volume treats this subject in a very positive yet realistic manner. The emphasis is on aging rather than menopause. It addresses issues such as myths about older women and sexuality (80-81) and presents comments from many women on their experiences with sex and aging (81-82). It also discusses masturbation and sexual fantasies (82), heterosexual and lesbian relationships (including the dilemma faced by women who are bereft of their partners by illness or death) (82-86), and the physical and emotional changes that accompany aging in females and in males (86-90). It also includes illustrations of various positions that may facilitate lovemaking between aging partners (92-93). The chapter concludes with a reassurance that "[a]s long as we want it, sex can be a part of our lives" (97). The biomedical model focuses quite narrowly on conventional heterosexual practice and thus sees menopause as the harbinger of the end of "normal" sex. However, the emphasis in the accounts that represent the feminist paradigm is that as women age, their sexual practices may alter and partners may change or disappear, but sexuality continues to the end of life.

Theme III: Interpretation of Physical Changes

The women writers refer to the somatic changes accompanying menopause in a positive, feminist manner slightly more often than they mention them in a negative way more consistent with the biomedical paradigm. However, in three categories of this theme, ovarian changes, hormone levels, and vasomotor changes, the culturally dominant

biomedical model eclipses the feminist paradigm with an equal or greater number of mentions. Nevertheless, these authors devote approximately three times more of their textual space to discussions that fit the feminist model. Thus, while the female authors frequently use the pejorative terms coined by the biomedical model to describe the physical changes of menopause, their overall treatment of these subjects is predominantly feminist.

Ovarian or gonadal "failure," atrophy, and decline are the terms preferred by the medical establishment to describe changes in the ovaries which feminists would rather refer to simply as ovarian changes of menopause. Greer, Sheehy, Taylor and Sumrall, and Barbach all include ovarian "failure" or an equivalent phrase in their books. However, Barbach is the only one who uses it consistently. Claman and Sand do not broach the subject. Sheehy suggests substituting "ovarian fulfillment" for ovarian "failure" in describing the cessation of ovulation and hormone production that occurs at menopause (40).

Many women writers legitimately resent the implication of inferiority suggested by the term ovarian "failure." Dori Appel's biting poem "Meaning Menopause" recounts her intense reaction to her gynecologist's use of the term and ends with the following lines:

> I am going to lie right here,
> howling and kicking my feet
> on the stirrups
> until he recants--this man
> so certain of his truth,
> whose testicles

know nothing but success. (Taylor and Sumrall 180-181)

My findings are mixed on the question of whether or not women authors in the subsample believe that postmenopausal women have a sufficient amount of estrogen in their bodies. The female writers refer to an estrogen or hormone "deficiency" at menopause slightly more often than they allude to the feminist stance that menopausal women no longer require high levels of the reproductive hormones. Nevertheless, the feminist position dominates the discussion in five works of the sample, with three times more page space given to various versions of the argument that "evidence of deficiency is anything but clear" (Greer 171-172).

Barbach asserts that "[a] postmenopausal woman is no more hormonally deficient than a girl of six with no breasts. Each is normal for a female of that age" (8). Several writers make the point that androgens, produced by the adrenal glands after the climacteric, are converted to a form of estrogen, and are stored in fat cells (Barbach 25, Callahan 183-184, Doress and Siegal 120, Taylor and Sumrall foreword). Most of these also mention that it is therefore advantageous for postmenopausal women to have a little extra body fat. Doress and Siegal declare that the use of the term hormone "replacement" is inappropriate since "the use of hormones after menopause is adding, not replacing, hormones" (269). Finally, Jane L. Mickelson's essay "Changing Woman" warns women to "[b]e wary of any article, book or person . . . who tries to convince you that menopause is an illness or an estrogen deficiency disease," adding that those who do "have something to gain (usually money) by convincing us that we need chemical and/or

physical intervention" (Taylor and Sumrall 38-39).

The women writers give slightly more mentions and page space to the feminist position that a new and different, but normal, hormonal milieu exists postmenopausally. However, the influence of the biomedical model is also quite evident, with Greer, Sheehy, and Barbach all alluding to hormone "imbalance" and discussing its effects on moods and emotions during menopause. Both Sheehy and Barbach note that this situation of disequilibrium is temporary, while Greer comments that "[s]ome of our negative feelings about menopause are the result of our intolerance for the expression of female anger" (118). Taylor and Sumrall and Doress and Siegal are the most adamant advocates for the feminist position.

The Taylor and Sumrall volume contains an excerpt from Genia Pauli Haddon's book Body Metaphors: Releasing God-Feminine in Us All as well as reflections on it in "Beyond the Stethoscope: A Nurse Practitioner Looks at Menopause and Midlife," an essay by Maura Kelsea. Kelsea cites the increased assertiveness and sexuality that often accompany menopause because of "a changed and more even hormonal balance--a balance which brings women hormonally closer to men." She also warns that "putting women back into hormonal cycling" via HRT might disrupt "the ancient hormonal pattern which has fostered Wise Women. What will these hormones do to the potential healers, teachers and communal grandmothers of our society?" she asks (277-278). With regard to the issue of hormone balance/imbalance the female writers present the feminist position slightly more often than the biomedical one and give it more than twice as much

textual space.

The women authors who include material on genital and urinary changes accompanying menopause are in accord with the feminist stance by wide margins in both mentions and page space. I did not find this topic mentioned in the Barbach and Sand volumes, and Greer and Sheehy mention vaginal "atrophy" (the biomedical term) very briefly. The most extensive treatments of the subject are found in the works by Taylor and Sumrall, Doress and Siegal, and Claman. Vaginal dryness is referred to briefly in the Callahan volume in the section "Common Changes" in the essay by Ann M. Voda (174). All these texts refer to vaginal changes, such as thinning and dryness, as a normal development of menopause rather than the pathetic wasting away implied by the term "atrophy." These writers' language is notably more neutral in quality than that employed by authors more influenced by the biomedical paradigm. In her essay "Our Legacy: Medical Views of the Menopausal Woman," Mary Lou Logothetis assails "medical labeling" of normal menopausal changes in the female body. She asserts that terms such as "atrophy" and "senile vaginitis" reflect "an extremely negative view of women as shrunken neuters with wasted bodies and of the natural process of menopause as a biologic withering" (Taylor and Sumrall 41). I found the material on genitourinary changes of menopause in this subsample to be closer to the feminist model by a margin or more than two to one in mentions and six to one in page space.

The women writers give the final indicator, treatment of hot flashes as "vasomotor instability" or as a normal accompaniment of menopause, fewer overall mentions than

other indicators in the theme of interpretation. Sheehy, Taylor and Sumrall, and Claman did not mention the topic. However, the power of the biomedical model to influence how women experience and describe hot flashes is discernible; those writers who did raise the subject used the term "vasomotor instability" or its synonyms more often than they used more neutral ones such as "fluctuation." Greer utilizes the term "vasomotor disturbance" four times in her discussions of hot flashes (76, 81, 95, 102). Sand reports that flashes "are called vasomotor instability and they occur when the brain's temperature-regulating center goes haywire" (3). Barbach refers to "vasomotor irregularity" (95). In contrast, Voda suggests "[a] nontechnical, woman-generated definition of the phenomenon" and suggests that a hot flash be depicted as "an emergency heat release mechanism" (Callahan 173). The Doress and Siegal work also portrays hot flashes in a more evenhanded manner. As a group, the women writers devoted more page space on this issue to discussions consistent with the feminist model.

The totals for the theme of interpretation show that the women writers use language agreeing with the biomedical paradigm nearly as often as they use neutral terms when describing the physical changes of menopause. However, their discussions of these changes are more characteristic of the feminist model in regard to page space, with nearly three times more text devoted to a woman-centered view.

Theme IV: Perceptions of Menopause as Pathological or Nonpathological

The women writers in this sample clearly associate the climacteric with pathological conditions and mention menopause as a causative factor in certain disorders slightly more often than they allude to other sources. This tendency is most apparent with regard to insomnia but is also evident in the material on genital "atrophy," cardiovascular disease, and depression. They also use the term "symptom" with much greater frequency than "sign." Nevertheless, these authors once again devote more of their page space to feminist arguments against the "pathological" nature of menopause in all the conditions I investigated with the exception of insomnia. Thus, my findings for this theme are mixed, with more mentions consistent with the biomedical paradigm but more page space given to the feminist perspective.

On the issue of the causes of osteoporosis, the women writers agree with the feminist model more often in both mentions and page space. All the authors except Doress and Siegal mention menopause as a cause of osteoporosis, but they mention other factors such as heredity, aging, diet, lack of exercise, and smoking more often.

Of the eight books in this sample, Sheehy's volume contains the most mentions as well as the greatest amount of material linking menopause with osteoporosis. She dubs this bone-robbing malady a "major thief of menopause" (108). Sand also places a large share of the blame for osteoporosis on menopause. She declares that it "takes the biggest toll of all on the skeletal system" and is "[m]ore dangerous" than any of the other nine

risk factors she enumerates (76).

Greer, Doress and Siegal, Barbach, and Callahan assert most strongly that the climacteric is only one of a large number of possible factors in bone loss. Greer calls osteoporosis "a disease of affluence," stating that it is rarely found in Indian peasant women who "do not eat red meat and do eat yogurt and green vegetables and walk for tens of miles each day, usually carrying loads on their heads" (130-131). The "Osteoporosis" chapter by Kathleen I. McPherson in the Doress and Siegal work contains the most extensive and thorough treatment on the subject of risk factors, more than five pages (261-266). Nowhere in this exposition is menopause treated as a major factor in the loss of bone. Similarly, Barbach contends that "hormones are only one factor in a complex matrix that determines bone health. Exercise, genetics, and calcium are equally important" (213). Voda repeatedly asserts that osteoporosis is a multifactorial disorder. She further states that the current medical insistence on attributing bone loss primarily to menopause has led to the widespread practice of endorsing HRT for all women when only a small number are actually at risk for osteoporosis. She criticizes Sheehy's role in contributing to the fear and medicalization of menopause through her writings linking menopause and osteoporosis in Vanity Fair and other popular women's magazines. Voda notes that "Sheehy has far too limited a perspective on the sociohistorical dynamics of both menopause and osteoporosis, and it leads her to false conclusions" (Callahan 177). The majority of the material on risk factors for osteoporosis in this sample is more closely aligned with the feminist than with the biomedical model.

I had hoped to find the women writers in the sample using the term "signs" more frequently than "symptoms" to describe the physical manifestations of menopause. However, the authors of all but one of these works, although they repeatedly assert that menopause is not a disease, use the term denoting pathology by overwhelming margins. The Doress and Siegal volume is the only exception, unequivocally stating that "'[s]ymptoms' is not an appropriate word to describe changes at menopause" since it is not a pathological condition. Furthermore, they assert that there are only three "signs" that are "clearly associated with menopause: cessation of periods, vaginal changes, and hot flashes" and that of these three, only one, cessation of periods, is common to all women (117). This decidedly feminist treatment of the issue is in marked contrast to the practice of the other authors, who not only use "symptoms" extensively but also employ it to designate a much larger number of physical and emotional signs which they link with menopause.

I found the largest numbers of the terms "symptom" or "symptoms" in the volumes written by Greer and Barbach. Both authors used these terms that conform to the medical model more than 100 times, employing "sign" very infrequently. Barbach uses "symptom/symptoms" sixteen times in three pages in the section addressed to the male partners of menopausal women. Sand uses "symptom/symptoms" exclusively, as do the writers in the Claman anthology. The other authors in the sample use "sign" sporadically but write "symptom" much more often when discussing physical and emotional manifestations of menopause. In the Taylor and Sumrall anthology, for

example, I counted more than 50 instances where "symptom" is used compared with three for "sign."

Germaine Greer writes that "[o]ne of the basic tenets of feminism is that women must define their own experience" (17). She is also very critical of what she deems "medical ignorance" concerning menopause and devotes an entire chapter to the subject (141). Yet, ironically, the "symptom" language she uses in her discourse on menopause reflects the medical view of the climacteric as pathological. The conspicuously predominant usage, even by presumably feminist women writers, of this medical-based terminology strongly suggests the great degree to which the biomedical "disease" bias has permeated women's attitudes toward menopause via the mainstream of popular media. Thus, even many female authors who advocate that women define their own menopausal experience inadvertently couch their arguments in the linguistic tradition of the medical hegemony.

It is important to note that there is no word in standard English that precisely represents the concept of a nonpathological physical manifestation of menopause. According to the Sapir-Whorf hypothesis of linguistics "language shapes our perceptions, determining not only how we think about things but even what we can conceive" (Thorne, Kramarae, and Henley 10-11). Thus, language predisposes people toward certain perceptions of reality by enabling them to be aware of and express some concepts and limiting their ability to think about others.

As linguist Suzette Elgin so clearly portrayed in her novel Native Tongue, our

language exhibits many lexical gaps in regard to female life experience. Women's reality has remained largely "unencoded" in language (22). For example, although many women do not regard hot flashes as unpleasant or as an indication of disease, no word, other than very general terms such as "sign" or "manifestation," exists to conceptualize the experience as normal. Thus, regardless of how much they desire to do so, women can not adequately describe or define their own experiences within the limits imposed by our language as it currently exists.

I would maintain that these omissions from the lexicon explain, at least in part, why most women writers use the term "symptom" so often in relation to menopause, insisting all the while that they do not consider the climacteric pathological. Very simply put, there is no equivalent term without negative implications. Exclusive use of the term "sign" in relation to menopause by feminist writers such as Doress and Siegal is a positive step in that it enables women to conceive of menopausal changes as neutral and non-threatening. However, I believe that to truly remove the stigma of disease from our cultural perceptions of menopause, we need a new and more appropriate woman-centered vocabulary with which to conceptualize the midlife transition. Therefore, I propose the term "femindicator" as a positive feminist alternative for "symptom" to be used when specifically referring to uniquely female, nonpathological anatomic and physiologic processes such as hot flashes.

On the question of women writers' perceptions of menopausal "epidemiology" versus demographics, the preponderance of data in this sample seems to reflect the

feminist view of the climacteric as a normal life stage marking the end of menstruation and reproductivity. None of the writers give much attention to this topic, and Barbach does not mention it at all. Greer is the only author in the sample who actually uses the medical term "epidemiology of menopause" (107). All the other treatments of the subject employ the more neutral language of demographics. Most of the discussions of the rapidly increasing population of menopausal and postmenopausal women center on the role of the baby boom. Several authors incorporate comments on the potential for increased drug and medical profits in their discourse on the burgeoning population of older women. Sheehy, for example, writes that "[w]ith the baby boom bulge shifting eight hundred thousand women into the target group in '92 and projected to add over a half million women to the mid-life population each year for the rest of the decade, the menopause market is becoming big business" (22). In both numbers of mentions and page space, the women writers were nearly unanimous in dealing with the matter of "epidemiology" versus demographics in a fashion consistent with the feminist paradigm.

In their discourse on genitourinary problems, Greer, Sheehy, and Voda (in the Callahan volume) tend to focus primarily on menopause as the causative factor for vaginitis, urethritis, and incontinence. Greer cites the "inevitability" of difficulties created by the "atrophy of the tissues of the vagina and urethra" which "literally do dry up when ovarian function ceases" (98-98). Sheehy's discussion of vaginal "atrophy" includes a gynecologist's comparison of the size of two vaginas. The "normal, estrogenized vagina of a woman in her thirties" (emphasis added) is described as "about

five inches long and the width of two middle fingers." However, the vagina of a woman of sixty who has taken no estrogen, the physician states, is so shrunken "I can hardly insert my pinkie" (104).

In the section of her essay on common somatic changes that accompany menopause, Voda, too, concentrates on the role of the withdrawal of estrogen in vaginal dryness as well as incontinence. Voda is Professor of Nursing at the University of Utah. She reports that her own study discovered that "seventy-five percent of menopausal women experienced stress or urge incontinence which was unrelated to childbirth or bladder pathology." However, she also states that these changes are "normal and predictable" (in Callahan 173-174). Therefore, her ties with the medical model notwithstanding, I would contend that there is an important qualitative difference between Voda's treatment of the subject and that of Greer and Sheehy. I consider Voda's discourse closer to the feminist paradigm than the other two authors since she begins her discussion of bodily changes with a presumption of normalcy. In contrast, Greer and Sheehy seem to define only the "estrogenized" vagina as normal. Furthermore, neither of them mentions the possibility that childbirth or urinary pathology might contribute to incontinence.

I found the most thorough treatment of the causes of bladder-control problems in the Doress and Siegal volume. Factors which they include in their discussion include weak muscles, obstetric use of episiotomy and forceps, poor diet, insufficient water intake, infections, medications, sexual trauma, medical treatments (radiation and

hysterectomy), certain diseases (diabetes, Alzheimer's, multiple sclerosis, and Parkinson's), and emotional problems. They also mention hormonal changes, but they do not dwell on reduced estrogen production as a major cause of incontinence (284-286).

Similarly, Barbach comments, "If you are experiencing frequent urination, first rule out other medical causes before you blame The Pause" (78). In addition to some of the factors mentioned by Doress and Siegal, Barbach also cites poor voiding habits as a "major cause of urinary incontinence." She states that the decrease in muscle tone and nerve function which accompany aging may be exacerbated by the stress on the pelvic floor muscles produced when women push instead of merely relaxing their pelvic muscles when urinating. Quoting Dr. Richard Schmidt, a urologist at the University of California Medical School in San Francisco, she reports that "'[a]fter many years of this practice . . . pelvic muscle tone can diminish significantly'" (79).

The data totals for this subject indicate that women's accounts in this sample mention decreasing hormone levels as a factor in genitourinary problems slightly more often than they cite other causes. However, the authors who do name additional factors devote more page space to their explanation of them. Thus, my findings on this topic show more mentions consistent with the medical model but a greater amount of text conforming to the feminist model.

In terms of both mentions and page space, the feminist paradigm dominates the discourse on cardiovascular disease in the women's accounts I analyzed. They mention other causative factors more than twice as often as they mention menopause. In addition,

they devote more than three times as much text to the role of hypertension, smoking, a high fat diet, and other components. I found no direct mention of this issue by Greer nor by the authors in the Claman and the Taylor and Sumrall volumes. Sheehy's entire exposition of the matter is consistent with the ideology of the medical model, and Doress and Siegal uniformly present the feminist position. Sand, Barbach, and Callahan present mixed treatments of the subject.

Sheehy seems to imply that heart disease is virtually inescapable for women who do not take estrogen after menopause. She reports that "[w]hen a woman stops producing estrogen, her 'good' cholesterol (HDL) level falls. 'Bad' (LDL) cholesterol levels start increasing during the transition into menopause . . .. Thus begins for women the narrowing of arteries that will gradually expose them to the cardiovascular disease from which estrogen protected them during their fertile years" (76).

Similarly, Sand asserts that "when estrogen levels decline, . . . the risk of heart attack and stroke increases dramatically" (172-173). However, Sand does expand the scope of her discussion to include the role of other factors, such as a diet rich in fats and a sedentary lifestyle (174-175). Barbach, too, comments on the role of postmenopausal blood lipid changes in heart disease in women, but she also lists other risk factors, including smoking, overweight, heredity, a high ratio of HDL to total cholesterol, and hypertension. Susan R. Johnson and Kristi J. Ferguson cite changing blood lipid profiles as a major risk factor for cardiovascular disease in their essay, "Making a Reasoned Choice about Hormone Replacement Therapy" (Callahan 139).

Two other writers in the Callahan work, MacPherson and Voda, take a more feminist stance on this issue. MacPherson discusses diabetes and oral contraceptives as well as other previously-mentioned risk factors for heart disease (149-151). She urges further study on aging, rather than on menopause, as the primary cause of cardiovascular disease in older women(152). She also asserts that "'[f]eminist distrust' [a phrase coined by Shulamit Reinharz] is currently called for in analyzing the medical reductionist focus on cholesterol levels as the major risk factor for CVD in postmenopausal women." She notes that epidemiologists consider menopause "a nondiscriminating variable in studies of women's health" and further asserts that "currently there is no evidence from vital statistics data that natural menopause per se (emphasis in original) increases risk of CVD." MacPherson contends that well-established risk factors such as hypertension, smoking, and family history, are "so predictive that they overwhelm the hypothesis of causation related to menopause alone" (155).

Voda also stresses the multifactorial nature of heart disease. She asserts that "[n]o data are presently available to document how lipid metabolism changes from pre- to postmenopause or whether changes that do occur place women at risk for heart disease" (180). Voda examines at length reports from The Nurses' Health Study, widely cited in the medical literature as evidence that taking estrogen produces a significant reduction in coronary-artery disease in postmenopausal women. She notes problems of design and methodology with this and other studies on the question of estrogen and heart disease. She also points out that various studies have produced conflicting results. She questions

the validity of using "indirect indicators," such as levels of lipoprotein cholesterol, "to support the assumption of an increased risk for heart disease in postmenopausal women" (177-180).

Doress and Siegal's treatment of this subject focuses on promoting understanding of the risk factors so that women may "make changes to improve [their] health and reduce the risks." Their exposition includes most of the factors previously mentioned. In addition, they mention stress as a possible contributor to cardiovascular disease, a component not alluded to by the other writers (317-318).

In summary, a few female authors, in agreement with the medical model, opine that menopause is a chief cause of cardiovascular disease in older women, but more of the women's accounts advance the feminist view that a large number of other more important factors contribute to this disease.

On the question of insomnia occurring during menopause, most of the women writers were more aligned with the biomedical paradigm in both mentions and page space. I found 18 references and nearly four pages devoted to insomnia resulting from hot flashes and night sweats, while there were only three references and slightly more than two pages attributing sleeplessness to other causes. All the works allude at least once to insomnia connected with manifestations of menopause. Only Greer and Doress and Siegal mention agents other than menopause that might contribute to sleep problems. The other writers' discussions of insomnia focus entirely on the role of hot flashes and night sweats resulting from the climacteric.

The majority of Greer's discourse on "nocturnal wakefulness" is concerned with changes in sleep patterns and requirements brought about by aging. Asserting that sleeplessness "is not necessarily a disadvantage," she points out that in many primate societies "the older members of the group are on watch at night, when the young are sunk in slumber." This circumstance, she maintains, "has an obvious function in ensuring the survival of the group and has probably been selected for." In addition, she notes that "[t]he wee small hours belong to older women," who treasure this time when they can be alone and free of the demands of other people in the household (138-139). Nonetheless, Greer is the only writer in the sample who attempts to portray wakefulness in a positive light.

Doress and Siegal comment that sleeplessness caused by hot flashes "can cause fatigue, irritability, and feelings of inability to cope similar to depression" (122). However, the section of their volume about coping with insomnia mentions many contributing factors other than menopause and offers suggestions for lifestyle changes which may help promote restful sleep. Among the causes of wakefulness they cite are: changing sleep patterns, worries and depression, late meals (especially those high in sugar), unsuspected caffeine in soft drinks or chocolate, vitamins B or C taken before bedtime, insufficient dietary protein, an over-active thyroid, smoking, and a long list of prescription and over-the-counter drugs (32-33).

The other women in the sample uniformly concentrate on menopause as a source of insomnia and view the loss of sleep as a major tribulation of the climacteric. Several

women mention that it was this vexation that initially prompted them to visit a physician and/or opt to take HRT. Evelyn M. Parke's account in the Taylor and Sumrall volume is representative. She writes, "I would fall asleep and after about 15 minutes heat up with a hot flash, and wake up, throw the covers off, and go back to sleep. Then . . . I would cool down and wake up, freezing . . .. This went on all night, every 15 or 20 minutes, night after night after night . . .. It was making me crazy" (7-8). The striking consensus in this sample between women's accounts and the biomedical model on midlife insomnia would seem to suggest that the medical paradigm in this case is an outgrowth of physicians' clinical experience with a problem common to many menopausal women.

The final question in the theme of menopause as pathological or nonpathological concerns whether the women writers view midlife depression and other psychological problems as the result of menopause or of other causes. On this issue, too, the data totals are mixed and show women's accounts giving equal numbers of mentions (21) to menopause and to other sources. However, once again the preponderance of the text is in accord with the feminist contention that the majority of psychological difficulties in aging women do not originate from the climacteric itself. The women's accounts had far more to say on this subject than on any other issue in the pathology theme. I tallied nearly 34 pages of text devoted to this debate. Sand's and Barbach's treatments primarily agree with the biomedical construct that hormone fluctuations during menopause induce psychological problems. Sheehy, Claman, Taylor and Sumrall, Callahan, and Doress and Siegal present both sides of the issue; Greer gives voice to the feminist argument.

Sand does not address the problem of depression, mentioning it only as a possible side effect of HRT. Her commentary on the issue of psychological problems is brief and limited to a description of a friend's difficulties with memory loss. In her typically breezy fashion, Sand describes the woman as "a first-class travel agent whose memory took a vacation during menopause" (115). Barbach deals much more extensively and thoroughly with the subject of psychological distress during menopause, which is not surprising given her background in clinical psychology. Although she pays some attention (slightly more than a page) to external stress as a component in emotional problems, the bulk of her discussion (more than 11 pages) is related to the effects of shifting hormones. Her chapter on this subject is titled "Riding the Emotional Rollercoaster" (29). She asserts that "[e]motional upheavals are a common accompaniment to The Pause. A disequilibrium in hormones can produce a disequilibrium in emotions for many women" (31).

Sheehy begins her exposition by noting that the association of depression with menopause has been "a subject of intense debate" (70). She takes an intermediate position in the controversy. "It is true," she states, "that clinical depression subsides in women over fifty" (emphasis in original) and that "irritability and depression in middle-aged women do have many other sources." "But," she asks, "mood changes are so commonly mentioned by women in the perimenopause phase, why should women be told there is no hormonal basis for feeling depressed?" (71). Similarly, Pat Rhoda's essay "This Is Living" in the Taylor and Sumrall anthology delineates some of the external

factors for emotional upsets: "memory loss because you're easily distracted due to increased concerns at this time of life; and nervousness, anxiety, or depression because of lack of support from family and friends, increased outside pressures, and children leaving the nest." She also comments, however, that "if anything can make one's brain sluggish and cause depression, lack of sleep from night sweats is on the top of my list" (58).

Greer mentions that "[m]any women feel during the climacteric that they are changing personality." Although she does not state that her description of this phenomenon is drawn from personal experience, this passage in her text is striking in its intensity. She writes that the "most unnerving, even terrifying, change is a sudden horrible propensity to blind rage." She asserts that this "choking rage," often "accompanied by a feeling of physical anxiety, amounting to pain, . . . is the reality behind what doctors refer to rather prissily as 'irritability'" (101). The remainder of her account is largely historical and anecdotal and is highly critical of the medical establishment's misunderstanding and maltreatment of menopausal women suffering from depression and other psychological distress. She suggests a multipicity of causative factors, ranging from lead pollution to societal attitudes toward aging women.

The most intriguing argument on the feminist side of the debate is presented by Jill Rips. In her essay "Who Needs a Menopause Policy?" (in Callahan), Rips challenges "the direction of causality between psychological and physiological phenomena" and comments that the "ovarian determinism of the nineteenth century seems to have been replaced by hormonal determinism in the late twentieth century." She asserts that "the

question of etiology between feelings and hormones is crucial here," noting that physicians posit hormonal fluctuations "to be the cause of changing emotions." She suggests, conversely, that emotions "contribute to hormonal changes" as evidenced by the "well-documented, but poorly understood" occurrences of "stress-delayed cycle and menstrual synchrony." Depression during menopause may, therefore, actually be "the effect of women's accession of lower self-worth resulting from society's view and treatment of menopausal and aging women." Hence, Rips contends, "byproducts of gender inequality come to be regarded as individual difficulties. Consequently, individual solutions are sought for collective problems resulting in individual acquiescence and acceptance, rather than group empowerment" (85).

All of the women writers seem to be in agreement that emotional upheaval is a common event at menopause. Differences of opinion hinge on whether or not the climacteric itself is the primary source of these problems. While these women writers mention menopause as often as they mention other causative factors, most of them devote the majority of their text to discussions which agree with the feminist model.

To summarize my findings from the women's accounts on the pathology theme, the data indicate that many women perceive of menopause as pathological, notwithstanding their protestations to the contrary. I found this to be particularly evident in the pervasive practice of referring to physical signs of the climacteric by the medical term "symptoms," suggesting the presence of a disease or an abnormal condition. The influence of the biomedical paradigm was also especially apparent in many women's

commentaries on insomnia and psychological distress. However, the data totals of this theme indicate slightly more mentions and nearly twice as much page space in accordance with the feminist model. It is notable that in regard to osteoporosis and cardiovascular disease, two maladies which the medical "experts" and the pharmaceutical industry have attempted to link inextricably with menopause, the majority of female writers in this sample agree with the feminist precept that these conditions have complex, multifactorial origins.

The degree to which women experience difficulty with menopause and the extent to which they associate it with pathological conditions, such as osteoporosis, heart disease, insomnia, and depression, undoubtedly determine whether or not they seek medical treatment and how closely they comply with their doctors' recommendations regarding hormone replacement medication and other therapeutic measures. The next section of this investigation explores women's discourse on the various options of menopause treatment.

Theme V: Views Regarding Treatment/Therapy

Some women writers in this sample seem to regard medical care as a real necessity during the climacteric and wax rhapsodic on the palliative effects of HRT on their menopausal "symptoms." Nevertheless, on these two subjects, as well as the question of alternative therapies, I found a striking difference between the attitudes of the women authors and those of the writers in the other two sample categories in this study.

While the physician-authors of gynecology texts and popular advice books strongly and nearly unanimously advocate special medical care and HRT for menopausal women, women writers themselves evince a far wider range of opinions on these issues. In regard to medical care and HRT, feminist arguments dominate the discourse in mentions as well as in amounts of page space. However, this finding is again more substantive in regard to page space, with nearly equal numbers of mentions given to both sides of the debate. The female writers are also in agreement on the necessity of lifestyle changes and are enthusiastic advocates of nonpharmaceutical treatments.

On the far-reaching question of whether or not menopausal women need hormone replacement treatment, Barbach and Sand exemplify most closely the position of the biomedical model. Sheehy is another strong proponent of HRT, but she also includes some of the feminist arguments against wholesale use of estrogen and progestin and seems to favor short-term rather than extended treatment. Authors in the Taylor and Sumrall, Claman, and Callahan volumes also present both sides of the issue, with more weight given in all these books to feminist opinions. Greer and Doress and Siegal steadfastly oppose the widespread treatment of menopausal women with hormones.

Barbach gives a great deal of attention to this topic with more than five pages of text advocating the use of HRT. Although she stresses that taking hormones is an individual decision and that not all women need them, she recommends HRT for nearly every conceivable complaint linked to the climacteric. These include: emotional problems (43), insomnia (62), joint and muscle pain (71), "gastric upset" (72), vaginal

dryness (124-126), increased sexual sensitivity (127) and desire (133), "mental fog" and irritability (151), heart disease (203-204) and palpitations (254), fatigue (251), skin sensitivity, breast tenderness (252), urinary difficulties (253), hot flashes (253), heavy menstrual periods, hair loss, unwanted hair growth (254), dry skin (255), and osteoporosis (256).

Sand's book is, in essence, an apologia for her own decision to take HRT. She begins by stating that she believes menopause is a "natural process" and that she does not "believe in hormones." "It is not natural to put hormones made from the urine of a horse in my system. Any claims to the contrary," she initially declares, ". . . are pure horse manure" (55). In a rather lengthy subsequent section, she raises many of the feminist objections to hormone treatment (58-62), and throughout the book she relates her experiments with alternative therapies. Ultimately, however, Sand is convinced by the advice of two female physicians, "professionals I respect," that taking HRT is in her best interests, particularly in the prevention of osteoporosis. "According to them," she relates, "HRT will take me from the hormonal hell of menopause and osteoporosis and deliver me to the carefree kingdom of hormonal heaven" (86). After taking HRT for a year, she reports herself free from a long list of "symptoms" and "consequences" of menopause. "My doctor was happy with my progress; I was ecstatic" (201). Thus, she changes over the course of her book from a sceptic to an enthusiastic convert to HRT.

While engaged in this research project, I attended a lecture on menopause presented by Sand and sponsored by the Sentara hospital system. There were several

hundred women in attendance that evening at a hotel in Virginia Beach, Virginia. Sand's talk was taken almost verbatim from her book. During the course of the event, attendees were given packets of information on menopause by Sentara personnel. Five of the pamphlets included in the packets were provided by Wyeth-Ayerst laboratories, manufacturers of Premarin. All but one of these brochures stress, not surprisingly, the use of estrogen therapy in "controlling" the "problems of menopause" such as "hot flashes/night sweats," "cholesterol," "osteoporosis (bone loss)," and "changes in vagina/urinary system."

Also included in the information packet was a short but revealing treatise on "The Menopause" by David F. Archer, M.D., a professor of obstetrics and gynecology at Eastern Virginia Medical School (EVMS). The article describes the "symptoms" of "ovarian failure" and is a nearly perfect concise representation of the medical model. Most telling, however, is a section with a large photograph of a woman lying on a large device used to measure bone density. The article reports that the "dual x-ray bone densitometer" was acquired by EVMS thanks to a "large grant" from, among other donors, Wyeth-Ayerst Laboratories. Sand's book, in my opinion, is a prime example of how some women's experiences and perceptions of menopause are used by the medical and pharmaceutical industries to "sell" the "need" for medical treatment and HRT to large numbers of other menopausal women by playing on fears which have been largely manufactured by the medical establishment.

Both sides of the HRT dilemma are effectively presented in Claman's anthology.

Ingrid Reti's poem "The Choice" poses the problem by paraphrasing Hamlet: "To take estrogen, or not to take estrogen: that is the question" (97). Lynne Walker, having made her decision, expresses her feelings about it in the first verse of her poem "For Brenda Star:"

> The doctor prescribed
> estrogen and progesterone.
> I can take them
> as long as I want to
> stay young.
> I feel good--like
> Mae West in combat boots,
> Mona Lisa with eyebrows,
> an over-sexed Squeaky Fromm. (96)

The reader can only wonder about Walker's choice of icons.

In the same volume, Elisabeth Holm elucidates her reasons for rejecting HRT in her essay "Escaping Eternal Compulsory Femininity: The Estrogen Question." She had begun a trial course of HRT on the recommendation of her physician although she was disturbed by "the grotesquery of being eighty and still bleeding every month." However, two subsequent events led to her decision to discontinue hormone therapy. First, she attended an "informational meeting on ERT, which had been promoted by the largest local hospital in town," a milieu very similar to the seminar I attended at which Sand spoke. "More than the words from the podium, however, the very scene in that ballroom was illuminating. If most of those women bought one pill a day for the rest of their lives as the presenters recommended, someone would stand to make a fortune!" she concluded (98-99). Second, she was horrified by the "reductionism" of a "bright young orthopedic

physician" whom she consulted on the advisability of HRT. "His answer was rehearsed and succinct and emphatic: If I got breast cancer 'they' could take off my breast; and if I got cervical cancer 'they' could take out my uterus, but if I got osteoporosis and broke my hip, 'they' couldn't help me. ERT was the way to go." She noticed that she "had been consigned to the dependent clauses" of his statement while the "subject of both parts of the compound sentence had been the collective surgeon" (100). She soon stopped taking estrogen and asserts that she is now actively caring for her own health and trusting her body "to do its own aging without interference" (101).

Greer's critique of the avid promotion of HRT by physicians and multinational pharmaceutical companies is scathing, sarcastic, and full of dark humor. Her book contains more than six pages of commentary on this issue. She avers that the "obstacle to understanding here is the defect that disfigures all gynecological investigation: we do not know enough about the well woman to understand what has gone wrong with the sick one." She further asserts that "[g]ynecologists are like motor mechanics who have never worked on a car that actually went" (143).

Greer scoffs at the male "experts" on menopause such as Wulf Utian and their concept of "menopause management," contending that their research on HRT "is characterized by poorly designed studies reflecting an unacceptable degree of bias" (13-16). Calling estrogen "the biddability hormone," she scoffs at Utian's promotion of it as a "mental tonic," insisting that it produces instead a "contented cow syndrome." "The possibility," she comments, ". . . that menopause puts women back in touch with their

anger after thirty-five years of censorship by estrogen is delightful to contemplate" (118). Greer argues that the "Masters of Menopause" are motivated not by a desire to "relieve the anguish" of women but by a "need to show that women cannot manage their own lives without the aid of men, a delusion that women themselves have gone some way to foster." The menopausal woman, she contends, is therefore "defined as suffering from a deficiency disease, and men will once again demonstrate their superiority by supplying the remedy for her defect" (18-19).

Doress and Siegal also question the validity of most research on HRT, criticize "the hormone industry," and state their belief that it is "unethical and medically unsound to prescribe hormones for all menopausal women." Furthermore, their volume warns women in bold print: "Be aware that the effects of long-term use of progesterone are not known." They list among the iatrogenic effects of progestin that it "can cause changes similar to those of diabetes, can unfavorably alter blood fats and . . . increase the risk of heart disease and strokes, and may stimulate the growth of breast cancer cells" (270-271).

I found the most extensive treatment of this subject in Callahan's work. Part two of the volume is entitled "The Hormone Replacement Therapy Debate" (121). The great majority of the material therein is feminist in orientation, with HRT recommended only by Susan R. Johnson and Kristi Ferguson in their essay "Making a Reasoned Choice about Hormone Replacement Therapy" (136). Upon noticing extensive use of the term "estrogen deficiency" in this article, I investigated and discovered that Johnson is a medical doctor and Director of the Menopause Clinic at the University of Iowa Hospitals

and Clinics. This explains her adherence to the biomedical paradigm in enthusiastically advocating HRT and downplaying the importance of its contraindications and possibly carcinogenic consequences (140-142).

In contrast, Kathleen MacPherson's essay in the Callahan work examines from a feminist perspective the "false promises" offered to women throughout the history of HRT and the "current dilemmas" of hormone therapy (145). She cites the risks of breast and cervical cancer, and, like Doress and Siegal, warns of the unknown effects of progestins in postmenopausal women, whose "natural progesterone levels are extremely low." She asserts that the prescription of progestins is an "untested hormonal experiment" (154) and that the long-term use of HRT is a potentially "reckless endeavor" (155). However, MacPherson states, "[o]ne thing is certain--women should inform themselves as thoroughly as possible before accepting HRT" (156).

Ann Voda bases her discussion of this issue on a detailed physiological analysis of "sex hormones as metabolic regulators" (Callahan 167). She stresses that hormones are powerful steroids, normally "present in the blood in very low concentrations." Voda presents astonishing facts on the daily dosages of estrogen and progesterone commonly prescribed for menopausal women and concludes that the pharmacological dosages are "more than a million times greater" than the natural physiological concentrations of estrogens and progesterone circulating in the blood prior to menopause. In addition, she notes that the structural similarity of all steroids enables the estrogen and progestins of HRT "to bind with receptors for other steroids and turn them on. That is, they activate

the DNA in cells other than those in reproductive target tissue" (169). Voda warns of the potential cumulative ill effects of "well women . . . manipulating and altering the function of their DNA with steroidal hormones" in the form of birth-control pills, ERT, and now HRT for a period of more than twenty-five years. She asserts that the "indisputable result of this manipulation has been a prescription for hazard and even death for some women" (185).

Voda concludes that "using hormones to intervene in a natural process is unhealthy and unethical." Furthermore, she contends, the argument regarding potential risks versus benefits of HRT "has been illogically conceived, since risk/benefit criteria for drug use in healthy people is not the same as it is for sick people." She declares that "well-intentioned but ill-informed mythologies" about female reproductive processes "thrive at the very highest bureaucratic levels of health care" (188).

Finally, Voda denounces the much-touted postmenopausal estrogen/progestin interventions (PEPI) multisite research project funded by the National Institutes of Health. This huge study seeks to determine the optimum amounts and combinations of HRT for women in their postmenopausal years. Unfortunately, Voda avers, "[t]he theoretical framework in which this research is grounded is Wilson's ideology of women as estrogen deficient at menopause." Instead of pursuing "answers to how women can most healthily live their lives," it attempts "to cure women of being women" (188-189). In summary, on the important issue of HRT women writers in this study express feminist opposition in both mentions and page space to the current medical trend of

recommending HRT for nearly all women. The margin of disagreement is again more apparent in regard to page space.

The patterns of the data on the question of medical care for menopausal women are similar to the patterns for HRT, with the feminist model predominating. The female authors did not, however, write nearly as much on this topic as they did on the hormone debate. References to the feminist model regarding health care slightly outnumber references to the biomedical notion that women should seek specialized health care for menopause and take care to find the "right" physician. In terms of page space, feminist opinions are also in the majority by a ratio of three to two. On this subject, Sheehy's and Barbach's discourses more closely resemble that of the biomedical model; the Taylor and Sumrall volume presents both sides of the issue, as does Sand. Greer, Claman, Doress and Siegal, and Callahan proffer the feminist premise that good general medical care suffices for the great majority of women during and after menopause.

Sheehy advises women to "find a topnotch physician partner to help you manage your menopause transition" (133). Barbach makes the brief statement in the beginning of her book that "not every woman needs to be treated when going through The Pause" (9). However, in a much longer section titled "Finding the Right Physician" she notes that "most gynecologists and family doctors can't keep up with recent discoveries and theories about how to treat women during The Pause." Thus, she recommends contacting the North American Menopause Society for referral to a specialist (166-167).

Sand devotes more than six pages to her discussion on finding the "right" doctor,

but some of her advice is closer to the feminist model in that she urges women to ask questions, resist feeling intimidated, make their own decisions regarding treatment, "take charge," and select "a doctor who shares your values" (23-28). Nevertheless, her attitude toward medical care during menopause changes over the course of her book in much the same way her approach toward HRT did. At first she asserts, "I don't need a doctor. All I want to do is see someone who will treat me like a normal healthy menopausal woman" (131). However, by the end of the book, she writes that modern women do not have to be "casualties of menopause" since they have "the luxury of climacteric medicine and full-service menopause clinics. . . . Many of the problems of menopause can be prevented if handled early enough" (188). Clearly, she regards specialized medical care as a necessity during the climacteric.

Greer, as previously noted, is very critical of the medicalization of menopause and writes an entire chapter on "Medical Ignorance" (140). She asserts that "[m]enopause is a dream specialty for the mediocre medic," requiring "no surgical or diagnostic skill." There is little risk of malpractice suits, she argues, and "[p]atients must return again and again for a battery of tests and check-ups," all of which contribute to the profits of physicians (15). Greer concludes her chapter on "The Unlucky Ones," women who experience difficulties during menopause, with the statement that those "who imagine that the solution to the complex of problems they must surmount during the climacteric can be supplied by the medical establishment have historically turned out to be the unluckiest of all" (102).

The Doress and Siegal work contains no section on medical care for menopause as such, which is a strong statement by virtue of omission. Their emphasis is rather on menopause as a normal part of female aging and on "the self-help approaches women have found to deal with menopausal discomforts and to avoid drugs and surgery" (118). They note that the American health care system "is geared to medical intervention for acute medical problems;" hence menopause has been defined as such rather than the normal life event it is (xxiv).

Jill Rips' essay in the Callahan work condemns medical "policy based on the reproductive/postreproductive dichotomy" that mandates "special health-care services, such as menopause clinics." She maintains that "defining women in terms of their reproductive status . . . does not serve women well, either in their reproductive or postreproductive years." Rips further asserts that most women do not consider "medical or psychological intervention" necessary during menopause. She concludes that special menopause clinics are therefore "neither necessary nor desirable" (86).

In summary, the majority of the female writers in this sample expressed opinions consistent with the feminist premise that while good general medical care is as essential during menopause as it is during any other stage of the life cycle, the climacteric in and of itself does not necessarily require medical intervention.

All the works by women included commentaries on lifestyle changes that could replace or supplement medical treatment to enhance health and well-being during and after menopause. Greer summarizes the situation well with her statement that during the

climacteric "one thing becomes clear, that is, that we must work at being healthy. We can no longer abuse the organism and get away with it" (215). Greer's emphasis in this subject is consistent with the remainder of her discourse. She concentrates not on menopause itself but on menopause within the general context of women's aging.

The women's accounts proffer an immense variety of suggestions on positive changes in diet, exercise, rest and relaxation, and relinquishing harmful habits. Among the things nearly all of them urge their readers to avoid are foods high in protein and fat, a sedentary lifestyle, stress, caffeine, tobacco, and alcohol. Sheehy cautions against strenuous efforts at weight loss (96). Other writers specifically recommend increased water intake (Greer 217), dietary inclusion of plants containing phytoestrogens (Taylor and Sumrall 295), dressing in layers to cope with hot flashes (Barbach 90 and Doress and Siegal 123), the practice of yoga (Sand 118), and avoidance of antihistamines and decongestants when vaginal dryness is a problem (Barbach 122). The Doress and Siegal volume contains the largest amount of material on this topic (more than 44 pages), with entire chapters on nutrition, exercise, and "habits worth breaking" (22). Sand and Barbach also incorporate sizeable sections of text advocating lifestyle changes in their works, nearly 34 and 20 pages respectively.

One of the most unusual and salutary forms of life-style modification is recounted by Chris Karras in her essay "Unexpected Changes" in the Taylor and Sumrall anthology. Karras describes her "intense urge to live alone" and need for distance from her spouse. The "mutually beneficial solution" was to establish her own exclusive living space in a

semi-detached portion of their residence. This "unusual and intuitive . . . living arrangement," she asserts, "did infinitely more for me than hormone replacement therapy, mood-altering drugs or tranquilizers, so often prescribed for 'difficult' women like me, could ever have done. Having my own apartment in my own house as well as our shared space was nothing short of therapeutic" (308-309).

The women's accounts were unanimous in advocating the benefits of a large variety of healthful lifestyle modifications for improving the quality of life during menopause.

One of the most striking findings of this study is the amount of attention given to alternative therapies by the women writers. While this subject is, not surprisingly, virtually ignored by the authors of gynecology texts and given cursory notice by most of the physician/writers of popular advice literature, women's accounts mention alternative and/or nonpharmaceutical remedies 73 times and devote more than 80 pages of text to their discussion. Furthermore, the authors of the other two sample categories generally confine their treatments of the topic to Kegel exercises, vaginal lubricants, and vitamin supplements. In contrast, the women writers mention and/or recommend a multipicity of nonmedical countermeasures for the discomforts and problems encountered by menopausal women.

In addition to the three alternative treatments previously mentioned, women discuss numerous other physical, as well as mental, spiritual, and social palliatives for ills associated with the climacteric. Greer devotes a whole chapter to alternative treatments.

Among the measures she mentions are homeopathy (218), ginseng (219), hypnosis (220), auto-hypnosis (221), meditation and biofeedback (222), and various herbal preparations (230-232). But the practice of gardening, she opines, "is the best alternative therapy" (234).

Sand recommends many of the same nonmedical options as the other women writers. However, she also suggests yogurt (both eaten and applied) and acidophilus capsules for the prevention of vaginal yeast infections (110). The female authors of the Taylor and Sumrall anthology also have a great deal to say on the subject of alternative therapies. In addition to those previously mentioned, their recommendations include stress reduction techniques such as progressive relaxation (293); acupuncture, massage, hydrotherapy, and aroma therapy (294); marijuana tea (298); and prayer, Tai Chi, and the Buddhist practice of Mindfulness (355-356). Doress and Siegal add music, imagery, friendship, and support groups to the already-lengthy list of methods for coping with menopause and aging. They also recommend enjoyable hobbies and adult education (14-21).

Barbach incorporates more material on alternative therapies than any other author in this subsample. Her book contains more than 38 pages on the subject, and, like Greer, she includes an entire chapter on nonmedical treatment options. Many of these have already been enumerated in connection with other writers. In keeping with her psychological specialty, she recommends counseling for women experiencing emotional difficulties (54). As previously noted, sexuality is another of Barbach's areas of

expertise. She advises that "in the best interests of your vagina, and possibly your psyche," menopausal women masturbate regularly, as a substitute for or in addition to sex with a partner. She also suggests the use of dildos or vegetables such as "carrots, zucchini, and cucumbers" to stretch the vagina and "ease painful intercourse" (130-131).

The tendency of the women writers in this sample to de-emphasize medical intervention and advocate a broad spectrum of alternative coping mechanisms for difficulties associated with menopause seems to reflect women's more holistic view of this universal female transition. While the physicians (in both gynecology texts and popular advice books) recommend HRT more often than either lifestyle changes or alternative therapies, the women writers favor modifications of lifestyle and nonpharmaceutical measures over HRT. By a margin of more than four to one in mentions and ten to one in page space, data totals for the theme of views regarding treatment indicate agreement of the women's accounts with the feminist paradigm.

To summarize my findings from the women's accounts, the grand totals of the data show more agreement with the feminist model of menopause by a ratio of two to one in mentions and four to one in page space. The Doress and Siegal work adheres most closely to all the tenets of the feminist paradigm. However, all the other books exhibit to some degree the internalization by their authors of aspects of the biomedical "disease" model. This trend is most striking in the widespread use of the term "symptoms" when referring to the physical signs of the climacteric. It was also noticeable to a lesser extent in discourse on the loss of reproductive function, hormone levels, vasomotor fluctuations,

insomnia, and depression. Sand seems to have been the most strongly influenced by the concepts of menopause and its treatment characteristic of the medical model. Thus, while the feminist model dominates the discourse in the women's accounts, the power of the negative medical and cultural ideology of menopause to influence women's perceptions of the transition and to convince them of the "necessity" for medical intervention is readily apparent.

CONCLUSION

In this study, I have delineated two distinctly different paradigms of menopause: a biomedical model which defines menopause as pathological and menopausal women as "hormone deficient" and a feminist model which defines the climacteric as a normal, often felicitous, passage of female life. As expected, gynecology texts exemplify the biomedical "disease" model of menopause more completely than either of the other two classes of menopausal literature I examined. Drawing their data and experience from a clinical population, the medical "experts" uniformly portray the female midlife transition as a process of hormonal deficiency and pathological decay requiring specialized medical care and intervention in the form of hormone replacement therapy.

Nearly all the popular advice books by physicians I analyzed appear to have been strongly influenced by the negative medical ideology on menopause as well. Most of these books, which purport to inform women about menopause, in fact present a biased and largely negative medical-oriented view of the midlife transition. This paradigm, scientifically and culturally constructed and transferred via these books (and other public media beyond the scope of this paper to enumerate) to women in or approaching menopause, has enormous power to affect the way in which they regard their own menopausal experience. It also influences them to comply more readily with increasing medical and social pressure to take hormones. The medicalization of menopause by the hegemonic medical and pharmaceutical industries has tremendous potential for enriching

their coffers while placing women at risk for breast cancer and other iatrogenic effects of powerful steroid hormones.

A feature of the popular advice books that appears to more closely resemble the feminist model is the significant amount of material they incorporate advising menopausal women to make healthy changes in their lifestyle. Even so, they seem to advocate lifestyle changes primarily as adjuncts to, not substitutes for, their treatment of choice: hormone replacement therapy. I believe that the emphasis in these books on nutrition and exercise is largely a function of the current accent on healthy living in American culture. Furthermore, several of the authors imply that wholesome food, regular exercise and the relinquishment of harmful habits are necessary not only for health reasons but in order for aging women to maintain a youthful, and therefore "attractive," appearance.

It is important to realize that, as Joy Webster Barbre has written in her essay "Meno-Boomers and Moral Guardians: An Exploration of the Cultural Construction of Menopause," these books reflect the contemporary notion that "today's ideal woman, whatever her age, is youthfully attractive and physically fit" (Callahan 33). Moreover, these books, unlike the gynecology texts, are "reader friendly," produced for mass audiences, and written by "authorities" who ostensibly seek to help women "survive" or "manage" their menopause. They are, therefore, a uniquely powerful and persuasive tool for convincing women that menopause is at least a medical event and quite possibly a medical crisis.

Conversely, the women's voices I surveyed speak eloquently of the great diversity of menopausal experiences and coping strategies. Some women describe severe problems associated with menopause: horrific hot flashes, disruptions in their sex life, disturbing mood swings, insomnia, and other maladies. On the other hand, many women experience few or minimal difficulties during the climacteric and do not dread its onset. In fact, women frequently write that they welcome the midlife transition since it may offer opportunities for personal growth and freedom from caretaking and from reproductive worries. The great majority of women assert that the climacteric is a normal part of female life and not a pathological state or an occasion requiring medical intervention. Rather than advocating wholesale use of hormones, women writers offer a multitude of suggestions for nonmedical, alternative therapies for the problems they encountered during the climacteric.

While the authors of gynecology texts and popular advice literature tend to see menopausal women primarily as a generalized group, female writers are much more inclined to concentrate on women as individuals. As Cynthia Russett has noted, "the normal practice of science" powerfully supports the medical view. Scientific method encourages physicians to classify and categorize menopausal women and generalize about menopause by focusing "on the larger collectivity rather than on the single individual" (193). Furthermore, as Geri L. Dickson notes in her essay "Metaphors of Menopause: The Metalanguage of Menopause Research," "science's very language builds certain images of social reality through the words and rules of the language"

(Callahan 37). Thus, women's accounts present a much more varied, multi-faceted, and accurate portrayal of menopause than the other two classes of literature. And while gynecology texts and popular advice books tend to focus on the physical aspects of female aging and menopause, women's discourse on the subject includes significant amounts of lively commentary on societal, psychological, and spiritual issues.

As during the Victorian era, radical changes in American patterns of work and family life have occurred in the last thirty years of this century with a resurgence of the feminist movement and more women pursuing careers and activities in the public sphere than ever before. These changes have produced widespread anxiety and social instability with a resultant cultural misogynistic bent, a resurgence of conservatism, and a backlash against feminism. The extensive public dissemination of negative ideology about menopause and the vigorous promotion of hormone replacement therapy for the prevention of osteoporosis, heart disease, and other horrific "consequences" of an unmedicated menopause may be seen as a form of hegemonic medical social control. Barbre states that the current scientific medical pronouncements on menopause as a pathological condition requiring medical "management" and drug therapy serves to bolster patriarchal notions of "women's biology, women's social roles, and women's aging" (Callahan 33). The image of an out-of-control crone is, I believe, one of the most terrifying nightmares of patriarchal culture. It is hard, therefore, to imagine a more effective way of defusing this "threat" than to convince women at the peak of their power that they are ill (or becoming so) and desperately in need of medical guidance and drug

therapy.

I would assert that it is vitally important that women seeking information on the menopausal passage read as widely as possible before making a personal decision to seek medical treatment for menopausal difficulties. I believe it is crucial for mature female well-being that we examine the discourse of other women on the subject of menopause before we allow ourselves to be influenced by the ideology of the dominant patriarchal biomedical view which overwhelmingly monopolizes the popular media.

Lois Banner asks, "Should women, by their silence, allow the medical profession to assert, by default, the predominating voice in the definition of menopause" (309)? I contend that menopausal and postmenopausal women must answer with a resounding "no!" We must, in the intellectual and political tradition of Antonio Gramsci, continue to explore and elucidate through our writing our own vision and experience of menopause in order to create for ourselves a new and healthier paradigm. We must continue to give voice to the pain and the power of a uniquely female journey. We must define for ourselves this singular passage in the terms of standard language and, whenever necessary, coin new terms to validate and entitle ourselves as aging "wise women." In this regard, Christine Downing's statement about why she chose to write about her own menopausal journey is particularly compelling: "I believe that as we find ways of speaking of the difficult and deep and joy-bringing experiences associated with the birth of our postmenopausal selves, we do true service to our sisters and to our species" (54).

WORKS CITED

Banner, Lois W. In Full Flower: Aging Women, Power, and Sexuality. New York: Vintage, 1993.

Barbach, Lonnie. The Pause: Positive Approaches to Menopause. New York: Signet-Penguin, 1994.

Bell, Susan E. "The Medicalization of Menopause." The Meanings of Menopause: Historical, Medical and Clinical Perspectives. Ed. Ruth Formanek. Hillsdale, NJ: Analytic, 1990. 43-63.

Benjamin, Fred, and Vicki L. Seltzer. "The Menopause and Perimenopause." Gynecology: Principles and Practice. Ed. Zev Rosenwaks, Fred Benjamin, and Martin L. Stone. New York: Macmillan, 1987. 165-187.

Bleier, Ruth. Science and Gender: A Critique of Biology and Its Theories on Women. New York: Pergamon, 1984.

Bloch, Ruth H. "American Maternal Ideals in Transition: The Rise of the Moral Mother, 1785-1815." Feminist Studies 4 (1978): 101-126.

Budoff, Penny Wise. No More Hot Flashes and Other Good News. 1983. New York: Warner, 1989.

Callahan, Joan C., ed. Menopause: A Midlife Passage. Bloomington: Indiana U P, 1993.

Cherry, Sheldon H., and Carolyn D. Runowicz. The Menopause Book: A Guide to Health and Well-Being for Women After Forty. New York: Macmillan, 1994.

Claman, Elizabeth, ed. Each in Her Own Way: Women Writing on the Menopause. Eugene, OR: Queen of Swords, 1994.

Coney, Sandra. The Menopause Industry: How the Medical Establishment Exploits Women. Alameda, CA: Hunter House, 1994.

Dawood, M. Yusoff. "Menopause." Textbook of Gynecology. Ed. Larry J. Copeland. Philadelphia: Saunders, 1993. 619-640.

Doress, Paula Brown, Diana Laskin Siegal, and The Midlife and Older Women Book Project. Ourselves, Growing Older: Women Aging with Knowledge and Power. New York: Simon and Schuster, 1987.

Downing, Christine. Journey Through Menopause: A Personal Rite of Passage. New York: Crossroad, 1987.

Droegemuller, William, Arthur L. Herbst, Daniel R. Mishell, Jr., and Morton A. Stenchever. Comprehensive Gynecology. St. Louis: C. V. Mosby, 1987. 1082-1107.

Ehrenreich, Barbara, and Dierdre English. For Her Own Good: 150 Years of the Experts' Advice to Women. Garden City, NJ: Anchor, 1978.

Elgin, Suzette Haden. Native Tongue. New York: DAW, 1984.

Fausto-Sterling, Anne. Myths of Gender: Biological Theories about Women and Men. New York: Basic Books, 1985.

Fellman, Anita Clair, and Michael Fellman. Making Sense of Self: Medical Advice Literature in Late Nineteenth-Century America. Philadelphia: U of Pennsylvania

P, 1981.

Femia, Joseph V. Gramsci's Political Thought: Hegemony, Consciousness and the Revolutionary Process. Oxford: Clarendon, 1981.

Ford, Anne Rochon. "Hormones: Getting Out of Hand." Adverse Effects: Women and the Pharmaceutical Industry. Ed. Kathleen McDonnell. Toronto: Women's, 1986. 27-40.

Formanek, Ruth. "Continuity and Change and 'The Change of Life': Premodern Views of the Menopause." The Meanings of Menopause: Historical, Medical and Clinical Perspectives. Ed. Ruth Formanek. Hillsdale, NJ: Analytic, 1990. 3-41.

Gass, Margery L. S. "Physiology and Pathophysiology of the Postmenopausal Years." Gynecology and Obstetrics: A Longitudinal Approach. Ed. Thomas R. Moore, Robert C. Reiter, Robert W. Rebar, and Vicki V. Baker. New York: Churchill Livingstone, 1993. 883-898.

Gillespie, Clark. Hormones, Hot Flashes and Mood Swings: The Menopause Survival Guide. Rev. ed. New York: Harper, 1989.

Goodman, Madeleine J. "The Biomedical Study of Menopause." The Meanings of Menopause: Historical, Medical and Clinical Perspectives. Ed. Ruth Formanek. Hillsdale, NJ: Analytic, 1990. 133-155.

Greenwood, Sadja. Menopause, Naturally: Preparing for the Second Half of Life. Volcano, CA: Volcano, 1992.

Greer, Germaine. The Change: Women, Aging and the Menopause. New York: Fawcett

Columbine-Ballentine, 1991.

Haller, John S. and Robin M. Haller. The Physician and Sexuality in Victorian America. Urbana, IL: U of Illinois P, 1974.

Hellerstein, Erna Olafson, Leslie Parker Hume, and Karen Offen, eds. Victorian Women: A Documentary Account of Women's Lives in Nineteenth Century England, France, and the United States. Stanford, CA: Stanford U P, 1981.

Jovanovic, Lois, and Suzanne Levert. A Woman Doctor's Guide to Menopause: Essential Facts and Up-to-the-Minute Information for a Woman's Change of Life. New York: Hyperion, 1993.

Judd, Howard L. "Menopause and Postmenopause." Current Obstetric and Gynecologic Diagnosis and Treatment. 6th ed. Ed. Martin L. Pernoll and Ralph C. Benson. Norwalk, CT: Appleton and Lange, 1987. 959-978.

Kase, Nathan G. "Menopause." Principles and Practice of Clinical Gynecology. 2nd ed. Ed. Nathan G. Kase, Allen B. Weingold, and David M. Gershenson. New York: Churchill Livingstone, 1990. 337-359.

London, Steve N., and Charles B. Hammond. "The Climacteric." Obstetrics and Gynecology. 5th ed. Ed. David N. Danforth and James R. Scott. Philadelphia: J. B. Lippincott, 1986. 905-926.

Markens, Susan. "The Problematic of 'Experience:' A Political and Cultural Critique of PMS." Gender and Society 10.1 (1996): 42-58.

Martin, Emily. The Woman in the Body: A Cultural Analysis of Reproduction. Boston:

Beacon P, 1987.

McCrea, Frances B. "The Politics of Menopause: The 'Discovery' of a Deficiency Disease." Social Problems 31.1 (1983): 111-123.

Morantz-Sanchez, Regina Markell. Sympathy and Science: Women Physicians in American Medicine. New York: Oxford U P, 1985.

Nachtigall, Lila E., and Joan Rattner Heilman. Estrogen: Revised and Expanded. New York: Harper, 1991.

"The New Pill Book." Good Housekeeping. October 1993: 112-113+.

Notelovitz, Morris, and Diana Tonnessen. Menopause and Midlife Health. New York: St. Martin's, 1993.

Reinharz, Shulamit. Feminist Methods in Social Research. New York: Oxford U P, 1992.

Reuben, David R. Everything You Always Wanted to Know about Sex. New York: David McKay, 1969.

Russett, Cynthia Eagle. Sexual Science: The Victorian Construction of Womanhood. Cambridge, MA: Harvard U P, 1989.

Sand, Gayle. Is It Hot in Here or Is It Me? A Personal Look at the Facts, Fallacies, and Feelings of Menopause. New York: HarperCollins, 1994.

Sheehy, Gail. The Silent Passage: Menopause. New York: Random House, 1992.

Smith-Rosenberg, Carroll. Disorderly Conduct: Visions of Gender in Victorian America. New York: Oxford U P, 1985.

Summey, Pamela S., and Marsha Hurst. "Ob/Gyn on the Rise: The Evolution of Professional Ideology in the Twentieth Century--Part I." Women and Health. 11.1 (1986): 133-145.

Summey, Pamela S., and Marsha Hurst. "Ob/Gyn on the Rise: The Evolution of Professional Ideology in the Twentieth Century--Part II." Women and Health. 11.2 (1986): 103-122.

Taking Hormones and Women's Health: Choices, Risks, Benefits. Washington, DC: National Women's Health Network, 1989.

Taylor, Dena, and Amber Coverdale Sumrall, eds. Women of the 14th Moon: Writings on Menopause. Freedom, CA: Crossing, 1991.

Theriot, Nancy. The Biosocial Construction of Femininity: Mothers and Daughters in Nineteenth Century America. New York: Greenwood, 1988.

Thorne, Barrie, Cheris Kramarae, and Nancy Henley, eds. Language, Gender and Society. Cambridge, MA: Newbury House, 1983.

Utian, Wulf H., and Ruth S. Jacobowitz. Managing Your Menopause. New York: Fireside-Simon and Schuster, 1990.

Vines, Gail. Raging Hormones: Do They Rule Our Lives?. Berkeley: U of California P, 1994.

Walsh, Brian W., and Isaac Schiff. "Menopause." Kistner's Gynecology: Principles and Practice. 5th ed. Ed. Kenneth J. Ryan, Ross Berkowitz, and Robert L. Barbieri. Chicago: Year Book Medical, 1990. 450-479.

Willson, J. Robert. "Aging." Obstetrics and Gynecology, 9th ed. Ed. J. Robert Willson and Elsie Reid Carrington. St. Louis: Mosby Yearbook, 1991. 616-626.

Wilson, Robert A. Feminine Forever. New York: M. Evans, 1966.

Worcester, Nancy, and Mariamne H. Whatley. "The Selling of HRT: Playing on the Fear Factor." Feminist Review 41 (1992): 1-26.

Yalom, Marilyn. "Introduction to Part IV: The Older Woman." Victorian Women: A Documentary Account of Women's Lives in Nineteenth Century England, France and the United States. Ed. Erna Olafson Hellerstein, Leslie Parker Hume, and Karen M. Offen. Stanford, CA: Stanford U P, 1981.

APPENDIX A

SAMPLE OF GYNECOLOGICAL TEXTBOOKS

Benjamin, Fred, and Vicki Seltzer. "The Menopause and Perimenopause." Gynecology: Principles and Practice. Ed. Zev Rosenwaks, Fred Benjamin, and Martin L. Stone. New York: Macmillan, 1987. 165-187.

Dawood, M. Yusoff. "Menopause." Textbook of Gynecology. Ed. Larry J. Copeland. Philadelphia: Saunders, 1993. 619-640.

Droegemueller, William, Arthur L. Herbst, Daniel R. Mishell, Jr., and Morton A. Stenchever. "Menopause." Comprehensive Gynecology. St. Louis: C. V. Mosby, 1987. 1082-1107.

Gass, Margery L. S. "Physiology and Pathophysiology of the Postmenopausal Years." Gynecology and Obstetrics: A Longitudinal Approach. Ed. Thomas R. Moore, Robert C. Reiter, Robert W. Rebar, and Vicki V. Baker. New York: Churchill Livingstone, 1993. 883-898.

Judd, Howard L. "Menopause and Postmenopause." Current Obstetrics and Gynecologic Diagnosis and Treatment. 6th ed. Ed. Martin L. Pernoll and Ralph C. Benson. Norwalk, Ct: Appleton and Lange, 1987. 959-978.

Kase, Nathan G. "Menopause." Principles and Practice of Clinical Gynecology. 2nd ed. Ed. Nathan G. Kase, Allen B. Weingold, and David M. Gershenson. New York: Churchill Livingstone, 1990. 337-359.

London, Steven N., and Charles B. Hammond. "The Climacteric." Obstetrics and Gynecology. 5th ed., Ed. David N. Danforth and James R. Scott. Philadelphia: J. B. Lippincott, 1986. 905-926.

Walsh, Brian W., and Issac Schiff. "Menopause." Kistner's Gynecology: Principles and Practice. 5th ed. Ed. Kenneth J. Ryan, Ross Berkowitz, and Robert L. Barbieri. Chicago: Year Book Medical, 1990. 450-479.

Willson, J. Robert. "Aging." Obstetrics and Gynecology. 9th ed. Ed. J. Robert Willson and Elsie Reid Carrington. St. Louis: Mosby Yearbook, 1991. 616-626.

APPENDIX B

SAMPLE OF POPULAR ADVICE BOOKS WRITTEN BY PHYSICIANS

Budoff, Penny Wise. No More Hot Flashes and Other Good News. New York: Warner, 1983.

Cherry, Sheldon H., and Carolyn D. Runowicz. The Menopause Book: A Guide to Health and Well-Being for Women After Forty. New York: Macmillan, 1994.

Gillespie, Clark. Hormones, Hot Flashes and Mood Swings: The Menopause Survival Guide. New York: Harper, 1989.

Greenwood, Sadja. Menopause, Naturally: Preparing for the Second Half of Life. Volcano, CA: Volcano, 1992.

Jovanovic, Lois, and Suzanne Levert. A Woman Doctor's Guide to Menopause. New York: Hyperion, 1993.

Nachtigall, Lila E., and Joan Rattner Heilman. Estrogen. New York: Harper, 1991.

Notelovitz, Morris, and Diana Tonnessen. Menopause and Midlife Health. New York: St. Martin's, 1993.

Utian, Wulf H., and Ruth S. Jacobowitz. Managing Your Menopause. New York: Fireside-Simon and Schuster, 1990.

APPENDIX C

SAMPLE OF WOMEN'S ACCOUNTS OF MENOPAUSE

Barbach, Lonnie. The Pause: Positive Approaches to Menopause. New York: Signet-Penguin, 1994.

Callahan, Joan C., ed. Menopause: A Midlife Passage. Bloomington: Indiana U P, 1993.

Claman, Elizabeth, ed. Each in Her Own Way: Women Writing on the Menopause. Eugene, OR: Queen of Swords, 1994.

Doress, Paula Brown, Diana Laskin Siegal, and The Midlife and Older Women Book Project. Ourselves, Growing Older: Women Aging with Knowledge and Power. New York: Simon and Schuster, 1987. Foreword, Preface, Chapters 1-3, 5-7, 10, 19, 21 and 23.

Greer, Germaine. The Change: Women, Aging and the Menopause. New York: Fawcett Columbine, 1991.

Sand, Gayle. Is It Hot in Here or Is It Me? A Personal Look at the Facts, Fallacies, and Feelings of Menopause. New York: HarperCollins, 1993.

Sheehy, Gail. The Silent Passage: Menopause. New York: Random House, 1991.

Taylor, Dena, and Amber Coverdale Sumrall, ed. Women of the 14th Moon: Writings on Menopause. Freedom, CA: Crossing, 1991.

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