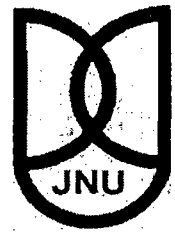
# 'THROUGH MENOPAUSE': A SOCIOLOGICAL STUDY OF THE MIDLIVES OF WOMEN

*Dissertation Submitted to Jawaharlal Nehru University in partial fulfilment of the requirements for the award of the degree of*

MASTER OF PHILOSOPHY

PALLABI ROY




CENTRE FOR THE STUDY OF SOCIAL SYSTEMS

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## DECLARATION

I declare that the dissertation entitled **'Through Menopause': A Sociological Study of the Midlives of Women** submitted by me in partial fulfilment of the requirements for the award of the degree of Master of Philosophy of Jawaharlal Nehru University is my original work. This dissertation has not been submitted for any other degree of either this university or any other university.

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## CERTIFICATE

We recommend that the dissertation be placed before the examiners for evaluation.

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She stored up the anger
For twenty-five years,
Then she put it on the table
like a casserole for dinner.

"I have stolen back my life," she said.
"I have taken possession
Of rain and the sun
and the grasses," she said.
"You are talking like a madwoman,"
He said.

"My hands are rocks,
My teeth are bullets,"
She said.
"You are my wife,"
He said.

"My throat is an eagle.
My breasts are two white hurricanes," she said.
"Stop!" he said.
"Stop or I shall call a doctor."

"My hair is a hornet's nest,
My lips are thin snakes
Waiting for their victim."

He cooked his own dinners,
after that.

The doctors diagnosed it
common change-of-life.

She, too, diagnosed
it change of life.
And on leaving the hospital
she said to her woman-friend

"My cheeks
are the wings
of a young
virgin dove.
Kiss them."
(*The poem "Midpoint" by Kathy Kozachenko cited in Martin 2001*).

# Chapter One

# Introduction

## 1.1 Menopause and Midlives: The Beginning

Unlike research on childhood, adolescence or the youth, the research on middle age/midlife/the middle years of adulthood has been comparatively recent. Many scholars claimed that as life expectancy increased and ageing of populations became more apparent, there was new attention being paid to middle age. (Rossi 1980) On similar lines, anthropologist Margaret Lock (1993) argued that it was till as late as 1959 that the traditionally preferred period of life to study and raise research questions on, was limited to a particular segment of the life cycle - the youth. The reason for this bias amongst the research community according to Lock was that research on ageing might provoke uneasy feelings, thus making it an unsuitable subject for the purpose of objective examination. But with changing demographics leading to a significant proportion of the population living beyond their youth, there was an acknowledgment of ageing as a part of the life cycle which commences relatively late in life and as a result, new questions for research were being proposed in contrast to the earlier ones. Thus, it was only in the late twentieth century that research on senescence as a part of the life cycle was considered seriously, thus bringing forth some reconsideration of the biases that were present earlier. It was with the acknowledgment of this larger process of an individual's life cycle within which certain important aspects were being identified. One of those aspects in the larger process for women writes Lock, was menopause – an aspect whose initiation happens during puberty through menarche, an aspect which continues well into the middle age, and has repercussions for the woman's old age. (ibid)

An important point that Lock points out is that many books and articles published about menopause in the recent times stated that it was due to the increasing woman's life expectancy that menopause has been identified only recently. For instance, Gail Sheehy (1991: 227 cited in ibid) claims that "At the turn of the century, a woman could expect to live at the age of forty- seven or –eight." Such statements (in medical literature and otherwise) implied that women rarely lived past what is now middle-age until the beginning of this century – an implication which Lock finds absurd and regards it

largely as a pervasive myth in the literature being published then. She writes that an examination of the demographics historically shows that there were many women who lived quite comfortably for almost a quarter of a century even after passing their menopause and women did not just drop dead in their forties! The assertions made over the years that women living beyond their menopause is an abnormality and contrary to nature's purpose, according to Lock, is a way of disguising the widespread assumption that

> "...reproduction of the species is what the female life is about, and that the situation we now find ourselves in, of having a large number of women of postreproductive age living in 'advanced' societies, is not only an anomaly but a costly superfluity" (ibid: xxvii).

Lock notes that even though men also become biologically inefficient during the second half of their life cycle, there is hardly any research on whether and how aging also affects men and their reproductive capacities. It is assumed that men have the "natural" potential to reproduce successfully throughout their lives. It seems as if the aging of women is seen as pathological in most societies, if not all - and even though the aging of men is also just as true as the aging of women, the former apparently poses no problems.

Emily Martin (1987) writes that while menstruation was seen as being a consistently pathological state among women and as a state having no analogue in men, menopause was also seen as being unique to women and many, if not most, medical accounts saw menopause as a time of crisis among women. As Coulbrooke (2002) writes reiterating the same point,

> "Menopause is a strictly female passage, no matter how much we hear the term 'male menopause[1].' The manufacture of sperm, barring medical complications, is a daily, life-long occurrence for men, and they do not suffer the myriads of peri-menopausal events that women do." (2002: 170).

Understood as a transition by biological anthropologists (Sievert 2006), a developmental transition by psychologists (Mishra et al 2003) and/or a turning point or

[1] The male analogy of menopause – andropause – will not be discussed in the present study as it would be beyond the scope and rationale of the study as a whole.

'change of life' (Furman 1995) - whether it is defined in terms of endocrine, psychological or social changes, there is a general consensus that it is a time of change in a woman's physical and mental health as well as in her sexuality (Dennserstein 1996; Utian 1987; Kaufert 1984; Greer 1991; McKinlay et al. 1992 cited in Mishra 2003). Thus combining all the different aspects, the understanding of menopause can be summarised as,

> "Understanding menopause as a transitional process involves understanding the hormonal changes that accompany the transition, the symptoms associated with the process, as well as the various aspects of life that influence the experience along the way" (Sievert 2006: 8).

Thus, the aspect of midlife that is unique and exclusive to women is the aspect of menopause and from a strictly physiological perspective it is the most notable event for women during their midlives (Govil 2013). But before digging in further, let's begin with the simple and primary question – what is menopause? 'Meno' is derived from the Greek word *menos* for month and 'pause' is derived from the Greek word *pausis* which means a pause or a cessation. Before the term menopause itself was used, it was known as the 'change of life'. Menopause defined in layman's terms would be that universal biological event in a female's life when her menstrual cycle comes to an end and consequently, her fertility.

Menopause is characteristic of human females, but unlike human females there are few other species that experience a long post reproductive life after the cessation of their menses (Sievert 2006). With many synonyms such as the 'change of life', 'midlife transition', 'rite of passage', 'the last taboo', natural menopause[2] is said to have occurred after 12 consecutive months of amenorrhea and a woman would know about her final menstrual period only in retrospection (Canadian Consensus Conference on Menopause and Osteoporosis 2002). There seems to be no consensus among the scientific community regarding what is the underlying cause of menopause. It is not clear whether menopause is caused by primary hypothalamic failure or whether it is

[2] I use the term 'natural menopause' here as opposed to simply writing menopause. The reason for this is that apart from 'natural' onset of menopause, a female can also undergo 'surgical menopause' i.e. hysterectomy. For all intents and purpose, menopause would refer to natural menopause throughout the dissertation.

triggered by insufficient numbers of ovarian follicles. However, there is a consensus on the fact that menopause does involve both the depleted ovarian follicle numbers and changes in levels of three major hormones - estrogen (starts declining approximately six months before menopause), follicle stimulating hormone (FSH) (generally increase after menopause until a few years of postmenopause), and inhibin B. The few ovarian follicles that are left in the woman's body during menopause are incapable of maturing (Wallace and Kelsey 2004 in Blell 2009).[3]

### 1.1.1Menopause: One-Stop Event or Transitional Phase?

Sievert (2006) writes that menopause has been viewed both as a one-time, abrupt event as well as a gradual process. As a one-time event, menopause is seen as a medical event within epidemiological studies and a marker of estrogen levels declining in a woman. Menopause is also understood as a onetime, measurable event from a life history perspective. Additionally, the researchers who are interested in studying the variation in timing of menopause view menopause as an event instead of a process. However, women themselves experience menopause as a transition, as a gradual process and not just as an event. This distinctive transition which occurs in a woman's life is that of a reproductive stage to a postreproductive stage. A woman usually starts undergoing this transition from her late thirties or early forties, or maybe even later, depending on a range of factors such as her diet, use of contraception, number of pregnancies, smoking, and alcohol intake and so on. The transition begins with the menstrual periods becoming irregular after a certain stage for the woman and ends about one year after the last menstrual period. This period of transition in most countries is called the 'climacteric' which is derived from the Greek word *klimakterikos* meaning "a dangerous point", the rung of a ladder" or from the Latin word *climactericus* meaning "of a dangerous period in life". However, in few other parts of the world, mainly in the United States, researchers use the term 'perimenopause' or 'perimenopausal transition' instead of climacteric. The period of perimenopause is characterized by hormonal fluctuations, irregular menses and other signs and symptoms. (ibid)

[3] Since this dissertation is not aiming for a scientific/biomedical study of menopause, I will refrain from going into any detailed scientific/biomedical description of the same.

Rarely viewed as a one-time event any longer, The Seattle Midlife Women's Health Study in 2000 (cited in the Canadian Consensus Conference on Menopause and Osteoporosis 2002) identified three distinct stages of phases during a woman's menopausal transition, although these stages are not fixed for every woman. The first stage is 'Early Menopause' i.e. 'Premenopause' which comprises of regular menstrual cycles with noticeable changes in the amount and length of blood flow. This stage is followed by 'Middle Menopause' i.e. 'Perimenopause' which is when the menstrual cycles start becoming irregular but the cycles do not get skipped. The final stage is that of 'Late Menopause' i.e. 'Postmenopause' when there is either skipping of menstrual cycles, atleast two or more months apart or the complete cessation of the menses. (ibid) Thus viewing menopause as a one-time phenomenon would be an inaccurate representation of a rather long, drawn-out, transitional phase in a woman's life.

## 1.2 The Evolution of Human Menopause: Theories and Advantages

Evolutionary theories of menopause were for the most part prompted by the difference between the life-history patterns of human and non-human primates. However, one thing that reproductive biologists seem to agree on is that the universal nature of menopause is unique among primates and such a long phase of postreproductive life is experienced by no other primate. (Shanley et al 2007)

The question that arises is, why do women have menopause? Why is it that fertility ceases in women at a certain age through natural menopause before actual senescence renders reproduction a biological impossibility? (ibid.) Sievert (2006) questions that how can the long postreproductive life of human females be explained?

Blell (2009) explains that despite the prevalent conceptions of menopause as pathological among the biomedical community, there are others like the anthropologists, feminists, women's health activists and reproductive biologists who consider menopause to be a normal part of female reproductive ageing. The question of why menopause has evolved in the human species has been answered through the following seven main hypotheses (all of which are not necessarily mutually exclusive and in fact, some of them are mutually compatible and overlapping):

a) *The self-protection hypothesis* suggests that menopause evolved to protect the female from wasted reproductive effort in the form of pregnancies that are unlikely to result in live births due to decreasing follicle quality and increasing hazards of fetal loss or birth defects due to chromosomal abnormalities.

b) *The mothering hypothesis* suggests that menopause evolved to allow ageing mothers to shift investment to provisioning existing offspring rather than investing in new offspring, thereby increasing the fitness of their children.

c) *The grandmother hypothesis* suggests that menopause evolved to increase the survival and fitness of grandchildren who carry similar genes since non-reproductive grandmothers can then help their daughters to raise children.

d) *The human longevity hypothesis* suggests that menopause is a consequence of selection for longevity in our species and has not been selected for; thus the human female lifespan outstrips the supply of follicles.

e) *The time-delayed antagonistic pleiotropy hypothesis* suggests that menopause itself has not been selected for but is actually a consequence of selection for traits which make successful reproduction early in life more likely.

f) *The patriarch hypothesis* is similar to the human longevity hypothesis but instead suggests that menopause is a consequence of selection for longevity in men, thus women are 'dragged along' because the longevity trait or traits are on the X rather than the Y chromosome, leading to a lifespan which outstrips the supply of follicles.

g) *The absent father hypothesis* suggests that menopause evolved because paternal investment decreased (due to either death or defection) as maternal age increased, making births to older mothers increasingly costly." (ibid: 5-6).

Of all these aforementioned hypotheses, the most often believed and investigated is the *Grandmother Hypothesis* which will be discussed below.

Woods (1998) writes that biologically menopause can be characterized broadly as a non-adaptive event or as an adaptive event. The non-adaptive model is based on the position that human females were designed in a way which was meant for them to reproduce as long as they lived and women are defined by their function and capacity to reproduce. When this function is completed, the rest of the woman's life doesn't hold much justification and the end of her reproductive capacity is seen as an endocrine deficiency disease. Medical intervention is seen as becoming necessary for the correction and treatment of this 'disease'. The evidence used to support this model is based on studies of nonhuman species, fossils and other mammals.

On the other hand, menopause as an adaptive event is justified by stating that the end to the woman's reproductive capacity is functional both for the woman herself as well as for the society. With the woman no longer having to spend time in pregnancy, childbirth and parenting, she can contribute more to the society. The woman has the opportunity to move beyond the boundaries of family life and participate in the society at large. The validity of this model rests on data which supports the evolutionary theory of menopause. In other words, the adaptive model justifies itself by showing that females have been evolutionarily selected to cease their child bearing as there are associated benefits to it as far as biology is concerned. With the occurrence of menopause,

> "women's reproductive energies would be better redirected to caring for their dependent children, providing their grown children with additional support so that they might devote their energy to caring for their children, and caring as grandmothers for their children" (ibid: 7).

Evidence for such evolutionary theories of menopause are usually derived from the studies of non human species, from fossils of humans living a long time ago and from contemporary hunter-gatherer societies such as the !Kung (ibid).

Corroborating and furthering Woods' argument, Sievert (2006) in her seminal piece of work, *'Menopause: A Biocultural Perspective'*, explains that natural selection favours menopause and/or postreproductive life in a number of ways. Firstly, it is menopause which ensures that the mothers remain young enough to survive not just their

pregnancy and delivery, but also the infancy of their offspring. Menopause allows women to have a long life post-reproductive life so that they get ample amount of time and energy to rear the child/children. As pregnancy and childbirth make many demands on the woman, both physiologically and mentally, it's important for the woman to get sufficient time post her reproductive period, time which is ensured by menopause. Secondly, menopause also ensures that old and abnormal eggs do not become fertilized. "Rather than risk a compromised pregnancy or birth, it may be adaptive to invest in offspring already born" (ibid: 44). The third reason mentioned by Sievert is linked to the previous two reasons - maternal energy is conserved by the end of the menstrual cycle. The evolution of menopause happened so that the energy that was getting spent in the menstrual cycle could otherwise be invested to rear for the offspring's survival. In a nutshell then, menopause can account for the end to a woman's menstrual cycle by being understood as an "adaptation to ageing mothers, ageing eggs, and excessive energy expenditure" (ibid: 45), but these do not explain why human females have such a long postreproductive life after having attained menopause. There are many authors who have answered this dilemma by putting forth the grandparenting argument or the "grandmother hypothesis". Shanley et al (2007) proposed a similar hypothesis for the foundations for the evolution of menopause. They proposed that menopause enhances fitness – a feature unique to humans - and produces grandmothers, especially maternal grandmothers, who can assist the mother in caring for the highly dependent offspring. They also mention that with increasing age, there is an increased rate of maternal mortality. So in such a situation where risks outweigh the gains, it makes sense for the female to cease her menses and thus her reproductive span. Through this particular hypothesis, (this is also the fourth reason put forth by Sievert (2006) because of which menopause may have been favoured by natural selection) menopause is portrayed as an advantage in the context of extended families. The crux of this hypothesis can be stated as follows,

> "...during human evolution, as offspring dependency increased and more adult care was required, females contributed more genes to the population gene pool by investing in their grandchildren than they could have contributed by continuing to produce children of their own." (Alexander 1974; Dawkins 1976; Hamilton 1966; Williams 1957 cited in ibid: 45)

In the article titled 'Evolutionary Advantage of Menopause' (1982), Mayer sums up the hypothesis with the concluding statement of his article,

> "Since only successful mothers become biological grandmothers, female hominid life histories demonstrate the apparent paradox that improved mothering meant eventual termination of the period of motherhood" (Mayer 1982: 490).

The final reason that Sievert (2006) provides as to why menopause can be considered adaptive from an evolutionary perspective is within the context of the contemporary, industrialized society where there is early menarche, late childbirth and low parity patterns. With menopause, the human female is less exposed to the periodic elevations in her estrogen levels which she otherwise experiences throughout her reproductive phase. Without the cessation of her menses, increasing estrogen levels would expose her increased risks of breast cancer and other estrogenically sensitive tissue(s) even when she reaches her seventies and eighties. Thus in a way, menopause protects the female by lowering the risk of breast cancer and other ailments to a certain extent.

Thus, it is the combination of all the theories and their advantages mentioned above which are used to explain the evolution of menopause in the human female species.

### 1.3 The 'Rhetorics' of Menopause

Before going into the literature survey of menopause, I would like to discuss here what Jacquelyn Zita refers to as the 'rhetorics' of menopause in her chapter "Heresy in the Female Body: The Rhetorics of Menopause[4]" (in Joan C. Callahan's *Menopause: A Midlife Passage*, 1993). Zita's discussion is of the three ways in which menopause has been rhetoricized and each one of them interprets female embodiment in a different way, thus implying different consequences for menopausal women. According to Zita, these rhetoricized understandings of menopause and the menopausal body do not have a meaningless existence. Rather, these understandings are designed in such a way that

[4] Zita's discussion of the rhetorics employed for menopause research by different schools of thought is a continuation from the popular article by Geri L. Dickson titled, "Metaphors of Menopause: The Metalanguage of Menopause Research" (Available in Callahan's *Menopause: A Midlife Passage*, 1993).

the larger cultural picture of the relations between the sexes gets obscured. These rhetorical understandings, writes the author,

> "...are atleast in part a creation of a masculinist gerontocracy invested in the penultimate disempowerment of the female sex" (ibid: 60).

The first of these rhetorical readings is *biological gender essentialism*, i.e. the reading of menopause and the menopausal body of the woman in essentially biological terms. "The gendered body appears as a biologically bound entity, which at menopause commits a heresy against its own nature" (ibid: 62). Menopause is seen as a disease and/or an ovarian dysfunction resulting in the loss of womanhood as a woman's true essence is seen in her ability to be able to biologically reproduce. The body of the woman is seen as a biological text and the menopausal body is seen as a deviance from the 'normal' gendered body of the feminine Medical intervention is deemed necessary in the form of hormone therapy to let the woman's womanhood be restored, barring which menopause converts a woman into a non-woman or a neuter.

*Scientific reductionism* which has both a common ground and differences from biological essentialism is the second rhetorical reading. The common ground is that scientific reductionism also sees the woman's body as a biological text. But unlike biological essentialism which views the body with respect to gender, scientific reductionism views the body with respect to health. So the conceptualization of the woman's body as being either 'normal' or 'deviant' is seen with respect to the medical norm of being healthy. Menopause is viewed as a disease, as a crisis and/or as a dysfunction. The menopausal woman is seen to be suffering from a loss in her health due to some lack of internal functioning inside her body and she is described in terms of symptoms and syndromes. While in both scientific reductionism and biological essentialism menopause is a disease requiring medical intervention, the reasons differ. In the former "menopause is a dysfunction in the body's health status" (ibid: 63) while in the latter, "menopause is a deviance in gender ontology" (ibid). In both, the preferred way of "treating" this "disease" is by hormone replacement as menopause is perceived solely as a hormone-deficiency disease. The biological body is seen as being completely isolated from the cultural, social and historical events and the authority of examining the menopausal female subject as an object of clinical enquiry lies with the medical practitioner.

The third and final rhetorical reading is the feminist critique of the previous two readings, the rhetoric which Zita terms as *feminist valorization*. Feminists challenge the existing understanding and cultural construction of the woman, menopause and the menopausal body as well as the medical gaze which asserts an exclusive authority over 'reading' the female body. Feminists have argued through their empirical research over the years within and across different societies that menopause is not to be understood as a standardized process with universal experiences and more importantly, the experiences of women in non-clinical situations cannot be ignored. The multiple voices and lived experiences of women's menopausal experiences are acknowledged by this rhetorical reading. The feminists argue that the female body should be seen as a bio-cultural text as per which the body is partly biologically given and partly culturally constructed. Also, the body is seen in the entirety of its life cycle and menopause is seen as a transition like the other transitions that a woman undergoes in her life cycle. Zita concludes by saying,

> "In contrast to the norms of youthful femininity (bio-gender essentialism) and hormonal high-functioning (scientific reductionism), a feminist approach advocates integration, multiplicity, and resistance: self-acceptance of the body image and life cycle process, defiance against social practices which disempower older women, and celebration of the transforming landscapes of the female flesh" (ibid: 69).

Having discussed the three broad strategies of interpreting menopause and the menopausal body, I will now briefly look into the literature survey of menopause between 'the West' and 'the Rest' where any one of the three rhetorical readings as discussed or an amalgamation of any two, or all three of them have been employed in different societies and in different times as theoretical groundwork(s) to strengthen the arguments regarding menopause and the menopausal woman.

### 1.3 Literature Survey of Menopause in 'the West' vis-à-vis 'the Rest'[5]

> "If a menopausal woman has pain or makes trouble, pound her hard on the jaw." (Egyptian medical text, 2000 B.C. cited in Seaman 2003: 7)

[5] What I mean by 'the West' and 'the Rest' will be explained more explicitly in the section of this chapter titled Research Problem.

The aforementioned statement is one of the earliest known references for the 'treatment' of menopausal women from a medical text in Egypt, 2000 B.C. However, almost five centuries ago during the period of Renaissance, saner remedies than practicing violence were prescribed in the medical textbooks – such as recommending physical exercise with something herbal such as a concoction of myrrh and apples. Notwithstanding that, instances of attempts at medicating menopausal symptoms have been around for centuries now. For example, in 1889, the Merck Manual Diagnosis and Therapy prescribed a powder made from the dried and pulverized ovaries of a cow, called Ovariin for menopause and other ovary related problems. This Manual also contained twenty eight other remedies for a woman's menopausal time – remedies which were believed to have some estrogenic effect. (ibid) Historically, menopause hasn't been a new phenomenon and references to menopause have been available for many centuries now, even though the increase in life expectancy, women entering into menopause and a long postreproductive phase seems like a recent and modern phenomenon. It's just that there has been a noticeable increase in the incidence of menopause in the recent times. In fact, according to the timeline of menopause through centuries[6], it was as early as 300 B.C. that Hippocrates observed and associated breast cancer with menopause. There are some other references to menopause in history of menopausal symptoms in the book by Robert Burton called "The Anatomy of Melancholy" in 1628. Another reference to menopause was in 1701 by the physician Thomas Sydenham who described the tendency of women to have hysterical fits when they reached their late forties. But it was only in the early 19th century that the term menopause was coined by a French physician named C.P.L. de Gardanne in his book "*De la ménopause, ou de l'âge critique des femmes*". He used the French word "*la Ménépause*" for menopause as a medical syndrome. The first complete book on menopause which explained symptoms of menopause as a response to the death of a woman's womb was written by another Frenchman, C.F. Menville in 1839. The first comprehensive discussion of menopause however, was presented by Andrew F. Currier in 1897 which generated a great deal of scientific interest. It was in 1899 that one of the earliest and clear descriptions of menopause (although in a negative and pejorative sense where menopause was seen as requiring attention from the clinical physicians) was published in an article titled 'Epochal Insanities', under the heading of "Climacteric Insanity". By

[6] Refer to: Appendix A.

the beginning of the twentieth century, menopause was being seen as "the death of the woman in a woman"[7].

Although menopause like menarche, pregnancy and childbirth is a natural phenomenon and life event for a woman, it has recently been listed as a disease in the International Classification of Diseases – 9 and 10 (Beyene 1989), Disease Data Base, e-Medicine and Medical Subject Headings (Govil 2013). In 'the West' – North America, Canada, Europe and Australia for the purpose of this study – menopause was largely looked at from a biomedical standpoint (with a theoretical underpinning of biological essentialism as well as scientific reductionism as discussed in the earlier section) wherein it was (and even now to a large extent) seen as a problem of hormone deficiency and it required hormone therapy as the obvious solution. In doing so,

> "...it becomes situated in the medical province of gynaecologists, endocrinologists and menopause clinics. Menopause becomes a part of a world of clinical investigations, diagnoses, treatments, and close monitoring. In this way, menopause becomes 'medicalized.'" (Marilys 2002: 37)

It is however, the pharmaceutical companies which are perceived to have the maximum gain at the cost of women's health 'problems' by being able to medicalize menopause, through the 'marketing' of menopause (ibid) – an issue which will be dealt with in detail later in this study.

Bulbeck (2001) notes that until the 1990s, there was hardly any significant literature produced on female midlife experiences beyond North America, Western Europe and Australia. The International Menopause Society, founded in 1994, brought out two official publications – *Maturitas* and *Climacteric* – both dealt with issues within a biomedical framework and medical and psychological journals like these had an absence of women's midlife experiences beyond 'the West'. If biology is universal and applicable to women everywhere, then where is the 'non-Western woman' who is also experiencing this menopausal transition because it is not as if it was only the 'Western woman' who was experiencing menopause. Rice and Manderson in 1996 (cited in ibid.) suggest that despite the escalating literature on ageing, the literature on menopause and

[7] Refer to: Appendix A.

other non-reproductive aspects of a woman's life was relatively rare. The difference in the availability of literature is especially stark when compared to the corpus of work one finds on the reproductive aspects of a woman's life. For instance, in China, there is barely any written work on either menopause or ageing. Similarly in India, while work on menopause is sparse, there is relatively a little more work on ageing in general. A major reason for the paucity in literature on menopause seems to emanate from a historically embedded fact, writes Bulbeck. Historically, menopause was not even a term used in many of the non-western societies as a literature survey of that part of the world would show. In China for example, there is no equivalent translation of the word 'menopause'. Rather, euphemisms such as 'heaven sunflower' or 'fifties shoulder' were used where the latter focused attention on the ageing body's aches and pains and not on the cessation of menses as such. Deliberate attempts were in fact made in the Chinese society to not use terms like menopause which associated itself with the menstrual cycle as menstruation was seen to be a polluting event and not to be discussed. Similarly, the Indian society does not prefer using terms which make a direct connection to the menstrual cycle as noted by Uberoi and Bahadur (2000 cited in ibid) and Indians prefer using phrases such as "'it is over" or the "monthly period has stopped".

With cross-cultural, anthropological studies being conducted in the non-western societies from the 1970s (based on the rhetoric of feminist valorization which has been discussed in the previous section), the 'non-Western woman' was largely seen as experiencing her midlife as a status passage, a passage which was made meaningful by the social roles that were associated with her during this phase of her life as opposed to the 'Western woman's' midlife which the medical community constructed as embodied and physiological. With the cessation of menstruation and no longer having to undergo childbirth, the non-Western woman views her midlife as a time of freedom of movement. The social meaning of the passage is related to factors such as the ending of the taboo and impurity associated with menstruation, where age is valued over youth (for instance in the Indian context where having passed the polluting taboos of menstruation, the woman has passed onto a stage of cleanliness, social power, religious freedom and a higher status conferred on her) and the kinship connections that women have and build (for instance in Japan as demonstrated by Margaret Lock's research in the 1990s where Japanese middle-aged women find taking care of the elderly in the

family as being more important that fussing over physiological problems associated with menopause in the West). In societies where women gain a higher social status having reached menopause, researchers have found that in such societies menopause is eagerly anticipated and is seen as a favourable event. Thus, the non-Western, and the Asian ageing woman in particular, was being posited as having a symptom-free midlife transition as compared to the millions of women in the West who were experiencing severe symptoms in their midlives as a result of menopause. (ibid)

A literature review of this subject would be incomplete if one did not look into two important aspects of menopause – the age at onset of menopause and the symptoms of menopause. More importantly, the variations in age and symptomatology will give the reader an insight into the fact that menopause as a phenomenon cannot be seen as being universal for women everywhere.

### 1.3.1 Age at Menopause

Although the mean age at menopause for the most part is determined to be in the age bracket of late forties to early fifties, studies across and within cultures have shown that there are visible discrepancies as far as age at menopause in concerned. Discussing the age at menopause is a complicated matter in itself due to the wide range of variations that exist across populations as well as the various factors, singularly or in conjunction with others affect the age at menopause. While some women reach their menopause quite late in life, there are others who reach menopause at an earlier age, thus implying that menopause as a universal biological phenomenon is questionable – an aspect which has been demonstrated in prior discussions as well. The question that one could ask is why does determining the age at menopause become important? How does it make a difference if a woman reaches her menopause at fifty or at some other age in her life span? The reasons given are that knowing the age at menopause becomes crucial for investigations into the health and aging of women at large. It also helps in determining the health and well being of a population, not only with respect to individual women but for the population at large. Additionally, the age at menopause might be used a marker for chronic diseases such as heart failure and other cardiovascular diseases, breast cancer and osteoporosis (Sievert 2001 cited in Kaczmarek and Szwed 2001).

### *Variations in Age at (Natural) Menopause*

The variations in age at menopause have to do with both natural menopause as well as the surgical menopause i.e. hysterectomy. Also while some studies are conducted to find the mean age, there are others which find out the median age and there are yet others which determine both the mean and median ages. To begin, using the table provided by Sievert (2006) and Sievert et al. (2001), here's a look at some of the countries, their mean and median age at menopause along with their references.

| Country (site) | Mean age at menopause (years. months) | Median age at menopause (years. months) | Reference(s) |
|---|---|---|---|
| Amritsar, India | - | 47.54 | Sidhu, Kaur, and Sidhu (2005) |
| Asuncion, Paraguay | 47.9 | - | Sievert and Hautaniemi (2003) |
| Finland | - | 51.0 | Luoto, Kaprio, and Uutela (1994) |
| Italy, Milan | 49.4 | - | Parazzini, Negri, and La Vecchia (1992) |
| Karachi, Pakistan | 49.0 | - | Adhi et al. (2007) |
| Massachusetts, USA | 48.9 | - | Sievert et al. (2004) |
| Mexico, Rural Maya | 42.0 | - | Beyene (1986) |
| Multicenter, USA | - | 50.1 | Stanford et al. (1987) |
| Netherlands, Utrecht | 50.2 | - | Van Noord et al. (1997) |
| Puebla, Mexico | 46.7 | - | Sievert et al. (2004) |
| Puerto Rico | - | 51.4 | Ortiz et al. (2003) |
| Rural El Salvador | - | 48.9 | Borchelt, Conlisk, and Cremer (2009) |
| Spain, Madrid | 50.0 | - | Prado and Canto (1999) |

| | | | |
|---|---|---|---|
| Venezuela | 48.9 | - | Reyes et al. (2005) |

### *Factors Associated with Age at (Natural) Menopause*

The trend as visible from the various studies seems to be that the average age at menopause is earlier in developing countries as compared to the highly developed, westernized countries. But the difference among the countries can be attributed to many factors and one of them is the difference in the way the average age at menopause is calculated using different methods. The two methods of analysis that are commonly used among researchers to determine the median age at menopause is the method of probit analysis and the life table analysis. The former is in which the dependent variable is the menstrual status and the age of the woman at the interview is the predictor. This method of analysis does not rely on the memory of the woman to recall her age at menopause and therefore, the chances of faulty recall are largely diminished. The method of life table analysis, for instance the Kaplan-Meier estimation, is more suitable for smaller populations and women those who have undergone natural as well as surgical menopause are included. However, a drawback of this method is that it relies on the memory of the women to recall their ages at menopause and that might lead to faulty analyses. With the difference in methods of computing the age, the comparison of ages between countries becomes problematic. Moreoever there are other methodological differences such as how is menopause defined in different contexts; the women who get selected for the study, do they attain natural menopause or surgically and after computing the ages, how are they analysed. (Sievert 2006)

From a strictly biological point of view,

> "...the age at menopause in a woman is determined by the number of eggs a woman is born with, the rate of loss of those eggs across the entire lifespan, and the threshold number of ovarian follicles required to maintain menstrual cyclicity" (ibid: 101).

So to discuss as to which factors are associated with the increase or decrease in age at menopause, one would need to look at those cultural factors which are responsible for the increase or decrease in the number of the woman's eggs during her fetal period. Or in other words, the cultural factors which increases or decreases the degeneration of

ovarian follicles i.e. the rate of atresia before birth, before puberty and before menopause need to be discussed (ibid). Below are the main factors which Sievert (ibid) discusses which in complex interaction with one or more of the mentioned factors account for the wide range of variation in the age at menopause.

i. *Age at Menarche*: There are very few studies, with conflicting results mostly, which have shown that the age at menarche and age at menopause are related – women who have an early age at menarche usually have a late menopause. And there are studies such as the one on Polish women by Kaczmarek and Szwed (2001) which have also shown the opposite that earlier the menarche, the earlier is the menopause. But largely most studies have found no connection between age at menarche and age at menopause. Sievert (2006) argues that there would not be a consistent association between the ages at menarche and ages at menopause across population because while menarche occurs after approximately a decade of life, menopause occurs after four or five decades of living. The time between the two events is more than enough to become dissociated.

ii. *Characteristics of the Menstrual cycle*: Depending on how long or short a woman's menstrual cycle, her age at menopause can be affected by that. For instance, studies have found that as women ovulate more with regular or short menstrual cycles, those women have an earlier onset of menopause (Stanford et al. 1987; Whelan et al. 1990; Cramer and Xu 1996 cited in ibid). On the other hand, there are studies which show no association between age at menopause and the regularity or irregularity of the menstrual cycles (Parazzini, Negri and La Vechha 1992; Obermeyer 2005 cited in ibid).

iii. *Marital Status*: There have been a number of studies in this area of finding an association between the age at menopause and the marital status of women. In their article titled 'Marital Status and Age at Natural Menopause: Considering Pheromonal Influence' (2001), Sievert, Waddle and Canali study's of the women in Greene County, New York showed that married and widowed women usually report a later age at menopause when compared to women who were single and

divorced women. Literature has reported consistently over time that women who have never been married have an earlier age at menopause. The reasons attributed to this causal connection between age at menopause and marital status are many possible reasons such as income levels, frequency of sexual activity, parity, use of oral contraceptives, smoking habits. However, the preferred reason according to the authors is the presence of a male in the household who affects the onset of menopause through the influence of primer pheromones i.e. chemicals which indirectly influence the physiology of others. (ibid)

iv. *Reproductive History*: Studies over time have consistently shown that women who have never given birth have an earlier age at menopause when compared to women who have given birth (Cramer and Xu 1996; Do et al. 1998; Elias et al. 2003; Parazzini, Negri, and La Vechhia 1992; Sievert and Hautaniemi 2003; Whelan et al. 1990 cited in Sievert 2006). There are also studies which have found that those women who have an increased number of pregnancies have their menopause at a later age (Garrido-Latorre et al. 1996; Stanford et al. 1987 cited in ibid). Whelan et al. (1990 cited in ibid.) through their study found an association between the age at menopause and the number of children a woman had. Women with no children had their menopause at 50.0 years, women with one or two children had menopause at 50.5 years, women with three to four children reached menopause at 50.7 years and women with five or more children reached menopause at 51.0 years. However, there are other studies which have found no relation between the age at menopause and the number of children a woman has had (McKinlay et al. 1992; Shinberg 1998 cited in ibid).

v. *Smoking habit*: Most of the studies, if not all, that have been conducted on smoking habits in relation to age at menopause have consistently shown an earlier onset of menopause in women who smoke. The earlier a woman starts smoking in her life span, the earlier the age of her menopause. Smoking results in the decline of the number of oocytes in the ovaries, decline in the estrogen levels and it also affects the level of the pituitary and hypothalamus (ibid). Pawlinska-Chmara and Szwed's study (2005) on Polish women showed how habitual

smokers had their menopause around two years earlier than those who had never smoked. Sievert, Waddle and Canali's study (2001 cited in Sievert 2006) among women of Greene County, New York showed that single and divorced women are more likely to smoke than married women and the former group of women also have an earlier age at menopause.

vi. *Alcohol intake*: As compared to the number of studies on how smoking affects age at menopause, very few studies have been conducted on how the intake of alcohol affects the same. The few studies done and the one with small sample sizes have shown that an earlier age at menopause can be the result of chronic alcohol abuse (Gavaler 1985 cited in ibid). Another study done in United Kingdom by Torgerson et al. in the United Kingdom (1994, 1997 cited in ibid.) showed that when taken in moderation (where moderation was defined as being more than zero but less than seven drinks a week), alcohol intake resulted in a later age at menopause.

vii. *Socioeconomic Status*: It has been found by most studies that women who are of a lower socioeconomic status undergo an earlier onset of menopause compared with women who are of a higher socioeconomic status (Garrido-Latorre et al. 1996; Johnston 2001; Stanford et al. 1987 cited in ibid). But the problem lies with how different researchers define the term socioeconomic – some define it based on the occupation of the woman and her family members, some define it based on the woman's level of education and some base it on the type of health insurance that the woman has (ibid).

The aforementioned factors are not exclusively responsible for determining the variability in the age at menopause. Some of the other factors are the rural-urban continuum within the same society or country (Beyene 1986); level of education (Luoto et al. 1994, Shinberg 1998); childhood nutrition (Shinberg 1998, Elias et al. 2003, Sievert and Hautaniemi 2003, Leidy 1996 cited in Sievert 2006); body mass index, mother's and sister's age at menopause, physical activity, coffee preference, residential area (Park, Kim, and Kang 2002 cited in ibid); occupational classification, income level,

self-rated social class (Do et al. 1998 cited in ibid); epidemiological factors such as genetic disposition and exposure to exogenous noxious agents (Keck 2005 cited in ibid).

Having discussed the wide range of factors responsible for determining the age at menopause, the next subsection will examine the symptoms of menopause and symptomatic variation across populations.

### 1.3.2 Symptoms (or Discomforts) at Menopause

The common presumption regarding the symptoms at menopause is that because menopause is seen as a biologically and physiologically observable event in human females, the symptoms for this event would also be ubiquitous (Avis et al 1993). Due to the lack of cross-cultural research in non-western societies until recently, the symptoms that were found in the menopausal women of North America and Europe were assumed to be applicable to women universally. Symptoms such as hot flush (perhaps the most common and prominent symptom of menopause), cold sweats, vaginal dryness, depression, insomnia, dizziness etc. were thought to be found in all menopausal women. As menopause in the West was conceptualised as a disease, like every other disease it was seen as having certain signs and symptoms which would lead the medical practitioner to diagnose that particular disease. The medical language of menopause, argues sociologist Susan Bell, demonstrates the pathological and disease model of menopause and the medical acceptance of it by using terms such as menopausal symptoms and the menopausal syndrome (Houck 2006). This is not to say that menopause should be seen as being completely devoid of symptoms – with the hormonal changes in a woman's body during the menopausal phase a woman may experience physiological changes. The problem however, lies in attributing these changes solely to the woman having to go through menopause. The signs and symptoms (or as Sievert (2006) calls it "discomforts" – a term I am more comfortable using than symptoms as symptoms would imply a medical perspective) might be a result of menopause itself or related menopausal events or the aging process in general. A woman's reporting of her discomforts during her menopausal transition might be getting affected by many other social changes in her life span such as her children getting married and leaving home, children going away for higher education, divorce, illness and death of her parents or even the death of her husband and other loved ones, her own anxieties and insecurities about aging in societies which are obsessed with

youth and fertility, retirement from job, increasing loneliness and loss of financial security and so on (Hallad and Khan 2010).

The results of the various cross-cultural studies since the 1970s showed that not only was menopause experienced by women in very different ways, physiologically and otherwise, but even the discomforts like hot flash which were so common in the women of one part of the world were absolutely missing in women in another part. For instance, regarding the occurrence of hot flashes, WHO (1996) reported that while there were 80% Dutch women who reported having hot flashes during menopause, there were no Mayan women who reported the same. And not just that – there were variations in the reporting of the discomforts found among women within the same culture, depending on their socioeconomic backgrounds for instance. Moreover, there are also variations in the way the women describe their discomforts and the frequency of those discomforts. With such stark variations, it became important that such comparative studies be carried out at a greater rate, both intra- and inter culturally. As Nancy Avis and colleagues state:

> "Evidence of cultural diversity in the perception/reporting of symptoms at the time of menopause would lend further weight to the thesis that the experience of menopausal symptomatology is not ubiquitous, but specific to distinct cultural or population groups" (Avis et al 1993: 17).

In 1996 based on the several studies done on menopausal discomforts, the World Health Organization (WHO) classified the symptoms of menopause into vasomotor discomforts, urogenital atrophy, irregular menstruation and other discomforts (WHO 1996).

Vasomotor discomforts i.e. the physiological discomforts would primarily include hot flashes/hot flushes and night sweats. Insomnia is also reported as a discomfort among and by women, but that is for the most part a consequence of the night sweats. A.C. Wentz (1988) describes the hot flash as:

> "...a sudden feeling of heat in the face, neck and chest, associated with diffuse or patchy flushing of the skin, profuse perspiration and frequently with palpitations. The feeling of heat initially centred in the upper part of the body, spreads upwards and downwards throughout the body. It is

associated with a feeling of discomfort and lasts about 3 minutes" (cited in ibid: 24).

However, Sievert (2006) argues that hot flashes are not a discomfort associated only with menopause. Rather, hot flashes can occur whenever there is a sudden decline in the estrogen levels in a woman. For instance, just after childbirth, some women experience hot flashes when the sex steroids decline (Naftolin, Whitten and Keefe 1994 in Sievert 2006). In fact, according to Ginsburg and O'Reilly (1983) and Linde et al. (1981) in Sievert (2006), even men can experience hot flashes after orchidectomy i.e. the removal of the testes or after the administration of a gonadotrophic releasing hormone agonist.

Secondly, postmenopausal women sometimes report of urogenital atrophy as a discomfort, also commonly known as vaginal atrophy, wherein the wall of the vagina i.e. the vaginal mucosa becomes thinner and drier. The dryness of the vaginal walls results in dyspareunia i.e. sexual intercourse becoming a painful affair for some women, while there are some women who no longer worried about unwanted pregnancy enjoy their postmenopausal status of sexual freedom. Along with dispareunia, urinary problems are also one of the oft-reported discomforts among menopausal and postmenopausal women. Women get affected by discomforts of 'urgency of micturion' i.e. the difficulty to hold urine for a time long enough to even get to the washroom; 'nocturia' i.e. the need to urinate several times while sleeping at night; 'dysuria' i.e. painful urination and/or 'stress incontinence' i.e. when women have a small amount of urine leakage while partaking in some regular activity such as exercise, running or simply while laughing, sneezing or coughing. (ibid)

The change in the menstrual cycle is the third kind of discomfort that women have to face during menopause. The flow of the menses change over time – for some women the flow becomes heavier and for some it becomes lighter. The frequency of the cycle also changes - while some women bleed for more number of days than their usual monthly cycle, there are others who do not bleed for a couple of months at all.

Lastly, along with the discomforts mentioned above, WHO took into account those discomforts which need not necessarily have any physiological manifestation(s). These discomforts were the ones which were sociocultural or psychological in their origin

(WHO 1996 cited in ibid). Some of the common discomforts of this category are – depression, headache, joint aches, stiffness of muscles, chronic fatigue, dizziness, irritability, mood swings, memory loss, weight gain or weight loss, palpitations etc.

### *Variations in Discomforts at Menopause/Symptomatic Variations*

Cross-cultural studies show that hot flashes and other discomforts at menopause, along with being a physiological event, can also be understood as a phenomenological event and are experienced subjectively as well (Kronenberg 1994 cited in Sievert 2006). No discomfort can be seen or understood by itself in a vacuum. For instance, Sievert (ibid.) gives an apt biocultural model of how hot flashes have to be seen as a result of the interaction of three factors – Biology (which includes hormone levels, genetic variation and sweating patterns); Culture (which includes religion, marriage, diet, medicalization, smoking, reproductive patterns, hysterectomy rates and attitudes) and Environment (which includes climate and altitude).

These cross-cultural studies also highlighted the fact that the terminology and vocabulary that is used for the experiencing of discomforts varies across cultures. And in fact, a particular kind of vocabulary used in one cultural setting cannot be easily and literally translated into another cultural setting. For instance Lock's study demonstrates that in Japan there is no exact translation for the discomfort of hot flash. Women generally used the terms *nobose* or *hoteri* to describe when they felt flushed or they used the phrase *kaa to suru* which would mean them getting hot (Zeserson 2001). Neither of these terms would mean the exact same thing as a hot flash. So the question that arises here is, what common grounds do researchers use to measure the variations in discomforts across cultures? According to Sievert (2006), some objective grounds need to be built before measuring the discomforts across populations – for instance when it comes to measuring hot flash, the temperature changes of the hand and chest skin conductance levels, changes in finger-pulse volume ratios, changes in the respiration levels and changes in the core body temperature can be taken into consideration. Zeserson (2001) however goes one step ahead of Sievert and argues that considering that there are differences in the terminologies used across and within cultures to talk about the discomforts and symptoms, two things have to be kept in mind before researching the variations. Firstly, if the aim of the researcher is to assess the occurrence of the discomfort, he/she must "give full importance to vague, informal

expressions used by those experiencing the symptom" (ibid: 189-90). The researcher cannot ignore the nuanced meanings along with the informal expressions and those nuanced meanings can get lost or hidden once they get defined under one overarching medical terminology. Thus, the researching while measuring the occurrence of the discomfort also needs to bear in mind who is doing the defining and describing of that particular discomfort. Secondly, whether a discomfort exists in a particular cultural context or not depends to some extent on how much importance the society places on it. In Zeserson's words,

> "...the coining (or not) of a term for a physical sensation does not signal the existence (or absence of the sensation) but, rather, society's intention in relation to it" (ibid: 190).

Hallad and Khan (2010) give an account of the following studies which demonstrate the variations in discomforts women experience in various parts of the world. Kaur et al. (2004 cited in ibid) in their study in North India found that the diminished acuity of vision was the most common discomfort and only 17% of the women reported having hot flashes. In a study in Egypt, out of the 302 women, Sayed et al. (2000 cited in ibid) found that 75% of the women experienced hot flashes and 83% of the women experienced menopausal discomforts. Regarding variations within the same country, one could consider the example of menopausal discomforts in India. Sharma, Tandon and Mahajan (2007 cited in ibid) give an overview of the most common menopausal discomforts within different parts of India. The most common discomfort in Jammu is fatigue and lack of energy (72.93%), in Pune it is loss of interest (93%) and in Mumbai it is muscle and joint pains (37.4%) (ibid).

Thus, there is no clear picture of the typical symptom prevalence among women in the non-western societies as shown above. There are dramatic differences in frequencies of discomforts across these studies and even among studies in the same region or city. In many cases, it is not clear whether the authors used checklists or open self-report of symptoms so it is difficult to be sure why the frequencies differ to the degree they do. Moreover, the translatability of symptoms from one language to the other becomes problematic. In such a complex scenario, it's a challenging task for the researchers conducting these studies. (Blell 2009)

## 1.4 Research Problem

Whatever the disciplinary grounding, all scientific approaches to the body are based on the assumption that the event or thing to be studied can be represented most accurately using an objective approach. And the majority of the disseminated approaches to conceptualize and understand menopause, the ageing body and female ageing are based on research in the sciences and epidemiology, along with their applications in clinical medicine. The scientific account of ageing is further complicated by the disciplines of sociology, anthropology, psychology and psychiatry. Thus, as one can see, the understanding of menopause and the process of ageing are grounded in various avenues of knowledge – avenues which do not interact and intersect consistently to produce a comprehensive picture. These inconsistent intersectionalities among the different sets of knowledge lead to various debates and arguments, and usually it is one particular set of knowledge which dominates over the others in a particular historical and social context. The situation becomes complicated even further when Western scientific tradition gets imported and imposed on local systems of knowledge, both scientific and popular, in complex geographical settings such as those found in the non-western societies. (Lock 1993)

This dissertation is an attempt to investigate and critically analyse these complex avenues which interact and intersect regarding the conceptualizations of the midlives of women from the focal point of the menopausal transition. As the title of the dissertation suggests, **the aim of the study is to examine the various aspects of the midlives of women 'through menopause' from the standpoints of different actors** such as the medical community, the pharmaceutical companies and the media. More precisely, it aims to explore the broader picture about the dimensions of menopause, sexuality of middle-aged women and related process of ageing. The endeavour throughout this dissertation would be to look at these dimensions by employing a comparative framework of analysis wherein examples from 'the West' and the 'the Rest' i.e. from both western and non-western societies will be provided to substantiate any ongoing discussion. Here, I would like to clarify here which are the societies exactly that I refer to by 'the West' and 'the Rest'. By 'the West' I refer to North America and Europe primarily, as well as Australia. And by 'the Rest' I refer largely to the societies beyond

the orbit of 'the West' which would include the Asian societies and Africa. However, this is not to say that in either of western or non-western societies, one would find a monolithic, homogeneous and/or a rigid understanding of menopause and middle-age. Exceptions can always be found and more importantly, historical changes in understanding the societies are noticeable as I aim to explore through this study.

My reason for this comparative analysis between 'the West' and 'the Rest' is shaped and inspired largely by the ideas of medical anthropologist Margaret Lock (1993) who has one of the most landmark comparative studies on this subject between North America and Japan. Lock's intention behind her study was

> "to challenge views taken as self-evident and universal about menopause and, further to question the responsibilities assigned to middle-aged women by their respective societies (1993: xx)."

I locate the design of my dissertation in her central argument wherein I state that it is important to look at the variations between the different societies so that the apparently self-evident and universal understanding of menopause can be challenged. Although I had started this study looking only at the Western understanding of menopause, it struck me that doing so would give me a very distorted and one-dimensional picture. Thus, I decided on conducting a study which required me to look at literature from different parts of the world as a result of which I can seek out the variations much more clearly. I also argue taking cue from Lock (1993) that it is not sufficient to merely describe the contested definitions of what menopause means to different people. It is important to ask where these definitions of menopause are arising from i.e. the knowledge production responsible for the understanding of menopause and the larger questions of gender, sexuality and ageing also need to be addressed.

By delving into a large body of secondary literature from different parts of the world, the aim shall be to treat the literature not just as mere documents but as objects for critical analysis and interpretive exercises with regard to the question of understanding the menopausal transition within the midlives of women. The reading of texts that I have undertaken has been interdisciplinary in nature. With menopause having been studied through multidisciplinary lenses, it would have been inadequate to look at it

from only one or two perspectives. Thus, I have attempted to use the perspective(s) of the biological anthropologist, the medical anthropologist, the historian and the feminist[8]. Ultimately, my attempt shall be to sociologically connect all the arguments from the different perspectives and make a concrete argument(s).

The dissertation explores the following **hypotheses:**

a) Women's understanding and experiences of their menopausal transition and middle-age are a result of the prevailing discourse(s) of menopause and of gender, sexuality and ageing in the socio-cultural context where they live.

b) To gain a complete understanding of menopause one needs to locate it within the larger framework of the woman's entire life course and the process of ageing, instead of viewing it in a vacuum as an exclusive event.

and,

c) Women's bodies (middle-aged women's bodies in this context) have served as a socio-cultural-medical canvas where the larger questions of the nature of women, their social roles and their concerns (regarding health or otherwise) have been played out as per the convenience of different actors in the society.

The aforementioned hypotheses will be tested by exploring research questions through a critical investigation of the existing body of work on menopause and broadly, on the midlives of women (with examples from both 'the West' and 'the Rest'). The three **research questions** are as follows:

a) The first research question concerns itself with the different knowledge regimes which determine what should be accepted as the truth and what should be rejected. To put it contextually - who/what produces the knowledge available in the society on menopause and broadly, female midlife? The knowledge based on which women experience this stage; the knowledge based on which different images of the menopausal woman are shaped and; the knowledge based on which menopause is

[8] I refrain from using the perspective of the psychologists and the psychiatrists, largely because that would be too wide an ambit for the study to coherently examine.

theoretically conceptualized from different perspectives - where does this knowledge production come from and on what grounds does it get legitimated and reproduced?

b) The debate between the medical community and the feminists and women's health activists on how menopause should be conceptualized forms the subject matter of the second question. In other words, how does one critically look at the debate between the 'medicalization' of menopause on the one hand, and the 'demedicalization' of menopause on the other hand? Can it be said that the 'natural treatment' of menopause is the healthy alternative as compared to the 'medical treatment' of menopause?

c) The third research question moving one step ahead of the 'medicalization' of menopause, is concerned with the 'medicalization' of ageing women's physical appearances and body image, wherein the middle-aged woman is seen as a pathological entity. From Robert Wilson's *Feminine Forever* (1966) to the current motto of 'Forever Young', has the ageing woman's representation undergone any changes at all? The polarity of only 'the West' being obsessed with youth vis-à-vis 'the Rest' where ageing is considered to be a sign of elevated status - how much relevance does this polarity hold in the contemporary times?

The three chapters which will follow and the concluding chapter, will focus on these research questions individually and which have two main objectives - firstly, of trying to garner a sociological understanding of menopause and the midlives of women using different theoretical paradigms which would provide me with a firm theoretical foundation. And secondly, with the knowledge gained, I would like to raise some questions at the end of the dissertation with regards to menopause and middle-aged women in the Indian context and a few questions on a more generic note.

### 1.5 Why Study Menopause: Rationale and Significance of the Study

Whenever people around me, my family members, friends, co-research scholars, and professors, men and women alike, hear that I am writing my M.Phil dissertation on menopause, the first question they have asked me is why study menopause? As a young

woman in my twenties, why would I would be interested to conduct research on menopause? There have been people who have not regarded this as a "serious, sociological topic of analysis", some who have dismissed my topic altogether saying that what research questions could a "peculiar" topic like menopause possibly entail, some who said that this was a very "depressing" issue to be studying and there have been yet others who have ridiculed me over my choice of topic.

The reasons for me choosing to study the topic of menopause, and largely the midlives of women, reproductive ageing, sexuality, the issue of 'medicalization', are three-fold. Firstly, when asked why study menopause, I ask why not, considering that there are so many unanswered questions on this topic! Why is there so much variation in age at menopause? Why did my grandmother not experience any menopausal symptoms whereas my friend's grandmother in London experienced major menopausal symptoms for many years at a stretch? Why do women in the United States ask for medical intervention whereas women in India refuse to ask for any medical intervention? Why do some postmenopausal women have an increased desire for sex while others don't want to engage in any sexual intercourse anymore? What is the history of menopause? Does menopause only have to do with biology? How do women see menopause vis-à-vis menarche and the other reproductive events in their lifespan? Which is the best paradigm to understand the phenomenon (or is it a process or an event?) of menopause? When there are so many questions, examining the various aspects of this topic makes it to be an exciting and intellectually stimulating topic of research in every sense of the word.

Banister (1999) argues that while the popular press eagerly caters to the growing and changing needs of this increasing segment of the population i.e. the middle-aged women and their issues such as menopause, the research community as a whole has lagged behind with not many in-depth studies into midlife women's menopausal experiences. Three biases are pointed out by the author which until very recently have been impediments in this field of research. Firstly, barring a few studies, most of the studies on midlife transition have or had been described exclusively from the man's perspective. Secondly, the women's experiences of menopause and 'the empty nest' have more often than not been seen in a very narrow and often incorrect way. And finally, the lives of middle-aged women and their health issues have not been properly

understood using a scientific, quantitative approach. Lippert also (1997 cited in ibid) points out the need for conducting further research (both quantitative and qualitative) on midlife women's experiences to highlight the complexities that they experience in this stage regarding the physiological, sexual and psychological aspects.

Hence, what struck me, and also my second reason for studying menopause, is the large lacunae in literature on women's midlives, especially in the non-western societies. While there was abundant literature on the women in the reproductive phase of their lives, and then an abrupt jump into their old age, literature of the middle age was sparse. And as far as menopause was concerned, most of the literature available on it until the late 20th century was based on biomedical/clinical and epidemiological research among the Western populations. A large amount of work was available on menopause in the West from 19th century onwards, especially the latter part of that century, but the work on menopause beyond the West came into prominence only after the 1970s. This scenario of the lack in research on menopause and midlives of women was/is quite prominent in the Indian context thus making a study of this kind is all the more significant in such that it opens new vistas for research on these issues. Research on women in India has been confined primarily to their reproductive years[9] and women past these "prime years" have been neglected for the most part. With the strong focus on women in their reproductive life span and to a much lesser extent on issues relating to ageing and widowhood, middle age and menopause as such does not figure. Apart from the pioneering study conducted by Marcha Flint in 1975 and recently an in-depth study by Jyoti S. Hallad and C.G. Hussain Khan (2010) in the rural Dhalwad district of Karnataka, India, the few other studies[10] on menopause have been limited in their scope. More often than not, those studies stemmed from biomedical perspectives or to determine the age at onset of menopause. Thus, there hasn't been much effort to study the needs of women who are in the menopausal stage of their lives and of middle-age

[9] There is a large body of literature available in the India on women who are in their reproductive phase. Some of the seminal works in this field are by scholars like Tulsi Patel, Mary John, Uma Chakravarti, Rajni Palriwala and Prem Chowdhary.

[10] For instance some of the recent studies are: Verma, N. 1993. *Application of probit analysis to estimate age at menarche and menopause in Goan* women. International Institute for Population Sciences, Mumbai; Sharda, S et al 2005. Age at menopause in educated women of Amritsar (Punjab). *Journal of Human Ecology*. 18(1): 49-51.; Sudhaa, S and V. R. Tondon. 2007. Menopausal Symptoms in Urban women. *Indian Journal of Gynaecology and Obstetrics*. 9(1): 13-17.

and ageing in general. (ibid) The World Bank predicts that the number of postmenopausal women in the world will rise from 467 million in 1997 to 1.2 billion by 2030 and most of this increase will occur in developing countries –76% of the postmenopausal women will be in the developing parts (ibid). There is in my opinion, a crucial requirement for the understanding and management of health concerns of the middle-aged women and with such numbers and facts at hand, studies of the present kind become significant[11].

## 1.6 Chapter Plan

The present chapter i.e. the **first** chapter of the dissertation begins with an introductory note on menopause as the 'midlife passage', following which the theories of the evolution of menopause in the human female species are explored to answer the question of why do human females have such a long postreproductive life unlike other primates. Next, I outline a brief literature review of menopause in 'the West' vis-à-vis 'the Rest' to give the reader a quick scan of the broader conceptualizations of menopause, followed by the research problem (which include the hypotheses and research questions). The rationale and the significance of such a study both in the broader discipline and in the Indian context and the structure of the dissertation will be discussed in the remaining chapter.

The **second** chapter to begin with concerns itself with the Foucauldian understanding of discourse as a concept, followed by the discursive constructions of menopause and the knowledge systems or systems of thought which have existed and changed with time regarding this topic. Also related to the discursive constructions of menopause are the subjective meanings that are attached to menopause and the menopausal transition. Thus, how menopause is defined and more importantly, who defines it for whom will be examined. Finally, I aim to explore the various theoretical approaches which have been/are employed for the conceptualization and understanding of menopause and the menopausal woman and which theoretical approach do I intend on employing in the rest of the dissertation.

[11] However, I would like to clarify here that while I do argue for a more urgent need of health care facilities for the middle-aged women in India, I do not support its 'medicalization' as is prevalent in 'the West'.

Situating itself in the scientific/biomedical discourse of menopause and the biomedical theoretical framework of looking at menopause, the **third** chapter looks into how menopause is perceived as a pathology in the scientific/biomedical community; a pathology which requires medical 'treatment' in the form of Hormone Replacement Therapy. The historical medical trajectory of menopause will be traced and the creation of 'the menopause industry' by the pharmaceutical companies in the West will also be discussed. The discourse of 'alternative' therapy would form the second part of this research question, wherein, the feminist critique of the 'medicalization' of menopause and 'alternative' and 'natural' forms of 'treatment' for menopause in the non-western societies will be investigated.

The **fourth** chapter, situating itself within the life course theoretical framework is concerned with the intersectionality of menopause, sexuality and the ageing process. How menopausal women negotiate with the sexual changes, sexual relationships and sexual concerns forms the first part of this discussion. And the second part of this discussion deals with ageing, how the menopausal, ageing women's body becomes the recipient of the various 'messages' received in the society by the medical community, media and significant others and the anti-ageing discourse (using a Foucauldian approach) which looks at how ageing women are being constantly pressurised from different sources to try and stay 'forever young'.

By the discussion and arguments built through the previous chapters, the validity of the proposed hypotheses will be tested in the **fifth** and final chapter. This chapter would engage itself with the directions of further research in this field by raising questions within the Indian scenario. Additionally as most discussions of menopause and middle-age are based on the lives of heterosexual, married women, this final chapter asks some pertinent questions beyond this normative context.

# Chapter Two

# Menopause: Discourses, Definition(s) and The Paradigms of Research

## 2.1 Introduction

The topic of menopause has been explored and spoken about by the medical community, researchers and women themselves in a multitude of ways. It is this multidimensionality which makes the study of menopause a topic worthy of investigation. This chapter in its first two sections proposes to look into the matter of who defines menopause and on what parameters? More importantly, which are the discourses which have made an impact, and/or influenced the understanding of definitions and/or concepts in the field of menopause research as well as of the middle-aged women's position in their respective society? The raison d'être of these objectives stems from a poststructuralist perspective wherein an individual's subjectivity is seen as being "formed through language, concluding that there is no knowing, rational subject, only the subject that is constructed through systems of discourse" (McPherson 2002: 2).

The next sections within this chapter will examine the various paradigms, assumptions and conceptualizations that have been used and are currently being used to understand the menopausal transition in a woman's life. This section aims to be designed as a theoretical exercise which would be of assistance in two ways. Firstly, taking from the discussion on discourses, this section would highlight how certain forms of knowledge systems take precedence over the other forms of knowledge systems and how language plays a crucial role in qualifying one set of ideas and disqualifying the others, or simply putting them in the periphery. Secondly, it will assist me to make use of these paradigms at different points in this dissertation to engage with the different themes.

## 2.2 Defining Menopause: Whose Menopause Is It?

> "Menopause is the culture's defining consciousness about older women and within it there are several narratives of the 'problem'. There is the **medical-problem-medical-solutions story**, which treats it as an illness and is accompanied with lists of enough grim physical and psychological

> symptoms as to make you slash your wrists. It is heavily weighted towards hormone replacement therapy and frequently has a critical edge that implies that while menopause is a clinical condition requiring medical intervention, the woman is selfish and pathetic for seeking help to manage her symptoms. There is the **pull-yourself-together-so-you-don't-frighten-the-children-or-upset-the-men story**, which counsels women not to bore and embarrass others with this life- changing experience – 'just grin and bear it, and keep taking the tablets'. And finally there is the **I-did-it-my-way-with-the-help-of-the-goddess-and-a-few- archetypes**; this version is dreamy and mystical and often involves herbs, visualisation and rituals with shells and candles" (Sontag 1972: 31).

Goodman in her article titled 'Towards a Biology of Menopause' (1980) writes that one of the major stumbling roadblocks in the research of menopause is the problem of defining menopause itself. By simply assuming that menopause is a disease with a certain set of menopausal symptoms, experiences of only those women will be considered who report of those symptoms. Women who don't experience those established medical symptoms won't be taken into account. Although the next chapter of this dissertation would explore this in more detail, the medical definition of menopause, particularly in 'the West', has seen menopause in negatively (ibid). From the mid-twentieth century onwards, the medical community defines menopause as a 'deficiency disease', a disease with hormonal deficiency similar to other hormonal deficiency diseases such as diabetes. Defined as the breakdown of central control and failed reproductive ability in the woman, the language used by the medical community to define menopause uses metaphors of disease or abnormal degeneration such as "sex-steroid deficiency", "loss of womanhood and femininity", "vegetative symptomatology" (Callahan 1993).

The World Health Organization (WHO 1996) defines menopause as the permanent cessation of menstruation due to the loss of ovarian follicular activity. Although this particular definition uses a symptom that can be identified by a woman and a sign that can be measured, there are definitional drawbacks. Firstly, this definition is more suited for a clinical/medical purpose and does not take into consideration the variations

spanning across different cultures among women who define menopause in different ways. For instance while some women define menopause as the end of menstruation, some women define it as the end of their ability to procreate (Sievert 2006). There can be positive and negative perceptions surrounding the definition of menopause among women, which the definition by WHO doesn't consider. The definition also does not consider that a woman can attain menopause surgically i.e. through hysterectomy and these women can still have functioning ovaries – so, even in the absence of menses, follicular activity can continue. On the other hand, while follicular activity can cease, menstruation can continue with the use of Hormone Therapy. An end to fertility can also be brought about by tubal ligation, pelvic inflammatory diseases, polycystic ovarian syndrome (wherein ovaries produce very high amount of testosterone, giving rise to many a post-menopausal symptom but it isn't menopause), and not necessarily only by the cessation of menstruation. Sometimes, just the end to sexual activity brings about an end to fertility, but not to menstruation. (ibid)

As opposed to the definition provided by WHO, below are two examples of definitions that go beyond the biomedical ambit of defining menopause:

> "Menopause is often defined as being part of a woman's lifecycle that progresses from birth into childhood, adolescence, maturity and coalescence" (Sheehy 1993 in Berger 1999: 80).

> "We call it the change of life. It begins in mid-life, usually somewhere between 40 and 55, and can last roughly for a decade, its many and varied particularities (italics mine) appearing only in women" (Coulbrooke 2002: 152).

In her influential work *Encounters with Aging: Mythologies of Menopause in Japan and North America* (1993), Lock focused on the Japanese notion of '*konenki*' which is not the the same as the Western definition of menopause. Lock writes,

> "...menopause is not a 'fact', and hence it cannot be neatly packaged or contained in a single precise term that transcends time and space, history and culture. On the contrary, it is a concept with boundaries and meanings

> that shift depending upon the viewpoint and interests of speaker and listener...But despite its fuzziness, it contains some meaning about which surely everyone can agree, namely it has something to with becoming older" (Lock 1993: xviii).

Explanation of the term *konenki* by the Japanese women in the due course of Lock's research brought forth a wide array of responses depending on how a woman interpreted this phase in her life. While some women believed that "you can reach the end of menstruation without having *konenki*" (ibid: 8), there were others who believe that *konenki* "is closely tied if not defined by the end of menstruation" (ibid: 10). Even the Japanese medical textbooks did not have the exact word for the English word menopause – the term *'hekei'* was used for the end of menstruation which is probably closest to the current meaning of menopause in English (ibid).

Another example in the variation found in defining menopause based on how women experience this phase is cited in the book, *Menopause: A Biocultural Perspective* (1960) by Lynnette Leidy Sievert. Among the 470 women in Asuncion, Paraguay, who were asked to define menopause Sievert found that 31% defined it as the end of menstruation, 25% defined it as a normal change in life, 18% defined it as a negative change, 13% defined it as the end of fertility and the rest either didn't know about it or defined in other terms of the beginning of old age or the end of desire for sex. The definition given by WHO does not address the fact that menopause can have such multiplicity in meanings.

Difficulty also arises in defining terms such as premenopause, perimenopause and postmenopause. For instance, only by knowing the date of the last menstrual period does not necessarily indicate that a woman is peri- or postmenopausal. One also needs to consider the difference that would exist in defining natural menopause and surgical menopause or hysterectomy. Thus, with different women experiencing this phase in their lives in different ways makes having a single definition of menopause a daunting task.

Ferguson and Parry (1998) write that the definition of menopause has been manipulated and historically, the definitions have kept changing. Like many other so-called 'illnesses' (such as homosexuality, alcoholism, hyperactivity in children)

menopause was seen as a sign of sin and decay in the Victorian era. Then with Freudian influence in the early twentieth century it came to be seen as a neurosis. And finally with the easy and cheap availability of synthetic hormones in the 1960s, menopause was medicalized as a physiological disorder. So the question that still remains is - whose menopause is it? On what parameters does one define menopause? There are different actors such as health organisations like the WHO, there is the medical and clinical community, the drug companies and then there are the women themselves, women belonging to different social and cultural backgrounds - each with their own subjective definition(s) of menopause. The quote below puts the matter of defining menopause to rest.

> "There is no typical menopause, there are as many menopauses as women."
> (Iris Murdoch, The Good Apprentice, 1985 in Lock 1993: Prologue).

The following is a look into the discourse(s) which shape the subjectivities of women and how ultimately menopause is a 'constructed' concept and a concept through which other aspects of a woman's midlife also gets 'constructed'.

### 2.3 'Constructing' Menopause: A Foucauldian Framework of Analysis

In this section the attempt will be to describe the discourses through which menopause has emerged as "a heavily politicized lifespan identity construct and as a locus of interlinked but conflicting and shifting discourses" (Coupland and Williams 2002: 420). Before that let's take a quick look at the Foucauldian conceptualization of discourse and it's relation to language and power.

The central argument running throughout the Foucault's theoretical approach explains Hobbes (2008) is that different periods of history have constituted different systems of thought, or rather epistemological fields (what Foucault labelled 'epistemes'), which are in turn applied as formal systems of knowledge. Foucault was not conceptualising this movement from period to period as a type of evolutionary progress towards a 'better' knowledge system. Instead, he was interested in the shifts in the configuration of knowledge, or what a society considers and values to be knowledge from episteme to episteme. (ibid)

Thus, Foucault's primary focus was on how in certain periods of history, there are some competing discourses which shapes and create certain meaning systems which gain the currency of 'truth' and every other 'truth' gets marginalized, subjugated and/or rejected. The one dominant system of 'truth' dominates how the society defines and organises itself as well the existing systems or institutions in the social world. The formation of identities and practices for Foucault, are related to or are a function of historically specific discourses. The questions that arise within this Foucauldian framework are to do with how some discourses maintain their influence, how some 'voices' get heard whilst there are others which are silenced, who gets to benefit, how and at whose cost? Thus, it is important to understand these discursive constructions to make sense of the systems of meanings around us. (Hynes 2006)

Hobbes (2008) writes that Foucault's definition is as much about ways of thinking and practices as it is about language and according to Foucault "meaning and, thus, meaningful action are only made meaningful within the constitutive abstract space of a discourse" (2008: 7). Hence what distinguishes one episteme from another is a discourse which is in simple terms ways of framing how social beings think about certain topics, things and objects.

Whisnant (2012) writes that the prime object studied by the Foucauldian discourse theory is language and other forms of symbolic exchange. Language here as suggested by this theory can be broken down into different "[bodies] or [corpuses] of statements and utterances governed by rules and conventions of which the user is largely unconscious" (Macey 2000: 100 cited in ibid). This style of language, both spoken and written, is governed by a specific set of rules and patterns which combined together can be said to be a discursive formation. Or in a larger sense, when a discourse (which helps in both characterising and classifying particular epistemes) is manifested and found in a range of areas such as language, practices and institutions then that discourse according to Foucault is evident of a discursive formation. And ultimately, the prevalent knowledge systems or epistemes which are supported by discursive formations are made true through 'discursive practices' (Hobbs 2008). To sum up, in the Foucauldian sense discourse refers to very specific patterns of language that tell us something about the person who is speaking the language, the culture of which the person is part

of, the network of social institutions that the person is caught up in and frequently the most basic assumptions that the person holds (Whisnant 2012).

Now coming back to the subject of menopause, it is essentially a term coined in 'the West'[12] (by the French physician C.F. Gardanne in 1821) and within the Western society itself the meaning of menopause has changed in the course of history, depending on the knowledge about it as well as the politics, economy and culture of the particular time-period. Regarding the understanding of menopause in a society,

> "Different ways of talking and writing about menopause thus shape different images of menopausal women, and different discourses facilitate and limit, enable and constrain what can be said, by whom, where and when" (Willig 2003 cited in Hvas and Gannik 2008).

Up until recently (and to a great extent even now) the medical discourse of menopause has predominated according to which menopause was depicted as a time of deterioration (McPherson 2002). But there have been other discourses which have challenged this medical discourse and offered other ways of depicting menopause. In recent years, research beyond the medical sciences and epidemiology has seen the term menopause being subjected to "a complex and variable set of representations, all ideologically loaded, politicized and subject to cultural variation" (Harding 1997; Hunt 1984; Hunter and O' Dea 1997; Kaufert 1982; Lupton 1996; Wei Leng 1996; Worcester and Whately 1992 cited in Coupland and Williams 2002). The following sections will explore the various discourses that different researchers have described through their own work in the field of menopause research.

## 2.4 The (Conflicting) Discourses of Menopause Research

Coupland and Williams (2002) discuss three major discourses through which women make sense about menopause. The authors argue that neither of the discourses are uniform or diametrically opposed to one another. Rather, certain common and/or

[12] The word menopause is no longer limited only to "the West" and has been imported to other parts of the world as part of the biomedical framework. However, many women in the non-western societies do not associate their middle age with menopause exclusively as most (if not all) women do in the western societies. For instance as Lock's (1993) study shows that Japanese women do not use the word menopause as such and don't even have an equivalent for it in the exact sense of the word.

similar discursive elements play and replay themselves in all three, albeit with varying commitment and emphasis. For the most part, experiences of the British menopausal women of their study reflected polarised opinions, primarily based on two of the discourses – menopause as disease on the one hand and menopause as an unproblematic, natural life stage on the other. Let us take a look at the three discourses that the authors bring out through their study.

**a.** ***The Pharmaceutical Discourse:***

Represented by pharmaceutical brochures and other forms of texts this discourse uses a discursive strategy of 'speaking' with an authoritative 'medical voice'. They present the information as uncontentious 'facts', appealing to so-called logic and common sense by recommending the most 'obvious solutions'. There is also a certain unambiguity in the matter of 'who' is speaking to the target audience – is it the 'voice' of the pharmaceutical company itself or of some medical practitioner?

> "The ambiguous status of these texts, as marketing brochures or medical information leaflets, is perhaps clearest in the authorial voice they adopt" (Goffman, 1981: 144 cited in Coupland and Williams 2002: 423).

The pharmaceutical texts pathologize menopause through the dominant ideology according to which menopause is discursively construed as a medical problem with a host of assisted symptoms, most or all of which have medical solutions. Metaphors of deficiency, decline, depletion, disappearance and loss are used to construct menopause as a degenerative disease. These texts use the metaphor of body-as-machine which

> "...legitimizes a proposed drug regime; a mechanical fault has developed, which will right itself eventually; in 5 to 10 years, or the fault may remain for life. Mechanical faults can usually be fixed, and a potential inference is that HRT can 'fix' the fault more quickly" (ibid: 425).

**b.** ***The Alternative Therapy Discourse:***

As represented in popular printed media texts (usually written by alternative practitioners such as nutritionists and herbalists) which reject the medicalization of

menopause and hormone replacement therapy, focusing on *natural*[13] (italics mine) alternatives through self-help, a certain diet regimen, exercise and lifestyle management. While still looking at menopause as problematic and troublesome like the previous discourse, the solutions to solving this problem are constructed differently. Also, unlike the earlier discourse,

> "...themes of control over one's own body, self-determination and responsibility for one's own well-being are characteristic of the 'alternative' therapy texts" (ibid: 433).

### c. *The Emancipatory Feminist Discourse:*

This discourse reconstructs menopause as a significant positive rite of passage wherein it is a time of re-evaluation and new-found freedom. This discourse is strictly against pathologizing or medicalizing or problematizing menopause and proposes new ways of thinking and speaking about this transition. The feminist discourse, for instance as found in the work of Germaine Greer (1994),

> "...celebrates women's bodily states throughout the life-course and emphasizes spiritual power, and 'materialist' feminism which critiques the sexism of valuing women for their youthful attractiveness and sexual availability, at times used in combination." (ibid: 439).

However, these aren't the only three discourses that exist in the society. Hvas and Gannik (2008) in their research on Danish menopausal women and using 132 pieces of texts (booklets and informational material, articles from newspapers and magazines and popular science books) were able to identify seven different discourses on menopause as discussed below.

### i. *The Biomedical Discourse:*

[13] I italicised the word natural as this like the medical treatment for menopause has come under criticism – a discussion which will be taken up in the subsequent chapter.

Seen as a deficiency syndrome caused by deteriorating/declining hormones, menopause is seen as a cessation of the menses with a host of symptoms as well as a high risk of diseases in the years to come especially the risk of osteoporosis. This discourse constructs the menopausal woman as a patient who can be cured with medication if at all they want to maintain body control.

ii. ***The 'Eternal Youth' Discourse:***

This discourse promotes longevity, youth and youthfulness and ageing people, especially ageing women, are derided and made invisible. Menopause is considered to be a negative symbol of the ageing process and is seen as a threat to be counteracted by cosmetic surgery, moisturizers, hair colouring remedies and hormones. This discourse also promotes hormones as the 'magic pill' or a 'life elixir' which can act as an age-retarding commodity.

iii. ***The Health-Promotion Discourse:***

Physical fitness and good health are endorsed by this discourse as per which menopausal symptoms and risk of osteoporosis are seen to be averted/ modifiable with changes brought about in one's lifestyle. Menopausal women are told to be fit, follow dietary restrictions and stop smoking.

iv. ***The Consumer Discourse:***

Menopausal women through this discourse are seen as active consumers, who should be informed, educated and having consumer rights to make an 'informed choice'. However, they are encouraged to make their choice together with a physician, and can choose often only among the number of choices set up by physicians.

v. ***The Alternative Discourse:***

Although this discourse views menopause as a natural and often positive process, it is also sees menopause as a passing imbalance which might strain the woman's body. This imbalance can be treated with *natural* (italics mine) substances such as plants and tofu.

vi. ***The Feminist/Critical Discourse:***

Seen as a natural, mostly positive period in a woman's life, the proponents of this discourse criticize the medical professional and international drug companies for medicalizing menopause as a disease. It is not denied that women could experience severe symptoms during the menopausal transition but those symptoms could largely be a result of the other stressful events in their lives. Treatment is seldom deemed necessary and what is more important is that women should be well informed about their bodily changes.

**vii. *The Existential Discourse:***

Menopause according to this discourse is "uplifted to a process of self-discovery, a catalyst for change and personal growth...is a question of being able to accept life 'of good and evil'..." (ibid: 179). The menopausal symptoms are seen as a part of life itself and not necessarily as something negative. Menopause and ageing are seen as including a lot of possibilities, increased confidence, experience and competence for the women. Also a period of increased freedom, with menopausal transition comes the time for women to spend time for/with themselves as well have the possibility of becoming a grandmother. The focus of this discourse, thus, on midlife changes as a part of the ageing process rather than on the hormonal changes and symptoms that comes along with menopause.

The authors observed that although the biomedical discourse was found to be dominant, it was challenged by the other discourses by offering different scopes of action and/or resting on different fundamental values. Thus, depending upon which discourse the menopausal woman chose, her position could be that of an empowered woman who was capable of making her own choices in relation to her body and health or she could be a passive consumer.

Many of the Danish menopausal women in Hvas and Gannik's (2008) study used terms as promoted by the biomedical discourse such as 'a period of decline and decay', even if they did not necessarily agree with the ideas of this discourse. It was the existential discourse however, which permeated most of the interviews, more so when the conversations were about ageing, femininity and self-development. (ibid) This shows that there are women in the society who are constantly negotiating with the prevailing

discourse(s) and forming their own subjective interpretations of menopause. This is in consonance with the feminist adaptation of the poststructuralist theory which acknowledges women as having their agency and not as being mere subjects of the discourses in the society. Hence, the notion of agency and the embodiedness of the woman within society cannot be ignored. According to Chris Weedon,

> "even though an individual's subjectivity is formed through discourses, as capable individuals they are often able to act on the discursive knowledge they have acquired, in ways that might resist or serve to maintain the status quo" (1987 cited in McPherson 2002).

Let us now delve into the conceptualizations of menopause in the disparate paradigms of menopause research which have been influenced by the different discourses.

## 2.5 The (Disparate) Paradigms of Menopause Research

This section will be a discussion on the theoretical research paradigms, beliefs, assumptions and conceptualizations of menopause found in the language of research. The attempt will be to explore the interrelationship among the underlying assumptions about the different discourses, paradigms about menopause as well as about women. Seven theoretical paradigms of menopausal research have been identified across a thorough review of the existing literature and every paradigm will be substantiated with examples/case studies as a part of their trajectory they have followed since their beginning. Each one of the paradigms with differing (sometimes overlapping) foundational assumptions and their different theoretical perspectives on menopause will be explored (Dickson cited in Callahan 1993).

### a. *The Biomedical Paradigm*

The current body of work which is available on midlife women and menopause is conceptualised primarily using a biomedical approach. "Little research data are available that have not been strongly filtered through the biomedical perspective" (ibid: 36). This approach has been the perhaps the only approach used for understanding menopause in the West until the 1970s. Menopause and the female menopausal body using this approach are understood as a deviance from the "normal". The "normal" in

this case would be the male and the male body, while the menopausal, ageing woman is seen as being deviant from that "normal" and the biomedical approach reinforces the ageing woman as "abnormal". The following example from the controversial medical journal and bestseller, *Feminine Forever* (1966) by Dr. Robert Wilson, puts the case in point:

> "The unpalatable truth must be faced that all postmenopausal women are castrates....Our streets abound with them - walking stiffly in twos and threes, seeing little and observing less. It is not unusual to see an erect man of 75 vigorously striding along on a golf course, but never a woman of this age. Now for the first time in history, women may share the promise of tomorrow as biological equals of men. Thanks to hormone therapy, they can be feminine forever" (Wilson 1966: 362).

Emily Martin (1987) writes that the language used to discuss and understand menopause in the biomedical literature is problematic in itself. Menopause in this body of literature is conceptualized as a breakdown of central control and failed reproduction. Some other phrases and metaphors used for menopause in biomedical literature are - "sex-steroid deficiency", "vegetative symptomatology", "estrogen withdrawal symptoms", "loss of womanhood and femininity", "death of a womb", "death of a woman in a woman" and so on.

The beginning of this particular approach can be traced back to the beginning of the hormone studies in the 1930s and 1940s. The belief during this period was that women could be studied in a "dispassionately empirical way" (ibid: 38) and the changes and fluctuations in the hormonal levels of women could be universally treated with scientific methods. Dickson (cited in Callahan 1993) explains that there are three sets of assumptions, not mutually exclusive, that need to be understood why menopause was being seen (and is seen even now to some extent) as a biomedical variable with biomedical forms of treatment and outcomes. The first assumption states that science because of its empirical, rigorous and precise nature always results in true, objective, and unbiased knowledge. According to the second assumption, women are to be seen as products of their reproductive system and hormones. And the third assumption which is linked to the previous one, states that the women's reproductive system is inherently

pathological. The assumptions stated about women arise from the Freudian argument that for women biology is destiny and they are the victims of their changing bodies and fluctuating hormonal levels. Having established by the biomedical framework that women's functions are limited to their reproductive life span, with the onset of menopause, women are seen as medically old and socially useless. Menopause is seen as a physiological change with resulting psychological problems in the woman. Like diabetes, menopause is understood as a hormone deficiency disease and is considered to be "curable" and can be "treated" by Hormone Replacement Therapy or Estrogen Replacement Therapy.

**b.** ***The Sociocultural/ Cross-Cultural/Anthropological/Non-(bio) medical Paradigm***

The epistemology of this paradigm arises from the assumptions that firstly, the cause of any problem is either social or cultural, rather than being biological. Secondly, it is the position of women and their societal conditions which contribute to their reactions towards menopause (Dickson cited in Callahn 1993).

> "The roots and effects of knowledge and power, rather than being vested in the scientific discourse and clinical jurisprudence, as in the biomedical paradigm, are found in the everyday language of cultural, social, environmental, and philosophical phenomena" (ibid: 41).

Cross-sectional studies in the non-western societies were being conducted since the 1970s, posing a challenge to the medical practitioners in 'the West' who conceptualized menopause as a disease and wanted to use hormone therapy as its cure. Through these anthropological studies, the cross-cultural variations in the meanings and experiences of menopause, a supposedly universal biological phenomenon, have been documented well over four decades now (Kagawa-Singer et al. 2002). The lines below by Sievert (2006) summarize the significance of undertaking cross-cultural studies:

> "Cross-cultural studies broaden our understanding of the menopause transition by showing that age and symptom experience at menopause is an aspect of human variation, like childhood growth (Bogin 1999; Eveleth and Tanner 1990), skin colour (Frisancho 1993: relethford 1997), blood pressure (james and Brown 1997), or nose shape (S. Molnar 2002). Defining the "normal" menopause transition is useful for biomedical concerns: "normal" however, has

most often been based on data from Western populations. Anthropology expands the concept of normal by including the rest of the world: new ranges of variation refine our ideas of normality." (Sievert 2006: 65).

The pioneering work in this paradigm has been that of biological anthropologist Marcha Flint. As gynaecologist Malcolm Whitehead points out, "Flint's work inspired a generation of research" (Whitehead 1994 cited in ibid). In 1974 Flint studied menopause among 483 Rajput women of Rajasthan and Himachal Pradesh in India as part of her doctoral dissertation in the City University of New York, and her dissertation was titled 'Menarche and Menopause of Rajput Women'. In her article 'The Menopause: Reward or Punishment?' (1975) in *Psychosomatics*, Flint raised the question that how are there nearly two million women in the United States who face menopausal symptoms and are these symptoms found cross-culturally or are they peculiar to women of North America and Western Europe? On her fieldwork in India, the findings showed that the Rapjut women had very few problems after the onset of menopause and hardly showed any of the common symptoms that women in the West showed. Except for the fluctuation in their menstrual cycle and the cycle finally coming to an end, other symptoms such as depression, hot flashes, and dizziness were not experienced by the Rajput women. Flint explains this cultural difference based on the fact that in India, menopause brings about a positive change of role as well as an elevated status. Until their menopause, the Rajput women had to keep themselves isolated behind the veil but following menopause they had greater freedom in their mobility and they could participate in activities which were not allowed before. Menopausal women in Himachal Pradesh had the freedom to go out in public places and openly communicate and joke with the male members of the family and community. As menstrual blood in India is considered to be impure and a menstruating woman is seen as being dirty and contaminative, a menopausal woman is no longer seen as being dirty or a threat to the others around her. Flint explains how because the West is obsessed with youth and sex-saturated, in such a sociocultural context, menopause is seen as a punishment as opposed to most of the non-western cultures where menopause is seen as a reward (Flint 1975). In her three-page article in *Psychosomatics*, Flint crossed the boundary between social science and biomedicine and was able to communicate through her

study in India that "much of what we call 'menopausal symptomatology' may well be culturally defined" (ibid: 163).

Another influential ethnographic study during the 1970s was carried out by Donna Lee Davis in a Newfoundland fishing village called Grey Harbour. Davis's longitudinal study, titled "Blood and Nerves Revisited: Menopause and the Privatization of the Body in a Newfoundland post-industrial Fishery" (1997) illustrated "the changing meaning of womanhood and menopause in response to decreasing economic and social stability" (Kagawa-Singer 2002: 86-87). Davis through her study found that for the women of Newfoundland, menopause instead of being a biomedical issue was more of a social and/or personal problem. However, that changed over time and women started seeing menopause as a biomedical problem. What was interesting about Davis's study was how she emphasized the folk idioms of "blood" and "nerves" – "folk idioms of nerves and blood dominated the local systems of meaning and encapsulated all talk about health-related phenomena" (Davis 1997: 4). These folk idioms of "blood" and "nerves" at one point linked soma, psyche, tradition but they had been later replaced with the biomedical model of menopause. Unlike the Rajput women of Flint's study who faced no menopausal symptoms, Davis found that women in Grey Harbour complained of symptoms such as 'nerves', tiredness, loss of memory, loss of patience and lack of judgement. In the post-industrial fishing society of Newfoundland, changes have taken place in the way women conceptualize their reproductive life cycle events and other related processes. Unlike in the past, women had begun to accept the biomedical model and asked for medical intervention. Davis found that the body had become "privatized", wherein any kind of problem that women faced, they castigated themselves and looked towards the medical community for help.

Brian Du Toit's (1990) study is considered to be another important anthropological study which explored the beliefs and attitudes that women of Indian origin in Pretoria, South Africa have towards menopause (as well as menstruation). Du Toit found that most of the women believed that menopause meant that since a woman was no longer losing blood or using it to have a baby, retaining that impure menstrual blood in the body would cause a range of health problems such as varicose veins, high blood pressure, diabetes, cancer, obesity (with enlarged breasts and a bloated stomach), breathlessness as well as hot flushes (from having too much blood). More

premenopausal than postmenopausal women believed that menopause was natural, normal, and it was not the cause of ageing and ill health. But despite the belief that retaining the menstrual blood would cause health problems, both premenopausal as well as postmenopausal women said that their response to the menstrual cycle ending would be/is relief. Some explained (both Hindus and Muslims) that after menopause they can participate more in their religion practices and there were many postmenopausal women who believed that a postmenopausal woman no longer "feels for a man" and that after menopause women can have their own beds or bedrooms. However, there were a few women who believed that having menses was a good thing as it gave them a break from religious responsibilities and with the onset of menopause, they would lose that freedom. There wasn't much of a consensus among the women on the reasons for why did women experience menopause. While some Muslim women said that Allah does not want old women to become pregnant, there were others who said that as women grow older the amount of blood produced in their system keeps declining until they reach a point where they have the same amount of blood as men and thus don't need to shed the excess blood any longer.

One of the most renowned and landmark cross-cultural studies in menopause research was that of medical and cultural anthropologist Margaret Lock. Although she has written a number of journal articles and books, her book *Encounters with Aging: Mythologies of Menopause in Japan and North America* (1993) has been influential and inspiring for many social science researchers (including myself). Lock's book looks at how the Western culture particularly in North America, seeks to control the natural physiological/biological process of menopause by medicalizing and pathologizing its normal functions. "This detailed examination of ageing in Japan offers a basis for reflexive objectivity, a chance to look back at the United States with more clarity to see how the medicalization of women's ageing is a cultural peculiarity, rather than a biological necessity", points out Sievert (2006: 58). Lock's focus on menopause for discussing nature/culture dichotomies made for an insightful addition to the growing literature on menopause research and medical anthropology in general during the 1990s. She uses detailed interviews, statistics, historical and popular culture materials, and medical publications to produce a richly detailed ethnographic account of the lives of Japanese women. Lock's research in Japan demonstrates how culture plays a major

role in creating experiences and how this cultural influence exerts itself even on the experiencing of menopause among the Japanese women. In 1988 Lock had undertaken a large-scale study where she interviewed 30 gynaecologists, more than 100 general medical practitioners and had questionnaires filled in by more than 1100 women. The women hardly showed any of the menopausal symptoms baring a few like headaches, aching joints and stiffness in the shoulders which was a contrast to their North American counterpart. And the hot flush as a symptom was rarely mentioned and there wasn't even a literal translation for it in the native language. In fact, Japanese women did not have a literal translation in their own language for the term menopause. They used the term *konenki* which didn't have the same meaning as menopause. The definition put forth by Lock states "*Konenki*: the turn (change of life); the critical age; the menopause" (Lock 1993: 3). The interviews conducted by Lock brought forth a varied hue of answers when asked what the women understood by *konenki.* While for some it meant the end of menstruation, for others it meant being closely tied to the end of their menses but not completely while there were others who believed that "you can reach the end of menstruation without having *konenki*" (ibid: 8). For most Japanese women, *konenki* which was a gradual transition had more to do with their increased responsibility towards the elders of the family, towards dealing with their children moving out of the family, greying hair and failing eyesight than the end of their menstrual cycle. In Japan, the menopausal syndrome has been described as "a disease of modernity, a luxury disease affecting women with too much time on their hands" (Lock 1991: 1272). While the medical textbooks in Japan used the term *hekei* instead of *konenki* – where *hekei* was perhaps closest to the English word menopause referring to the cessation of menses – while conversing with the patients the doctors used the term *konenki.* Along with questioning the universality of ageing, Lock through her research over the years developed the concept of 'local biologies'. Instead of arguing that biological sciences are historically and culturally constructed, what Lock means by 'local biologies' is

> "...the way in which the embodied experience of physical sensations, including those of well being, health, illness, and so on, is in part informed by the material body, itself contingent on evolutionary, environmental, and individual variables...knowledge about biology is informed by the social, and the social is

in turn informed by the reality of the material. In other words, the biological and the social are coproduced and dialectically reproduced...The material and the social are both contingent - both local" (Lock 2001: 483-4).

Thus, Lock explains that menopause should not be understood only as a biological transformation influenced or modified by the culture in which it is happening. Rather, researchers should understand that biology and culture get coproduced within a certain kind of embodied experience and the subsequent expression. (ibid.) So in the case of the Japanese women, biology and culture need to be understood along with how these women embody their everyday, lived experiences.

Apart from the seminal studies mentioned above, there have many other cross-cultural studies on menopause including Asian and African populations, thus demonstrating variability in the menopausal experiences. Gabriella E. Berger (1999) gives a comprehensive account of the different cross-sectional studies that have been undertaken over the last few years. Studies were done by van Keep (1984), Flint and Samil (1990), and Samil and Wishnuwardhani (1994) in Indonesia where by and large menopause had a moderate impact on the daily lives of Indonesian women; Moore and Kombe (1991) studied a small sample of African women in Tanzania whose menopausal symptoms were quite similar to women in the West; women in Philippines were studied by Ramosa-Jalbuena (1991) and Gonzaga (1994) and women did not show much of the menopausal symptoms and assigned low priority to menopause compared to their Western counterparts. Anthropologist Kyra Kaiser (1990) conducted a study to compare the experiences of menopausal women across fifteen sociocultural groups - Northern India, Canada, New Zealand, Amazon Basin and Alaska were some of those sites. Overall, Kaiser found that women from these societies did not treat menopause negatively, showed few symptoms and viewed it as a natural transition in their lives.

### c. *The Biocultural Paradigm*

"Any effort to divorce biology of the menopause from the meanings, both ideological and individual, that are attributed to the associated social transition

are, in clinical circumstances at least, inherently fraught with danger" (Lock 1991: 1270-2).

In the study of menopause, the biocultural paradigm primarily involves a consideration of how human females experience biology in the entirety of their life span. The key to this paradigm is to take into account the broader factors of the social and cultural environment in which the woman has her daily existence (Melby and Lampl 2011). This approach, as the word biocultural itself suggests, sees biology and culture as being intertwined and can further be seen in a dialectical relationship, where biological variables affect the cultural variables and vice-versa. Additionally, this approach takes into account the various environmental and developmental processes that bring about human variation. So in other words, the interaction among the three factors i.e. biology, culture and environment help in the shaping of a particular phenomenon – in this case, the menopausal transition (Sievert 1960). But in no way does Sievert imply that either the biological variable is more important than the cultural variable or the other way around. One variable doesn't take precedence over the other and only by understanding both can a phenomenon and/or process be understood in its entirety.

One of the first explicitly bio-cultural analysis of menopause was done by Yewoubdar Beyene in 1986. Her book, *From Menarche to Menopause: Reproductive Lives of Peasant Women in Two Cultures* (1989) can be seen as a landmark when it comes to understanding the menopausal transition using a biocultural approach. Beyene's work addresses the interlinked biocultural factors of the reproductive history of women such as menstruation, pregnancy, fecundity and the somatic and social experiences of the rural Mayan Indian women in Yucatan, Mexico and rural Greek women from the island of Evia, Greece. Her study among the rural women of Stira, Greece and Chichimila, Yucatan, Mexico inspired a great deal of interest among the social scientists researching on menopause. As opposed to the western societies where menopause for a woman acts as a symbolic milestone on the path of ageing and ageing of women was seen negatively, Beyene observed that in both among the Mayan Indians and the Greeks, ageing women were associated with increased status, power and respect. With the cessation of their menses, these rural women were no longer considered 'impure' and thus could participate in the religious rituals of their community. The women

experienced more freedom in their social mobility and faced fewer restrictions from their husbands and other male members and social conventions of the society - these findings were quite similar to that of Flint's (1975) findings in India.

Biological anthropologist Lynnette Leidy Sievert's (2006) research work in the field of women's health and menopausal transition and her influential and widely acclaimed book, *Menopause: A Biocultural Perspective* utilizes a biocultural approach to understanding menopause. Sievert explains that in a biocultural approach, culture is more often than not treated in a way that it can be measured, but it also recognizes that certain cultural variables cannot be measured. Some examples of cultural effects or artefacts that can be measured are smoking and diet patterns, breastfeeding patterns, ageing patterns, birth control policy and so on. And some cultural variables such as cultural ideologies, norms, cultural meanings attributed to certain things and ideas cannot be measured. However, researchers who use the biocultural perspective are more concerned with measuring the outcome rather than the meaning. Moreoever, in biocultural research, culture is usually treated as being separate from and external to the physical body.

According to Sievert, the holistic biocultural approach can help a researcher to answer many questions regarding menopause such as the hows and whys of the evolution of menopause, the symptomatic variation associated with menopause and the variation in age at menopause. The four reasons she cites are firstly, this particular approach recognizes the basic fact that humans evolve over a long period of evolutionary history and among the different species, only the human females have such a long postreproductive life. An understanding of how menopause has evolved over time "sets the stage for examining widely shared aspects of biology and behaviour across all humans" (ibid: 24). The second advantage of the biocultural perspective is that by using this approach a researcher can examine the genetic, developmental as well as the environmental processes which result in human variation. Next, this approach can be used in such a way so as to take into consideration the views of biomedicine as well as cultural variations when it comes to defining the normal and the pathological. And the fourth and final advantage as per Sievert of this perspective is that it recognizes the fact that female reproduction can be curtailed by both biological as well as cultural boundaries. To illustrate this point, Sievert gives the example that while a woman can

stop engageing in sexual relations once she becomes a grandmother that might bring an end to her fertility but not necessarily to her menstrual cycle. Similarly, tubal ligation can end a woman's ability to reproduce but her menses will still continue. And on the other hand, by undergoing hysterectomy or surgical menopause, a woman can end her menstrual cycle but her ovaries can still function.

From the point of view of biology, writes Sievert[14], the biocultural approach can be understood by anthropologists based on broadly four different models or perspectives. The first is the *evolutionary model* or the evolutionary perspective wherein a phenomenon can be measured in terms of time - the evolutionary scale could span hundreds or thousands or even millions of years of length. The questions that the anthropologists ask could be based on either macroevolution or microevolution[15]. The second model that Sievert mentions to understand the biocultural approach is the *adaptive model* or the adaptationist perspective which is overlapping with the evolutionary model. Herein, along with studying the biological aspects, the anthropologists study those aspects in co-relation with the cultural aspects. The theory of natural selection plays a crucial role even in this model as "the questions formulated from an adaptationist perspective are driven by hypothesis derived from the theory of natural selection" (ibid: 18). Human biologists apply the biocultural approach by using the third model, which is the *ecological model* to study contemporary populations. Through a holistic paradigm, this model examines the relationships among biology, culture and environment with an emphasis on human adaptation. Factors such as blood pressure, morbidity (either diseases or sickness), work capacity and other such measures of the quality of life are taken into consideration. Finally, anthropologists to understand the biocultural approach delve into the *political-economic relationships* and

[14] For Sievert herself, the biocultural understanding of menopause does not use one perspective or model exclusively. Her understanding of this phenomenon has extracts and shares commonalities with all the perspectives and models that the anthropologists and biologists have used over time.

[15] Macroevolution would refer to "the formation of new species through the accumulation of evolutionary changes produced across many generations" (ibid: 15). How later species on planet earth actually evolved from the earlier species - this would be an example of macroevolution. Although macroevolution results in the formation of new species, all the evolutionary changes actually happen as a result of microevolution. And one of the primary forces responsible for these evolutionary changes is the force of natural selection.

the effect such relationships have on human biology, and vice-versa. Within this particular approach, anthropologists try to understand how the political and economic relationships and processes result in patterns of biological stress, consequently becoming a threat to the other social processes.

### d. *The Feminist Paradigm*

The feminist paradigm argues that the underlying assumption of feminist studies in general and specifically regarding menopause, is that the world is created by men where only the experiences of men are considered and documented by men themselves – women's experiences and their voices are pushed to the sidelines. It is men who define what it means to be a woman in the larger social and cultural picture according to the feminist theorists. Feminists have strived to develop a new form of sociocultural critique, a form of social criticism which moves away from the traditional philosophical assumptions. Thus, based on this paradigm of social criticism, feminist scholars challenge the very roots of knowledge and the long-standing authority of Western science and medicine by claiming that the tradition of Western science and medicine is based on patriarchy, male domination and consequently the subordination and subjugation of females. What feminists are concerned primarily are with finding and eradicating the sociocultural and political forces which assist in the domination of women along with patriarchy.

Unfortunately, there are a few feminist studies on menopause and the reproductive ageing of women – most of the feminist studies which look into women's life cycles deal with their menstrual cycle and their reproductive phases. (This also perhaps brings out an inherent, maybe a hidden, importance placed by the feminists for the most part on the women with child bearing capacity and the lack of attention to women in their midlives.) Women traditionally are seen as being "physically and emotionally handicapped by the menstrual cycle and therefore are subordinate to men" (ibid: 44). It is these traditional and cultural prejudices that according to feminists are disguised in the form of scientific and (bio) medical facts. Feminists however, argue that a woman's 'womanhood and femininity' does not lie in her hormones and is not restricted to the beginning and ending of her menstrual cycle. Menopause, just like menstruation, is seen as a natural process in the entirety of a woman's life cycle and not as a breakdown or

dysfunction in the woman's body. It is viewed as being a natural part of the process of ageing that encompasses its own social and class dimensions. They are also against the medical community's treatment of menopause as an abnormal stage in a woman's life. By treating the woman as becoming socially useless once she enters the menopausal stage of her life, women can be controlled socially as well as sexually, politically and economically. One of the main aims of feminist research in the field of menopause is to expose the medical construction of menopause. They argue against menopause being a taboo subject and argue that it should not be a topic shrouded in silence and secrecy. It is only very recently that the attempt by the Western biomedical system to "treat and cure" menopause has come under harsh criticism from the feminists[16].

### e. *The Postmodern Paradigm*

According to the postmodern approach, the primary importance is placed upon the kind of language that is used to formulate a particular discourse.

> "Language is important, not because of its syntax and rules of grammar or the specifics of actual speaking, but insofar as it allows people to think, speak and give meaning to the world around them" (ibid: 47).

What becomes important in postmodernism is the context and the inability to fix a single meaning. In other words, the plurality of meanings (and thus the plurality of discourses) depending on the interpretation of the language, in a particular context of knowledge is what the postmodern approach entails. According to the postmodern theory, an illness, sickness or disease needs to be seen as products of specifically social, historic and political circumstances (Lupton 2003).

There are certain underlying assumptions about women and menopause, writes Dickson (cited in Callahan 1993), that are held by this postmodern understanding of menopause. Women and their experiences, according to this approach are defined as being shaped by historical and social discourses. While differences between women and men are acknowledged, the differences do not translate into inequality. Men are not

[16] The feminist critique of the Western medical system in 'the West' will be discussed in detail in the following chapter.

seen as the norm and women are not seen as the 'other' – "women are assumed to be equal to, but different from men" (ibid: 48). Women are also seen as having had to experience the gender imbalances in the society and they have the capability as well as the capacity to address and resolve those imbalances. As far as menopause is considered, it's seen as a natural transition and individual experiences of menopausal women are accounted for.

> "The postmodern paradigm provide the opportunity to develop a kind of research on menopause that (a) takes into account the historical and sociocultural, as well the biological, and (b) generates knowledge that represents a truth, not 'the Truth' about menopause" (ibid: 49).

### f. *The Lifespan/Life course/Lifecycle Paradigm*

One of the most widely used concepts in the social sciences, 'life cycle', deals with stages, maturation and/or generations (O'Rand and Krecker 1990: 241). Alternative concepts such as life span and life course although used interchangeably quite often, "do not share the same intrinsic reference to generation or reproduction that transcends the single lifetime of the individual" (ibid). The concept of life span is about the duration from birth to death without taking into account the different stages or generations. And life course deals with the timing and the sequencing of the stages in the process of maturation from birth to death primarily at an individual level and does not have any reference to the generations.

Although in the past, the term used in the social sciences was 'life cycle', lately it has been customary to refer to the 'life span' when the work is being done by developmental psychologists and the 'life course' when the work is done by sociologists (Rossi: 1980). Mayer (2002) corroborates the point stated by Rossi that while life span is associated with psychology, life course is associated with sociology. But Mayer goes on to state that there should be efforts to converge and integrate the two concepts of life span and life course and bring about a common framework. J.A. Clausen in his article titled *The Life Course of Individuals* (Riley et al. 1972) pointed out that the term 'life course' was a more apt term to use than 'life cycle' as the concept of a 'cycle' lost its meaning in the absence of more than one cycle. What social scientists mean by the term 'life course' are

"the pathways through the age-differentiated structure in the major role domains of life" (ibid: 7). Mayer (2002) writes that, "by the term 'life course', sociologists denote the sequence of activities or states and events in various life domains which span from birth to death" (2002: 2). On the other hand, the term 'life span' which is employed by developmental psychologists entails an interest in "individual development and psychological qualities like ego strength, interiority, time perspective, rigidity, achievement striving" (Rossi 1980: 8).

Scholars like Rossi, O'Rand and Henretta argue that with the changing trends in longevity, the contours of the midlives of women have changed over the years. Rossi (1980) writes that extended longevity and low levels of fertility form the foundational framework within which women in their middle ages can be understood. The 'life course' model which "focus on the continuities among the middle, earlier and later life phases experienced by different age cohorts of men and women through time" (ibid: 158) is the model which I will be employing in this dissertation wherein I argue that menopause and a woman's sexuality cannot be understood in a vacuum. Stepping into puberty and menarche, the 'right' age to get married (so that the "biological clock' doesn't keep ticking), childbirth and finally the last stage, menopause - all these events or stages of a woman's life are linked to the woman's fertility, and consequently her femininity. Although it can be argued that "femininity is a fluid concept whose meaning varies with the social context" (Winterich 2007: 54), what cannot be disagreed upon is the fact that as per the normative trend in most societies there is an implicit association between fertility and femininity for a woman. Thus scholars like Carpenter (2010) use paradigms such as these where life course concepts such as menopause can be applied to the understanding of sexuality in a cumulative way through all the life stages.

### g. *The Bio-psycho-cultural paradigm*

Not much has been written on this particular paradigm in the available literature on menopause research. In one of the very few articles titled, "Cultural and Subcultural Meanings of the Menopause" (1990), the authors Marcha Flint and Ratna S. Samil correctly point out that every discipline looks at the issue of menopause and the climacteric from its own lens. Since the 1950s and 1960s, much of the research on the issue of menopause, had been done by physician researchers and psychiatrists from the

medical field who had focused on hormonal replacement theory for climacteric symptoms. And from the early 1970s, social scientists i.e. the psychologists, sociologists and anthropologists, began studying menopause cross-culturally, concentrating on age at the onset of menopause as well as the climacteric symptoms, research issues that were different from hormonal treatment. There had existed (or perhaps exists even now) a dichotomization between the biological or (bio) medical school of thought and the socio-cultural and environmental school of thought, the latter school having exclusively rejected the stance adopted by the former and vice-versa.

Flint and Samil thus propose a bio-psycho-cultural approach to the study of menopause so that interdisciplinary research can be undertaken. This approach on the one hand acknowledges the biological aspects of menopause (i.e. the estrogen level changes) and on the other hand the medical perspective is also acknowledged which prescribes estrogen replacement therapy for the treatment of menopause. The psychological aspects of this approach then are "seen as bridging this medical model to the social model (cultural aspects) of the menopause" (ibid: 136). Flint, who was the anthropologist and Samil, who was the physician, used this bio-psycho-cultural approach in a joint research project to understand menopause in Indonesia in 1985-1986. The researchers explain that for a physician to understand his patient better, he needs to understand that menopause is not only about symptoms resulting from estrogen deficiency but is a process defined by each woman's culturally conditioned beliefs, her own set of idiosyncratic behaviors and feelings as well as the kind of psychological conditioning she has had until then. It is only when the physician identifies these different aspects can he understand his patient in a more comprehensive and effective manner. Similarly, the social scientist who is already aware that he needs to consider the woman's psycho-cultural environment, now needs to encompass the medical and biological angle thus becoming more aware of the menopausal symptomatology. In this way, both the physician and social scientist become sensitive to each other's worlds of knowledge, providing a holistic way to understand the menopausal woman.

## 2.6 Conclusion

The medical/biomedical discourse and the pharmaceutical discourse however, still have a major influence on how women have an understanding of menopause and their own bodies. Regarding the gendered language of the medical discourse, not only does language help one express, but it also plays a major role in how ideas get conceptualized. For that reason, understanding the kind of language used in the society to conceptualize menopause and the menopausal woman becomes important (Ferguson and Parry 1998). Although medical practitioners claim that scientific language is objective, nonbiased and do not objectify the patient, Chambliss (1996 cited in ibid) states that the reality is a different story altogether. He argues that within medical settings, objectification and depersonalization do occur where the individual in question is not seen as defined by her whole identity but instead she/he is defined by her/his disease. Thus the menopausal woman is seen as "a warehouse of her diseased body parts of her imbalanced hormones" (ibid: 34). The next chapter employing a few of the discourses discussed in this chapter, will probe into the 'medicalization' of menopause in 'the West' and the (seemingly) non-medicalization of menopause in 'the Rest'.

# Chapter Three

## 'Constructing' Menopause through Medicine: Medicalization, Marketing and the 'Alternative(s)'

### 3.1 Introduction

A crucial part of this sociological study is to interrogate the midlives of women wherein 'menopause' becomes an 'object' of various actors. This objectification, most prevalent in the medical discourse and pharmaceutical discourse surrounding menopause, leads to advocating certain choices for women. These choices supported by the 'rationality and objectivity of science' have now become part of a constructed reality for women. This chapter will conduct an in-depth examination of the 'medicalization' of menopause through the medical discourse and biomedical paradigm; the 'marketing' of menopause through the pharmaceutical discourse and; their critique by feminists and women's health activists through the feminist/ emancipatory discourse and feminist paradigm. The chapter in the end will also look into how menopause has been 'treated' by the 'alternative' discourse which promotes the 'treatment' of menopause through more 'natural' means.

### 3.2 Medicalization: A note

Irving Zola (1975 cited in Berger 1999) defines medicalization as the process where aspects of everyday life come under the supervision, dominion and influence of medicine. Zola also stated that under certain conditions, virtually any human activity can be medicalized. Medicalization has also been defined by Peter Conrad (1992) as the license of the medical profession to provide some type of treatment for a so-called medical problem. In other words, medicalization as a concept can be defined as understanding a non-medical problem in medical language and within the purview of a medical framework, usually as an illness or a sickness or a disorder and using a medical intervention to treat or cure it. Through medicalization the labels "healthy" and "ill" can be applied to various aspects of daily human experience which had previously been outside the realm of medicine (Zola 1972). Medicalization can occur at three levels – conceptual/theoretical wherein a medical vocabulary or model is used to define the problem at hand; institutional/organizational where organizations may adopt a medical

approach to treating a particular problem in which the organization specializes and; interactional which is mostly the direct involvement of physicians who give a medical diagnosis and prominence of the physician comes under the limelight (ibid).

Usually, medicalization is spoken of in a pejorative way and has been used as a byword for all things negative about the influence of modern medicine on life and society. The term has largely become synonymous with the sense of a profession reaching too far - into one's body, mind, and even the soul. (Clark 2002) "Medicalization is not a value-neutral concept", writes DeGrazia (2006: 2). By stating that a particular phenomenon or a particular aspect of life has been medicalized, then one in all probability means that the way that phenomenon or aspect is being dealt with is problematic and consequently, features of the phenomenon or aspect are lost out on or distorted through this process of medicalization. Additionally, the medicalization of some phenomenon would usually imply that the understanding of that phenomenon is incomplete without a medical framework of understanding. In recent times, the common concern has been the medicalization of problems that are tilting more towards the mental/psychological, spiritual or social than the physical. For instance, in the late 1990s, mild depression in the United States was seen as an illness and it apparently required treatment by drugs (Conrad and Leiter 2004).

It was primarily from the 1970s that sociologists began to examine the process of medicalization and the expanding realm of medicine writes Conrad (1992). They looked into the complex social forces that were responsible for medicalization as it cannot be understood in a vacuum – factors such as social and political forces, class, age, race and gender need to be considered as well. Scholars have long pointed to social factors that have abetted medicalization: the diminution of religion, an abiding faith in science, rationality and progress, the increased prestige and power of the medical profession and the American penchant for individual and technological solutions to problems. While factors like these do not explain increasing medicalization over the past few decades, they have provided the contextual framework. Conrad writes that sociologists have examined two important contextual aspects affecting medicalization:

a. *Secularization*: Religion seems to have been nudged aside by medicine as the dominant moral ideology and institution of social control in modern societies. Medicine promotes secularization through its strict opposition to the public role of religion and instead, it advocates the medical regulation of society. Many conditions have been transformed from sin to crime to sickness of which homosexuality and fertility issues can be cited as examples. But the matter is not as simple as it appears to be and the interface of medicine and religion is more complex than a simple secularization thesis would suggest.
b. *Changing status of the medical professions*: The organization and structure of the medical profession has had an important impact on medicalization. There is a widespread monopolization of medicine over anything with the labels of health, sickness and/or illness. (ibid)

The medicalization critique in the sociological literature initially arose from the perspectives of liberal humanism and Marxism in the 1960s and 1970s, writes Deborah Lupton (cited in Peterson and Bunton 1997). The main argument put forth by those who critiqued medicalization was that in western societies, medicine and the medical practitioners had amassed a great deal of power and influence. Everyday problems were being viewed as diseases from the prism of science and medicine. Ivan Illich was one of the most prominent proponents of this school of thought. He argued that;

> "...rather than improving people's health, contemporary scientific medicine undermined it, both through the side-effects of medical treatment and by diminishing lay people's capacity for autonomy in dealing with their own health care." (Lupton in ibid: 95-96).

The critics of medicalization also state that as the common man generally lacks medical knowledge, it puts him/her in a vulnerable position, allowing the doctor to exercise power and control over him/her. This idea of medicine as an institution of social control was perhaps first conceptualised by Talcott Parsons (1951 in Conrad 2005). While numerous definitions of medical social control have been offered, in terms of medicalization, the greatest social control power comes from someone who has the authority to define certain behaviours, persons and/or things (ibid). Miles (1991 cited in Berger 1999) states that the medical system is a powerful instrument of social

control because it has the authority to judge who is sick and who is healthy. Based on the work of Michel Foucault, this form of medical social control suggests that certain conditions or behaviours become perceived through a medical gaze and that physicians may legitimately lay claim to all activities concerning the condition. Perhaps the classic example of this is childbirth, which despite all the birthing innovations of the last two decades, remains firmly under medical surveillance. Although Foucault was interested in social control, this interest of his has to be situated within his theory of power, writes Turner (cited in Peterson and Bunter 1997). Among the other social institutions that Foucault discussed in his body of work, the medical profession and the embodiment of power in the daily practices of that institution was one his major contributions in the field of medical sociology. His understanding of power was closely associated with his idea of discipline,

> "...namely that power exists through the disciplinary practices which produce particular individuals, institutions and cultural arrangements." (ibid: xii)

### 3.3 Menopause as a 'Disease': The Western Biomedical Discourse

The *Birth of the Clinic* (published in French in 1963 and translated in English in 1972) by Foucault in David Armstrong's words "is the cradle of Western hospital or pathological medicine" (Armstrong cited in ibid: 20). The subject matter of this book has acted as a prime conceptual framework in the understanding of medical sociology and broadly, the sociology of health and illness; in understanding how forms of power are directly, or indirectly, assumed by the medical practices. Through many significant publications influenced by the Foucauldian perspective, such as *Medical Nemesis* (Illich 1975), *Political Anatomy of the Body* (Armstrong 1983), *The Body and the Society* (Turner 1984), and *Medical Power and Social Knowledge* (Turner 1995), medical sociologists over the years have critically analysed the medical profession and its practices of surveillance and power. In addition to delineating the historical and sociocultural trajectory of Western medicine, biomedicine, the clinic and pathological medicine, Foucault's use of the term 'medical gaze' has been central to his text. His usage of this term was to explain the process through which the various categories of diseases come into existence according to western medicine. Related to the medical gaze was the concept of the individual body. Bodies according to Foucault are cultural

artifacts and are fabricated in the reading and writing of 'body texts'. Fox summarizes this idea of Foucault as:

> "As soon as one 'knows' one's own or another's body, it has been written discursively; there can be no knowledge of a pre-social essential body, yet the epiphenomena of spatio-temporal existence are always rewriting the ways in which we know bodies. Anatomy, epidemiology, psychology, medical sociology and other body texts frame bodies, often creating differends which know the body and exercise power over its reading" (ibid: 45).

Although medicalization as a term was initially used to refer to the treatment of socially undesirable or deviant behaviour as medical problems, the term has since been used for many other natural events of a woman's life cycle, including the medicalization of childbirth and other seemingly 'normal' events (Guillemin 2002) - could the medicalization of menopause be far behind?

Over the past three decades there has been a marked increase in the use of gynaecological services by midlife women in the US and in Europe. What used to be described euphemistically as the 'change of life' and regarded as private and somewhat embarrassing is no longer so. Women consult much more freely with both health-care personnel and one another about the end of menstruation, and in the process, female midlife has become increasingly medicalized. Most studies of medicalization have been in the North American context. It is not really clear whether medicalization is simply more advanced in the United States or whether other societies have yet to be studied in depth. Few cross cultural studies have explicitly focused on medicalization –significant exceptions are the cross-cultural studies that have been conducted on menopause. Feminist scholars, health activists etc. have learned in the last few years to question and critique the claimed objectivity and neutrality of this patriarchal science, particularly with regards to the scientific ideas that are generated about women's bodies. Feminists since the 1970s have been criticizing much of the medicalized menopausal research and the motives of the transnational pharma companies that manufacture the hormones. (Guillemin 2002; Callahan 1993)

Betty Friedan in her book *The Fountain of Age* (1993) writes about the "new menopause brouhaha" - a phenomenon on the rise at a time when approximately fifty million women are entering the menopausal stage of their lives on a global scale. MacPherson (1990 cited in Berger 1999) states:

> "The medicalization of menopause is a process in which the medical community attempts to create a market for its services by redefining certain events, behaviours and problems as diseases."

The paper titled 'Manufacturing Need, Manufacturing Knowledge' (2002 cited in Worcester 2004) gives many examples of how the knowledge bank of physicians and their prescribing practices are influenced to a large extent by the pharmaceutical companies. Worcester asks that we all know about those mugs, pens, prescription pads, free lunches, and industry-supported conferences, but how many of us have thought about how much our physician's knowledge about our health is manipulated by the drug industry that has managed or not managed to get a new product on the market? How many of the millions of women who have had prescriptions for hormone therapies for the prevention of heart disease know that these hormone therapies were never given approval by the Food and Drug Administration (FDA)? Pharmaceutical companies pay $8,000-13,000 per year to influence each physician's drug prescribing practices and these companies know that money spent influencing physicians is money well spent. (ibid)

To sum up, according to biomedical literature, menopause is a problem of hormone deficiency and it requires Hormone Replacement Therapy as the obvious solution. In doing so,

> "...it becomes situated in the medical province of gynaecologists, endocrinologists and menopause clinics. Menopause becomes a part of a world of clinical investigations, diagnoses, treatments, and close monitoring. In this way, menopause becomes 'medicalized.'" (Guillemin 2002: 37)

Let us now delineate the medicalization of menopause that occurred in 'the West', a process which is not a new phenomenon at all.

### 3.3.1 The Medicalization of Menopause in 'the West': A Historical Trajectory[17]

Anthropologist Emily Martin in her landmark book "*The Woman in the Body*" (1987) cites some important historical medical references and metaphors made for menopause. Both in the medical texts as well the popular books in the nineteenth century, what menopause for the most part implied was "the breakdown of a system of authority" (ibid: 42). According to the texts prevailing in that time, at every point in the menopausal system, the functions in the woman's body fails and falters. As functions fail, the members of the bodily system also degenerate and decline – "breasts and genital organs gradually atrophy, wither and become senile" (ibid). The language used for describing the menopausal state in a woman's body – regression, decline, degeneration, breakdown, decay, shrinkage, atrophy, 'the disused factory', 'the failed business' and 'the idle machine' – all these denote a negative view. The woman's body is seen as a 'hierarchical organization', a 'production machine', a 'factory' meant for reproduction and with the onset of menopause when this reproduction comes to an end, the woman's body becomes useless and worthless. Although most of the physicians viewed menopause negatively, there were a handful of medical practitioners who saw the period after menopause positively and regarded it as "the Indian summer of a woman's life – a period of increased vigor, optimism and even of physical beauty" (ibid: 35). Martin finally states that the majority of demeaning medical metaphors used for representing menopause fit very well with the traditional roles assigned to women.

Following the time frame utilised by historian Judith A. Houck in her book *Hot and Bothered: Women, Medicine and Menopause in Northern America* (2006) and Margaret Lock (1993), this section will look into the historical trajectory of how the medical community has interacted (or not) with menopause and 'the invention of the Menopausal Woman' (Lock 1993). The first time period is 1821-1937 and the second is 1938-1962. The events which ensued 1963 onwards will be covered in the subsequent sections.

**1821-1937**: Interest in menopause as a medical problem began systematically around the middle of the nineteenth century. By the 1870s and 1880s, there was an increasing

[17] Refer to Appendix A for a timeline of the medicalization of menopause in the Western part of the world.

medical attention on the female bodies. Prior to the Victorian Era, interest of the medical professionals in women's reproductive health issues was limited. Most of the physicians were indifferent to this stage of the woman's life cycle and a majority of the gynaecological texts had hardly anything to say about menopause. In 1897, American physician Andrew Currier was perhaps the first to observe that while menstruation in women was often discussed, menopause was mostly passed over and rarely mentioned in the ancient literature. He stated that menopause was not to be seen as a dangerous time period and most women pass through it without any major difficulty. Prior to Currier, there are a couple of names worth mentioning here - the first is that of French physician Gardanne who used the term menopause in 1821 for the first time. Perhaps the most influential physician in the treatment of middle-aged women during the 1850s was Edward Tilt in England. Lock (1993) writes that what makes Tilt's work of interest in the present times is that Tilt's experience was with women from all walks of life. This was a contrast to the majority of the physicians during that period who dealt solely with white, upper-class women. Like many of his contemporaries Tilt believed that a woman's menopausal passage was somewhat perilous, but notwithstanding that he did claim that menopausal problems were problems of luxurious women and physicians should act like social advisers. Tilt also went on to claim that menopause should be understood as a natural life transition and many middle-aged women welcomed this transition in their lives contrary to the popular medical belief. (ibid)

But the views of Currier and Tilt were among the exceptional views opposed to the dominant idea of the nineteenth century anatomy is destiny as far as women are concerned. Since the interest in the study of menopause began, the dominant ideology running among the medical community was that a woman's life was determined by her ovaries. Menopause was seen as bringing about a 'partial death' and 'biological weathering' (Dyer and McKeever 1986 cited in Berger 1999).

**1938-1962**: By the twentieth century, menopause had been classified as a hormone deficiency disease and medical professionals began prescribing the 'magic pill' to cure this disease. Estrogen replacement therapy, followed by hormone replacement therapy gradually became the therapeutic panacea for treating menopause. It became central in not only treating menopause but also to avoid related problems to menopausal and postmenopausal women such as osteoporosis, cardiovascular disease, skin and

mammary atrophy and so on. During this period the physicians had the upper hand in making the decisions and there was an absence of consensus between the doctor and patient in deciding about hormone therapies. Ultimately, women were treated like guinea pigs for the most part and their bodies "bore the consequences of medical interventions and debates" (Houck 2006: 59). The new biomedical developments during this period and the wide availability of cheap hormonal treatments made it easier for the physicians to prescribe them to the patients.

### 3.3.2 Wilson's *Feminine Forever*: Promoting False Promises

Brooklyn physician Robert A. Wilson and his wife Thelma in their article titled "The Fate of the Nontreated Postmenopausal Woman: A Plea for the Maintenance of Adequate Estrogen from Puberty to the Grave" (1963) wrote how menopause which was a way of nature's defeminisation, if left untreated, doomed women "to live the remainder of their lives as mere remnants of their previous selves" (Wilson and Wilson 1963 cited in Houck 2006: 152). Wilson and his wife argued that menopause was preventable and women could easily prevent it by taking up the right kind of medical treatment. In the article they suggested that,

> "A large percentage of women...acquire a vapid cowlike feeling called a 'negative state'. It is a strange endogenous misery...the world appears as though through a grey veil, and they live as docile, harmless creatures missing most of life's values." (cited in Furman 1995: 39)

Robert Wilson also established the Wilson Research Foundation (WRF) in New York along with all his publications. The aim of WRF was to to eliminate the estrogen and progesterone deficiency states such as menopause and ultimately be able to fight this battle against menopause. Seminars, educational campaigns, distribution of provocatively titled pamphlets, annual conferences and reaching out to the popular media were the ways in which Wilson propagated about his efforts at WRF. However, it was after the publication of his controversial bestseller in 1966 that the press coverage was intensified. (Houck 2006)

Wilson's widely (in)famous book, *Feminine Forever* (1966) focused on defining menopause as an estrogen deficiency disease similar to other hormone deficiency diseases such as diabetes or hypothyroidism and declared that "no woman can be sure

of escaping the horror of this living decay" (Wilson 1966: 43). Perhaps the most prolific and publicizing proponent of estrogen replacement therapy (ERT) in the 1960s, he referred to menopause as "a galloping catastrophe", a debilitating and incapacitating disease and he referred to postmenopausal women as "castrates" and equivalents of eunuchs. Although he did talk about the physical symptoms that are brought forth by menopause, most of his attention was focused on female sexuality and the female genitalia - the primary site which gets affected by the most devastating effects of menopause. He wrote in his book,

> "...entire genital system dries up. The breasts become flabby and shrink, and the vagina becomes stiff and unyielding, mak [ing] sexual intercourse impossible..." (1966: 42 cited in Houck 2006).

By arguing that the key to a woman's fate is her body, Wilson concluded that menopause robs a woman of her most central aspect i.e. her sexuality. It was essential, as per Wilson that married postmenopausal women should definitely make use of ERT as that was the only way they could remain sexually attractive, receptive and potent. The fact that ERT could enrich a woman's married life after her menopause, at a crucial time in her life when it's needed the most - that according to Wilson was the ultimate benefit of ERT. (ibid) As menopause was seen as posing a threat to marriage and consequent marital discord among middle-aged couples, maintaining harmony between the couples was seen as a compelling reason for the use of hormone therapies by menopausal women. According to the physicians in the popular literature, if women were not sexually receptive then their husbands would have to find other places and forms of releasing their sexual energies. So to avoid the husbands from philandering, to maintain a great sex life as well as to keep the women feeling 'womanly', menopausal women should make use of these hormone replacement therapies, claimed Wilson.

Thus for Wilson, a woman's body was to be seen as a biological text and the essence of her womanhood and femininity was defined as well as determined by her biology. Consequently, when the woman entered the menopausal stage of her life, according to Wilson's underlying ideology of the inseparability of a woman from her biology, she no longer remains a woman and becomes a neuter or a nonwoman, implying the loss of her gender identity. Thus, as per Wilson's understanding of gender ontology, menopause is

a deviant stage in a woman's life, the harbinger of loss and decay, which necessarily requires medical intervention to restore her 'true womanhood'. (Callahan 1993) And as mentioned earlier, this medical intervention had to be in the form of the 'wonder drug' i.e. estrogen. Callahan writes;

> "Wilson painted a compelling word picture of the horrors of a woman living her postmenopausal years in a body without estrogen - a body that would ultimately betray her through crushing fractures, a dried, cracked and bleeding vagina, clogged arteries and unbearable hot flashes" (MacPherson 1981cited in ibid 1993: 163).

According to Wilson, the "death of womanhood" brought on by menopause was completely preventable and curable and women could remain feminine, both physically and emotionally, for as long as they lived (Callahan 1993). Even before a woman underwent the hormone therapy for her menopause, it was suggested by Wilson that all women above the age of twenty should visit their doctor and demand a Femininity Index to ascertain whether their bodies are still as feminine as they should be (Houck 2006). Although synthetic estrogen was available in the market from the beginning of the 20th century, it was brought into prominence after the publication of Wilson's book. Considering he viewed middle-aged women as pitiable creatures, it was no wonder that he advocated the life-long use of hormones for women to remain "fully sexed" all through their lives; their necessity beginning from her puberty till her grave (Berger 1999; Houck 2006). Based on the case of one of his patients who claimed to have never reached menopause having taken the 'magic pill', he asserted that no woman who uses these pills will ever experience menopause (ibid). He prescribed the 'youth pill' which prolonged her youth and beauty and promised to turn back the clock on ageing. His prescriptions for the prevention of menopause and the subsequent preservation of femininity included combined doses of estrogen and progestin (differing in the dosage for older and younger women) - a combination known as Hormone Replacement Therapy (HRT) (ibid)[18].

[18] The difference between HRT and ERT is that while HRT combines estrogen and a synthetic progesterone and is appropriate for women with a uterus, ERT consists of estrogen alone and is prescribed for women who have had their uterus removed. HRT can be used a term to mean both ERT and HRT, but the same does not hold true for ERT (Furman 1995).

Callahan (1993) notes that Wilson's beliefs were an extension of the medical dogmas and negative characterizations of menopausal women from the years past. His book reflected the predominant perceptions about menopause and menopausal women which prevailed in 'the West' (particularly in North America) during the 1960s and continued even in the 1970s. Callahan succinctly puts it as:

> "Wilson's medical advice was shaped and formed by the culture's assumption that menopause presented a psychological crisis in women's lives and, like the Victorian doctors before him, his underlying message reflected and reinforced the era's cultural assumptions about women's social roles and women's biology" (ibid: 32-33).

So convincing and popular were Wilson's arguments that other prominent physicians in the United States, such as David Rueben (author of the bestseller *Everything You Always Wanted to Know About Sex But Were Afraid to Ask*, 1969) and William Masters (one of the pioneers in conducting research on human sexual response and the treatment of sexual disorders and dysfunctions until the 1990s) used Wilson's book as a primary point of reference and claimed that ERT could "stop ageing, prevent cancer and preserve sexuality" (ibid 1993: 146). An example of the statements being made based on Wilson's line of thought are the following lines from Reuben's book in 1969:

> "As estrogen is shut off, a woman comes as close as she can to being a man. Increased facial hair, deepened voice, obesity, and decline of breasts and female genitalia all contribute to a masculine appearance. Not really a man but no longer a functional woman, these individuals live in a world of intersex. Having outlived their ovaries, they have outlived their usefulness as human beings" (Reuben 1969: 290 cited in Houck 2006).

Popular magazines, especially women's magazines, such as *Vogue*, published excerpts from Wilson's book and the book began to be discussed extensively in the mass media. Within the first seven months of the book being published, 100,000 copies were sold and by 1970 the book had been translated into four different languages (ibid). According to Barbara Seaman, one of the prominent pioneers in women's health issues, the sale of estrogen tripled from 1967 to 1975. In fact, by 1975, *Premarin*, which is one of the popular brands of estrogen, had become one of the top five drugs being sold in

the United States and over six million women were taking this medication (Callahan 1993). After the work of physicians such as Wilson, Rueben and Masters, a medical movement was sparked which transformed ERT from being a prescription only for menopause to a therapy which was being given to women at large and commonly so, to fight female ageing in general along with menopause. The entire motive was to

> "...promote estrogen as a safe and perhaps miraculous cure for those women most bothered by menopausal symptoms" (Houck 2006: 173).

It is not as if the medical community accepted Wilson's views in its entirety – what is true however is that physicians in 'the West' during the end of the last century did prescribe hormone therapy more freely and for longer periods that they ever did before. And even the menopausal and postmenopausal women started demanding for medical intervention more than their predecessors. The level of anxiety and insecurities regarding ageing and loss of womanhood had been heightened among these women due to the publicity of the 'treatments' by the popular media. Thus by preying on the fears of ageing and by portraying the older woman as being "an unwanted commodity in an increasingly competitive sexual marketplace" (ibid: 162), Wilson and other physicians supplanted by messages promoted by the media, hormone therapy was being made more attractive among middle-aged, menopausal women.

But Houck raises an important question here –how and why is it that Wilson appealed to the very women whom he belittled? It thus becomes importance to understand his so-called "feminist" stance which Houck states as,

> "It is important to recognize that Wilson and his supporters also attracted women by placing the menopausal woman's needs at the center of public and medical discourse. Wilson portrayed himself as a friend to women, highlighting his efforts to take seriously middle-aged women and their ailments after centuries of neglect by male physicians" (ibid: 153).

In the western tradition, the view that women were defective versions of men goes far back to the time of Hippocrates. According to the physicians then, the principle which guided them was that women were normally supposed to be sick (Quinn 1991 cited in Berger 1999). In a context where a woman's experience such as menstruation was a chronic disorder, childbirth was a surgical event and pregnancy a disease, it wasn't

much of a surprise when physicians saw menopause as a disease and a physiological crisis which led to further diseases (Ehreneich and English 1973 cited in ibid). It was advised by medical professionals that on entering menopause, women should isolate themselves and stay secluded and away from the family. Skeptics who suggested that hormone therapies increased the risk of endometrial cancer among women were opposed by Wilson as he denounced these concerns of cancer as being false. Instead he argued that these therapies provided women with "cancer insurance". And thus, based on Wilson's argument, instead of being a cause for cancer, the hormone replacement therapies prevented cancer. Wilson was also supported by popular media assuring women that ERT was not carcinogenic. In such an environment, Wilson's prescription of hormone therapy which enabled middle-aged and older women to be stay *womanly* (italics mine) was welcome and like a boon in the prevailing sexist historical context. Although there were scholars and feminists who critiqued Wilson by stating that his seemingly pro-women stance was nothing but a façade for his inherent misogyny, male indifference towards women and profit-making attitude, Wilson was successful in situating himself as the advocate for middle aged women's issues and for rescuing those women in their years of so-called despair, as is evident by him being characterized as "a gallant knight". (ibid) The pharmaceutical companies and their marketing of HRT have been discussed next.

### 3.4 'Marketing' of Menopause: The Pharmaceutical Discourse

Since the end of the nineteenth century physicians and gynaecologists have been fascinated with hormones and began prescribing ovarian extracts for menopausal women even before scientists had isolated the female sex hormones (estrogen in the 1920s, progesterone in the 1930s) (Watkins 2001 cited in ibid). But during this period, it was found that the hormones were difficult to isolate, painful to administer and quite expensive and thus for most women using hormones didn't seem feasible. It was in 1938 that hormone therapy entered a new phase when the first synthetic estrogen called diethylstilbestrol (popularly known as DES) was developed by the British scientist Charles Dodds. The use of DES was approved by the FDA in the United States in 1941 for treating the direct symptoms of menopause such as hot flashes, night sweats and vaginal dryness. The very next year, an American drug company, Ayerst Laboratories, with due consent from the FDA, marketed another form of estrogen called

conjugated estrogen or *Premarin,* which was derived from pregnant mares' urine (thus the name - PREgnant MARes' urine). By the 1940s and 1950s prescription of *Premarin* by doctors in the United States and Europe became a common affair and this drug was not seen as having any side effects. However, the opinion that women should be taking replacement hormones for a long period of time found its greatest expression in the work of the physician Robert A. Wilson during the 1960s (the work of whom has been discussed at length earlier in this chapter). By the early 1970s, the medical profession and the drug companies projected a certain image of the postmenopausal woman, with adequate help from the media,

> "...to include not only the maintenance of strong bones but also physical appearance and emotional state, as defined by prevailing cultural standards." (ibid: 26).

But the fate of ERT was very much in question from the mid to late 1970s and "...estrogen turned from hero to villain" (ibid: 27). In 1975, scientific studies demonstrated that the use of estrogen increased the risk of endometrial cancer in women. During the same time, several other disturbing results related to drugs and women's health care were being highlighted. For instance, a link was found between oral contraceptives and blood clotting disorders; pregnant mothers who had used DES during their pregnancy were at an increased risk of vaginal cancer and; the users of the Dalkon Shield Intra-Uterine device (IUD) were known to report infections and septic abortions. Moreover, the medical community was facing a challenge during this period as far as their political influence, cultural authority and economic power were concerned. Women's health activists through the women's movement were trying to reclaim natural life events such as childbirth from the forces of medicalization. In such an environment, one would expect hormone therapies to have taken a backseat. Although ERT prescriptions did decline by the late 1970s, long-term HRT for postmenopausal women soon gained widespread popularity in the 1980s. In fact, by the 1990s, the hormonal brand of *Premarin* had become one of the most commonly distributed drugs in America. (ibid) Only the benefits of using HRT were being discussed in the public discourse where HRT was seen as an antidote to all menopausal symptoms and also as a preventive tool for some chronic diseases. In a paper on the history of HRT, Rothenberg (2005) writes,

> "Scores of observational and case studies supported the overwhelmingly positive view of hormone replacement therapy, and naturally drug makers and their advertising agencies enthusiastically embraced estrogen as well. After all, this was a billion dollar business" (2005: 2).

The following lines by Gabriella Berger in her book *Menopause and Culture* (1999) comprehensively states how with rising life expectancy, women now live approximately one-third of their lives in their postmenopausal stage and this is a phenomenon among both developed as well as developing populations.

> "Menopause societies have sprung up like mushrooms on a wet spring morning to hold regular conferences to debate various aspects of the physical experience and to suggest appropriate treatment. Pharmaceutical companies, who are overly well represented at conferences, are competing over the lion's share of an ever-expanding market of prospective hormone replacement therapy users, not only in developed but also developing countries" (Berger 1999: 1).

These lines by Berger imply that with the population of middle aged and older women rising, the potential of the medicine market and the healthcare costs associated with menopause is ever expanding. However, Coney (1994) argues that the increasing life expectancy among women and changing demographics were not the primary reasons for menopause becoming a topic of intense medical and popular interest in the Western countries. Rather, it was the discovery of the magic cure -HRT- which acted as the real catalyst in creating what Coney calls 'the menopause industry'. By calling it an 'industry', she refers to the management, marketing and the making of profits just like any other industry but in this case, at the expense of menopausal women. Unlike before where the midlife woman was seen as a hypochondriac if she visited the physician during "the change", that is no longer the case. The midlife woman has now become a target - a target with her own disease and the idea of the normal ageing process has been collapsed into a pathological state. Coney passionately criticizes the medical and pharmaceutical establishment by stating,

> "Research careers are being built around her; there are doctors and medical entrepreneurs who wish to measure her bones, her breasts, the cells on her cervix, and her hormone levels. People build machines to scan, photograph, x-ray, and magnify the most intimate parts of her body. The pharmaceutical companies have a veritable chocolate box of pills, patches, pessaries, and implants for the midlife woman. She can swallow them, have them sewn into her flesh, or even insert them into her vagina – from where the magic hormones will course through her body transforming everything they touch" (1994: 19).

Having established the idea of menopause in 'the West' as an illness which lasts for a lifetime and one which is inescapable for any woman, what follows is the 'treatment' of that illness (Miles 1991 cited in ibid.). More than male biology, it is female biology which has been treated more "aggressively" by medicine and the prescription of hormone therapy to middle-aged women is one of the prime examples of this "aggressive" treatment (Sievert 2006). Women's health activist Coney (1991) writes:

> "...all roads eventually lead to hormones because of medical professionals' love affair with estrogen...as white middle-class women tend to visit the doctor frequently...they have become the number one consumers of hormones" (1991: 153; 189).

Although medicalization is widely prevalent in the United States and parts of Europe, it is increasingly becoming an international phenomenon. For instance, Short (1994 cited in ibid) reports that the HRT market is becoming the biggest ever single market for any drug in Australia. This is partly the result of the expanding hegemony of western biomedicine, but it is facilitated by multinational drug companies and the global reach of mass media and the internet. Thus with globalization on a continuous rise, the process of medicalization also keeps expanding. By the 1990s huge changes in the world of medicine, medical knowledge and marketing had taken place. Pharmaceutical companies are the companies which make the maximum gain in the United States and there the menopause industry has become one of the biggest profit making industries in the recent times. (ibid)

Following Robert Wilson's work in the 1960s, menopause and hormones had become synonymous, writes Berger (1999) and the pharmaceutical companies have since then been aggressively promoting hormonal concoctions. She writes,

> "Wilson and Wilson's plea for 'adequate estrogen from puberty to grave' became a worldwide slogan that brought the power of consumerism into the doctor's office" (ibid: 11).

For the pharmaceutical companies, the manufacturing and marketing of hormones for menopausal treatment is a billion dollar industry – an industry which has a huge profit margin estimated at eighty percent before taxes (ibid.). Pharmaceutical companies such as Ayerst, Squibb, Schering, Abbott Laboratories, Upjohn, Roche and Lederle "seem to benefit disproportionately from HRT sales" (ibid: 16). One of the most well-known brand names of estrogen is *Premarin,* which is a big seller in the market due to the cheap cost of its large-scale production. The media has a pivotal role to play in the promotion of these hormone therapies among the masses. With the strong emphasis on the restoration of youth, beauty and sexual prowess once a woman becomes menopausal, the media with its lush advertisements conveys

> "...the message that estrogens are a cure-all for the anxious, wrinkled, sexually frustrated older woman who has to compete in this era of cocktail parties, sexual freedom and errant husbands" (Coney 1991: 159).

With the projected increase of the elderly population increasing with time, and consequently the ever increasing female population, the hormone market will be an ever-expanding market. Pharmaceutical companies, the big profit giants, can be expected to have substantial gains in the time to come. But the question remains – gains at the cost of what and more importantly, gains at the cost of whom? Guillemin (2002) argues that the pharmaceutical companies seem to have the maximum gain at the cost of women's bodies by being able to medicalize menopause. It appears to be that women are considered as easier and gullible targets as compared to men. Rather than being the subject of care, women have become the object of treatment and revenue production. With regards to women's health, it seems that with women being coerced, subtly or not so subtly, into a drug regimen, there has been a triumph of marketing over science.

The following section examines the criticism that has been lashed out, mainly by the feminists and women's health activists against hormone therapies which have been giving women 'false promises' of staying forever young.

### 3.5 Critique of the 'False Promises': The Feminist Discourse

During the same time that Robert Wilson was publishing his work on menopausal women and referring to them as castrates, one of the landmark books in the feminist world was also published –Betty Freidan's *The Feminine Mystique* (1963). Freidan's book and Wilson's *Feminine Forever* just three years later raised many issues involving the reconsideration of what it meant to be a woman, how womanhood was defined and women's roles in society. Questions were being raised particularly on the issue of menopause and menopausal women. Friedan wrote:

> "...menopause mania is characterised by a passive acquiescence to the medical model which reinforces the mystique of age and decline" (1993: 496).

While until the 1970s efforts to understand menopause were primarily shaped by the medical community, research since then has shifted away from an uncritical reliance on medical views of menopause and has attempted towards the 'demedicalization' of the menopausal transition (Jaiprakash 1999). Not only did feminists attack the widespread "medicalization" and the disease model of menopause in 'the West', but as part of the larger ongoing women's movement they also began conducting cross-cultural research in societies beyond the Western society to show that menopausal experiences were not universal and subjective experiences of women had to be taken into consideration. However, there were divisions among the feminists themselves– while there were some who believed Wilson was a benefactor to ageing women, there were others who vehemently opposed Wilson's work. But whatever the points of contention among the feminist scholars, the common belief and the larger philosophy contributed by them to the research on menopause was that,

> "...women should retain control of their bodies and participate fully in making decisions about their health. By controlling their bodies, they

believed, women could ultimately seize greater control of their lives" (Houck 2006: 210).

Jennifer Harding's paper entitled "Bodies at risk: Sex, surveillance and hormone replacement therapy' (cited in Peterson and Bunton 1997) critically looks at the Foucauldian ideas of surveillance, the production of power relations and the multiple sites of power and resistance vis-à-vis HRT as a contemporary 'technology of power'. Harding examines some of the key aspects of the medical discourses and women's health discourses on HRT to show how bodies may become sexed in discourse. As per the medical discourse, the postmenopausal woman's body is seen as a corporeal terrain where the sex-linked diseases of endocrine deficiency are situated. This body requires medical intervention, including both treatment and surveillance from the time of her menopause until her death. Opposed to this medical discourse is the feminist discourse according to which the body of the postmenopausal woman is seen as the terrain of normal, and not pathological or physiological processes. The body as such does not require any treatment (although exceptions might be there) but is "subjected to the colonising strategies of medicalization and commercialization" (ibid: 139). By subjecting the woman to treatment via HRT, not only is she exposed to the side-effects of HRT but "her real needs are subordinated to the interests of medical career-making and commercial profit" (ibid). The woman's body is viewed as the site where certain forms of discursive knowledge can be applied thus giving those very forms credibility and hegemonic status in a society.

Houck (2006) writes that feminist health activists challenged the conventional paternalistic doctor-patient relationship and urged women to not see all bodily events as medical events and to not relinquish the control of their own bodies to the doctors. Female self-help was promoted and health facilities with feminist principles were sought to be established rather than depending solely on the male dominated medical profession. The feminist critics argued that Wilson's work was infused with sexism and misogyny and through his work he "capitalized on women's fears of ageing" (ibid: 153). Feminists such as Barbara Ehrenreich and Deirdre English argued that,

"...misogyny was built into the medical profession...medicine had been used as an agent of social control to preserve patriarchy and to oppress women" (cited in ibid: 211).

It was not as if feminists denied the necessity of medical intervention at times, but at the end of the day it was the women who should be their own decision makers when it comes to making decisions about their bodies among other things. These were the central themes which provided the grounding for the feminist discussion of menopause and the subsequent critique of the "medicalization" of menopause.

In Callahan's (1993) collection of essays on understanding menopause, in one of the essays Kathleen I. MacPherson writes about the three false promises that have been made by HRT to middle-aged women by the physicians, pharmaceutical companies and mass media. The first false promise made was by Wilson during 1966-1975 which promoted the promise of eternal beauty and femininity as discussed earlier in this chapter. The second false promise made from 1975-1981 was that of a safe, symptom-free menopause. Drug companies continued their marketing campaigns even though there were papers being published on how HRT was related to cancer and the safety of the magic pill was coming under spotlight. Misleading information was getting circulated in the medical and popular literature that all women suffered at menopause. And finally, the third promise from the 1980s to the present day was the promise of escape from chronic diseases such as osteoporosis and cardiovascular diseases. Although 75% of women will never have osteoporosis, yet many midlife women are routinely started on HRT by their physicians at menopause to prevent wrist, spinal and hip fractures. Once started, they must continue indefinitely or bone loss occurs at a rate similar to that seen immediately after menopause in women not given HRT. Women taking HRT become dependent on expensive medical procedures such as regular pelvic and breast exams, Pap smears and biopsies. (ibid) Let us now look at how feminists reacted towards these 'false promises' which were being promoted.

Houck (2006) in one of the chapters of her book discusses the influence of feminism and the reaction of different feminist schools of thought to Robert Wilson's work on menopause. When ERT was first suggested by Wilson, it was not rejected by the feminist scholars right in the beginning. In fact, before the 1970s there were very few

feminists who discussed menopause at all – and the ones who did discuss issues around menopause, menopausal women and hormone replacement therapies, displayed ambivalent attitudes and opinions regarding the message that was being promoted by Wilson, his contemporaries and the popular media. Between 1963 and 1975 to be precise, feminists did not have a unanimous opinion regarding either the disease model of menopause or estrogen therapy.

Berger (1999) states that the concepts of health and illness are gender specific wherein the health experience of the male physiology is perceived as normal as opposed to the female physiology. Thus, female bodily experiences arising from events such as menstruation, pregnancy, childbirth and in this case, menopause, were described in terms of illness and were seen as being foreign to the medical profession – a profession which was primarily a male domain. In such a historical context, some feminist health activists enthusiastically supported Wilson's line of work arguing that unlike the male-dominated medical community which had been neglecting middle-aged women and their health problems, Wilson was providing ways of treating and curing those problems. Feminist writers such as Belle Canon lauded Wilson by stating that he was perhaps the "first and only stimulus to public and medical discussion of menopause" (Houck 2006: 213). Medical anthropologist Paula Weideger did not completely agree with Wilson's disease model of menopause but embraced the idea of estrogen therapy as the most effective and comprehensive cure for menopause. Weideger's book *Menstruation and Menopause: The Physiology and Psychology, the Myth and the Reality* (1976) communicated her support of ERT and women's need of medicine and science to a wider audience. Thus, Wilson's prescription of ERT was being seen by some feminists as well as some prominent women journalists as being a pivotal tool in securing women's liberation. This group of feminists put their faith more in science and medical technology rather than relying on the natural ability of the woman's body to adapt (Berger 1999; Houck 2006).

On the other hand, there were the group of feminist health activists who while showing gratitude to Wilson for his medical attention towards menopausal problems were unsatisfied with the negative portrayal of menopause and thus, largely rejected it. Although they agreed with ERT/HRT as a valuable tool for curing menopausal problems and felt that women should go ahead and demand these therapies, they also suggested

that the potential health risks involved with ERT/HRT should not be neglected. These feminists challenged the disease model of menopause and rather described menopause as being a natural process in a woman's life cycle just like menstruation. The bottom-line for these feminists was that it should be the women themselves who should have the final say in whether they want the hormone replacement therapies or not. Feminist writer Joan Solomon (1972) corroborates this statement by writing the lines below for the women readers of *Ms.* magazine:

> "It's a decision you alone must make, keeping in mind your medical history, psychological needs, and physicians' advice" (Solomon 1972: 16-18 cited in Houck 2006: 217).

One of the most relentless feminist health advocates in the United States and someone who was already leading a fight against the widespread use of contraceptive estrogens, Barbara Seaman, voiced an opinion similar to the above and an opinion supported by all feminist health activists:

> "We cannot gain autonomy over our minds unless we gain autonomy over our bodies as well. We must reject the majority of doctors who push us around or patronize us, and take our business to the few who are willing to treat us as full partners in our own health" (Seaman cited in ibid: 218).

By the end of 1975 there was rising concern among this group of feminist health activists regarding the new evidence that was emerging which linked estrogen therapy with the increasing risk of endometrial cancer. Research conducted during this period demonstrated that what was once being considered as a medical miracle cure might be responsible for making some women very prone to cancer. (ibid) Even until recently, the use of ERT in countries such as Finland, led to an increased risk of hysterectomies (Vuorma et al. 1998 cited in Sievert 2006) as was the case in the United States (prior to the use of HRT in the 1980s instead of ERT). Thus a more critical examination of the hormone therapies was necessary and feminists gradually began to condemn long-term hormone therapy for menopausal and postmenopausal women. Most feminists after 1975 began careful consideration of the meaning and significance of menopause and the so-called 'treatment' being prescribed for it by physicians. Houck (2006) writes that there were primarily three approaches to menopause and dealing with menopausal

problems on which the feminists agreed completely. The first was to understand that menopause was not a disease as had been propagated as such by science and the biomedical community. Rather, menopause was to be understood as a normal life event and a natural transition. Secondly, women were being urged by the feminists to think of themselves beyond the conventionally prescribed and ascribed social roles, thus stepping out of the conventional roles. And thirdly, the feminists adopted the position that the problems of menopause were more a result of social pathology rather than signs or symptoms of physical illness and thus, it was only with the liberation of women that they would be able to solve their menopausal problems. Feminists by the end of the 1970s were increasingly discouraging women to resort to hormone therapies for their menopausal problems. It was firmly believed by the feminists that the lives of menopausal and postmenopausal women improve considerably only when the social roles for women were changed in the society.

During the 1980s when the treatment protocol shifted in the United States to the use of a combination of estrogen and progestin (rather than just prescribing estrogen), HRT gained immense popularity points out Sievert (2006). After ERT, this was the second time that hormone therapy was being seen as a rejuvenator for middle-aged women and more so because progestin was demonstrating protection against endometrial cancer. By the early 1990s women were once again being urged to consider HRT as menopause instead of being seen as a disease in itself, was being seen as a risk for osteoporosis and cardiovascular disease. The strongest pro-argument for HRT was:

> "...cost-benefit analyses that demonstrated reduced social costs specific to osteoporosis and cardiovascular disease among women taking the medication" (Daly et al. 1994; Mishell 1989; Notelovitz 1989; Utian 1978 cited in ibid).

More than 45 million prescriptions for *Premarin* were given out in 2001 and more than 21 million prescriptions for *Prempro* i.e. the pill with the leading combination of estrogen and progestin (Rothenberg 2005).

However, the debate and controversy over HRT resurfaced in the United States after the findings of two large scale studies – the Heart and Estrogen/Progestin Replacement Study (HERS) and the Women's Health Initiative (WHI). The results of the WHI study

demonstrated that estrogen and progestin when taken orally increased the risk of coronary heart disease as well as breast cancer and the study was stopped in 2002. (ibid) Sandra Coney (1994) writes:

> "The WHI trail was stopped early by the National, Heart, Lung, and Blood Institute of the National Institutes of Health because after 5.2 years the risk of heart disease, stroke, venous thromboembolism and invasive breast cancer were increased in healthy women using continuous combined HRT, and these risks outweighed the benefits of reduced fractures and colorectal cancer" (1994: 3).

Ever since the WHI study, there has been a significant change in the level of prescribing HRT by the physicians and there has been severe fallout for the makers of HRT. The overall sales of hormones fell by 38% and sale of pills such as *Prempro* fell by 74%. Research by drug companies also showed that while in 2002 there were 18.5 million women using hormone therapy, in 2004 the number had dropped to 7.6 million women (Berger 2004 cited in Rothenberg 2005).

However, McCrea (1983) does suggest that in their efforts to fight off the stigma of menopause as a medical problem and to instead see it as a natural and unproblematic event, feminists have overlooked the group of those women who actually do need medical attention. She claims,

> "Most feminists in the health movement see women's oppression rooted in arguments of biological inferiority. Feminists have tried to settle the nature-nurture debate by showing that differences in socialization, not biology, account for women's inferior status. In their attempt to overthrow the dictum "biology is destiny," feminists have argued that menstruation, childbirth, and menopause are natural events and, in most cases, do not warrant medical intervention. They charge that myths surrounding these events function as social control. In so doing, feminists have attempted to substitute a new ideology (biology is irrelevant) for an old one (biology is destiny)" (1983: 120).

Thus the need is actually of studies which explicate "the structural affinities between the economics of health care and the status of women" (ibid).

### 3.6 Moving beyond 'the West': De-Medicalization and The 'Alternative' Discourse

Unlike in the western societies where biomedicine has maintained its hegemony as the dominant form of medicine, non-western societies have had what is known as 'medical pluralism', wherein multiple medical systems of healing systems exist simultaneously. For instance, in India, a number of medical systems have existed over the years such as homeopathy, ayurveda, naturopathy, unani and allopathy. In the societies where biomedicine hasn't been the dominant medical system, the process of medicalization hasn't been that rampant and pervasive (Lock 1993). In many if not most societies outside the western orbit, the medical system is such that it is more preventive in nature. One of the main reasons for the slow pace of medicalization in the non-western societies is the difference in the cultural understanding of gender, sexuality and ageing. While in the western society ageing women are seen as pathological, in non-western societies the ageing of women goes beyond a mere biological understanding. Moreover, how menopause is understood and dealt with in a society is a product of that society's history and culture, and changes with location and over time. (ibid) Below are a few examples of societies in 'the Rest' where women and the biomedical community have dealt with menopause by not medicalizing the issue or in other words, by de-medicalizing the issue, dealing with it in an 'alternative' and a (seemingly) 'natural' manner.

#### a. China:

Honora L. Woolfe's (1998) book *Managing Menopause Naturally with Chinese Medicine* will be referred to for how the Chinese society deals with the issue of menopause. According to Wolfe, western medicine is able to offer only a few satisfactory treatments for menopause as compared to Traditional Chinese Medicine (TCM) which offers many safe and effective treatments for menopausal problems and tips for how women should deal with menopause. The author cites the reasons for why she favors TCM over western medicine – the first reason being that TCM is holistic i.e. it has never created a mind-body dualism. The physical aspects are seen in conjunction with the psychological

and emotional aspects, which in the case of menopause and other gynaecological problems is highly beneficial. She writes,

> "...a good practitioner of Traditional Chinese Medicine sees and understands the whole pattern of this patient as if she were a landscape painting with various aspects – water, trees, mountains, etc. – but all of one piece. The practitioner then prescribes singly or a combination of acupuncture, herbal, nutritional, exercise, and/or massage therapies to work effectively with the entire pattern that each patient represents. " (Wolfe 1998: 10)

Related to the holistic aspect, TCM is also individualized i.e. it is more specific for every patient's needs and is personally tailored to suit every individual, unlike western medicine which has a 'one size fits all' kind of package. The next reason favouring TCM is that TCM is non-iatrogenic i.e. the treatment does not result in any troublesome side effects if the diagnosis has been correct, barring a few mild ones. TCM is more so a good choice for women and their health issues as TCM is preventive medicine and self-empowering for the women. Unlike in the western medical system where the initial signs and symptoms are seen as subclinical and not indicative of any disease, TCM can begin treating a disease at a very fundamental level which helps in the onset of other more serious diseases. Also, TCM is an empowering form of medicine which allows its patients to understand the disease themselves, become aware and be an active participant in the healing process. Last but not the least, TCM has had a long history of success having had existed for more than 2000 years as compared to western medicine which is just 50-100 years old. Wolfe does admit that in the cases of certain life threatening situations, western medical treatments are necessary and allow people more options, thus it's not advisable to dismiss this form of medicine. However, for chronic or functional disorders, TCM offers more alternative, viable and humane forms of treatment than the western biomedical system.

To understand menopause holistically from the point of view of TCM, one needs to understand various other issues such as

> "...menstruation, organ function, the emotion in relationship to the organs, yin and yang, and the production, storage and circulation of blood, energy (qi), body fluids, and vital essence (jing)" (ibid': 17).

Western forms of understanding the physiology and even the language used to describe western medicine needs to be kept aside when understanding how TCM works. Certain terms cannot have an exact translation as there is a difference in their cultural meanings, or vice-versa. In the Chinese society, menopause is a physiological event, a natural transition and "need not be accompanied by any discomfort" (ibid: 41). Some of the common menopausal symptoms among Chinese women are hot flashes, night sweats, insomnia, irritability, depression, nervousness/anxiety, vertigo, fatigue, palpitations, memory loss, weight gain, poor appetite, edema, blurring vision, headaches, constipation, diarrhea, nausea, joint pain, stiffness, cramps, abnormal bleeding, vaginal dryness, loss of sex drive and osteoporosis. The diagnosis of these symptoms in TCM is

> "...based on the discrimination of professionally recognized, named patterns of disharmony. Traditional Chinese diagnostic patterns are differentiated based on signs and symptoms, observation of the tongue, and palpation of the pulse, abdomen, channels and vessels. They are not based on laboratory tests. Traditional Chinese patterns of disharmony are usually directly descriptive of the patient's experience of their disease" (ibid: 65).

Menopausal women, according to Chinese medicine, should not be doomed to a 'hormonal nightmare'. The suggestions provided for menopausal women to prevent the symptoms from arising are exercise, abdominal self-massage, relaxation therapy, flower therapy, light therapy, magnet therapy, Chinese aromatherapy and a proper diet. But the times when medical help is required, then unlike western societies where ERT is prescribed to the menopausal women, TCM offers "other remedial and preventive options" (ibid: 125). The two main professional TCM therapies offered to menopausal women are acupuncture and Chinese herbal medicine. Regarding its views on ERT, Wolfe claims that ERT is not new to the Chinese medical system and in fact, it was by 125 BC that Chinese doctors has isolated sex hormones from urine and used those

hormones as rejuvenating supplements. But because of the many drawbacks of ERT, it is not prescribed to menopausal women and other (natural) alternatives are suggested.

**b. Japan:**

> "Why do Western women make such a fuss about menopause?" (Asked by a Japanese gynaecologist at a Florida conference, 1985 in Lock 1993: xvii)
>
> "It's not seemly for Japanese women to fuss about their bodies" (Kyoto gynaecologist cited in ibid: 256).

The work of anthropologist Margaret Lock in Japan during the 1990s was one of the first large scale comparative studies done on experiences of menopause and ageing from individual women as well from medical professionals between two particular societies from 'the West' and 'the rest'. The word menopause has no literal translation in the Japanese society and the term *konenki* is used instead which has multiple meanings - the end of menses, end of fertility and onset of old age being some of the meanings that Lock discovers through the women's narratives. Lock's study shows that in Japan *konenki* (as well as other life cycle events such as childbirth) are not as medicalized which is contrary to the rampant medicalization of menopause (and other life cycle events) in 'the West'. According to Lock's survey in the early 1990s, 60 percent of the women surveyed had never spoken to a doctor about *konenki.* Only 25 percent of the women had referred to a doctor and stated that received helpful information, while the rest of the women had found help from friends, television and magazines. Even within the 25 percent who had visited the doctor, a mere 7 percent had received medication and less than 3 percent of those were taking hormone therapy. As the social changes in the Japanese society were given precedence over the biological changes, Lock observed that Japanese women considered husbands and friends easier to communicate with that with doctors thus confirming the importance of the social rather than the biological changes during this stage.

Unlike in majority of the western societies, Japan has a widely distributed preventive medical system although there are very few preventive measures for middle-aged women writes Lock. And women themselves do not refer to a doctor until and unless their health is in a critical condition. Compared to North American women, Japanese

women use fewer sleeping pills, pain relievers and other medications. This statement comes as quite the surprise as Japan is the second largest pharmaceutical market worldwide and the largest per capita consumer of pharmaceuticals (Calder 1988 cited in ibid).

It is only in recent years that there has been an increasing interest in *konenki* and middle aged women within the medical community. The reason Lock explains for this change in that in recent years many Japanese women have started delivering their babies in high-tech, tertiary hospitals resulting in a decrease in the rates of abortion. Consequently, many gynaecologists have been facing financial losses and the need to recuperate those losses has led them to find a new target – the middle aged women. However, it hasn't been that easy for the gynaecologists to fulfil their goal as Lock argues that despite the increasing (albeit slow) trend towards medicalization, Japanese patients consult the physicians about *konenki* rather infrequently (although more in the recent years as compared to earlier) and in most of the cases, a large percentage of the physicians don't know how to deal with these particular group of women.

Lock makes the last statement above in the light that there is a certain degree of ambivalence(s) and contradiction(s) among the Japanese medical professionals themselves regarding menopause and the kind of treatment that it deserves, if at all. While there are some gynaecologists who feel that *konenki* doesn't deserve any medical attention as such, there are others who spend a good time of their day dealing with women with *konenki.* One of the most important reasons stated by Lock for the contradictions replete in the discourses of physicians is that menopause ranks quite low as a research priority, even in the medical teaching schools. In such a context, the physicians can choose their own mode of explanation for *konenki.* Keeping aside the contradictory explanations regarding *konenki,* there are some common grounds among the physicians. For instance, most of them barring a couple, believe that working class women do not complain of discomforts of *konenki* as compared to the leisured middle class, wherein the latter class has the free time to bother with *konenki* and take up the doctor's time. There is also a unanimous agreement on the fact that women with an unhappy family life are the ones more prone to having a difficult time at *konenki.* Also, most of the doctors take a strong stand against prescribing heavy medication for discomforts at *konenki* and are especially against prescribing HRT. One important

reason for the conservative use of either HRT or ERT is its similarity to the birth control pill and that both expose women to increased risks of cancer, heart disease and hypertension. Another reason that Lock attributes to the lack of interest in promoting HRT in Japan "relates to the differences in the epidemiology of the so-called killer diseases" (ibid: 295). The incidences of diseases such as osteoporosis, breast cancer and heart disease among Japanese women are relatively lower when compared to their counterparts in North America. Thus due to the resistance to HRT/ERT and supporting light dosage of medication, most doctors believe in practicing herbal medicine, a tradition that dates back to atleast a thousand years in Japan. Doctors also recommend the use of *jirutsu kunren* i.e. the disciplining or training of the autonomic nervous system through meditative exercises.

**c. Philippines:**

A comparative study among the menopausal women of Manila, Philippines and Brisbane, Australia was conducted by Gabriella Berger in 1995. While in Australia the medicalization of menopause has been occurring since the 1950s when menopause was viewed as a disease by the medical professionals and Australian women since then have been treated with hormones to combat menopausal symptoms, the case was not so in Philippines. The use of HRT has been recommended by the Australian Menopause Society as not only a treatment option but also as a prophylactic (MacLennan cited in Berger 1999). Whereas in Philippines, it is only of late that the medical professionals have had an increasing say in a limited matters of women's reproductive health such as pregnancy and childbirth. Regarding menopause,

> "There is an emphasis to rely on Mother Nature to determine the flow of events and in this vein menopause is still perceived as a normal, natural event" (ibid: 121).

Although in Manila a small 'menopause clinic' has been set up, only a small number of women are aware of and prescribed HRT. Most of the Filipino women managed their menopausal stage without feeling the need for any medical intervention.

In Manila, Philippines, another study was conducted by Ramosa-Jalbuena in 1991 wherein out of the 32 percent women (out of 1,015 women) who were affected by urinary incontinence, only 8 percent consulted a physician for treatment. A third study

of 447 patients in 1994 at the Philippine General Hospital Menopause Clinic in Manila, "as many as 70 percent of the patients were assessed as being eligible for hormone replacement therapy but only 10-15 percent of them were still taking the medication after a one-year follow-up" (ibid: 41). There seemed to be a certain amount of indifference to seek medical help and to take any medication among the Filipino women due to the women accepting menopause as a normal, non-life threatening stage in a woman's life cycle argues Berger (ibid).

**d. India:**

Similar to TCM, Bulbeck (2001) writes that Indian medical systems also have a holistic understanding and interpretation of the human body where the mind and body are equally important for the overall health of a person. Ill health is seen as a bodily imbalance and each individual symptom is treated to restore that balance. By Indian medical systems one refers to the medical pluralism that exists in the country i.e. the co-existence of different medical schools of thought such as homeopathy, ayurveda, unani, folk medicine and allopathy. Regarding menopause in particular, the Indian medical schools along with the ending of the menses also take into account other symptoms such as back pain, loss of eyesight and hot flushes – all of which point towards the ageing of the woman. Menopause is not understood as an individual entity in itself and is not isolated from the other events in the woman's reproductive life history. As a form of treatment, Indian medical systems offer yoga, *pranayama*, meditation, dietary and lifestyle changes to regulate the menopausal and postmenopausal discomforts. (ibid)

### 3.6.1 'Naturalizing' Menopause: A Critical Look at the 'Alternative' Discourse

Marys Guillemin (2002) in her paper entitled 'The Problem of Naturalising Menopause' explains that while on the one hand there are well-founded critiques of the medicalization of menopause, it cannot be completely ignored that there is a group of women for whom menopause is not merely a social construction but a biological and corporeal reality which does result in unpleasant to seriously debilitating discomforts. These women do voluntarily seek for medical help for the relief of their acute symptoms. Based on this argument, the author states that it is the recognition for women's need for medical help and/or therapeutic support, while at the same time not

enforcing the biomedical model of menopause as a disease on the women and the subsequent medicalization of menopause that has largely influenced the move towards what Guillemin terms as the 'naturalisation' of menopause – i.e. the use of 'natural' therapies and 'natural' products such as soy bread, primrose oil, linseed and yam cream. This 'naturalisation' of menopause is a part of the complementary and alternative medicine (CAM) model, which in turn is a part of the much wider holistic health movement of the 1970s. CAM is all about using alternative, 'natural' therapies which are considered to be non-toxic and safe. For Guillemin, the term 'natural' is fraught with problems and through her work she questions and challenges the notion of 'natural' as being necessarily good and safe in contrast to the critiques aimed at HRT.

Further, Guillemin explains that just like there are attacks on the medicalization of menopause, there have been critiques of the naturalisation of menopause as well. Her central argument is that just like medicalization, the focus of naturalisation is also on the deficiency of hormones in women except that the latter, claims to replace women's depleted hormones with 'natural' ones. Both HRT and the so-called 'natural' products have known and unknown risks and side effects; atleast for HRT there have been well-documented studies to assess those risks and side effects. Also, both models of managing menopause operate within a market-oriented ideology with profit-making as the ulterior motive. In short, according to Guillemin, the naturalisation model does not present a genuine alternative to the medicalization model when it comes to the management of menopause. She suggests that instead of conceptualizing menopause as a hormone deficiency, attention needs to be focused on developing some truly alternative models which do not focus only on replacing the depleted hormones in the woman's body. To quote,

> "If we return to the claim of menopause as one of the many phases of woman's life that acts as a significant social, emotional and physiological marker then maybe we can consider an alternative model that takes all these factors into account" (ibid: 48).

## 3.7 Conclusion

As discussed initially in this chapter, medicine uses science to legitimate the power of physicians to define both illness and its treatment. Ferguson and Parry (1998) contend

that the language and ideological framework used by the male-dominated medical discourse to represent menopause fails to represent the actual subjective, multiple experiences of women. It is essential that the language and experience of menopause be demedicalized as the first step to re-conceptualize what one understands by menopause. The language needs to be such that menopausal women are no longer stigmatized and the menopausal transition can be seen as a natural transition, not neglecting those menopausal women who might actually need medical attention. To quote the authors,

> "By rewriting menopause, women can begin to "own" menopause and claim a continuum of experiences, attitudes, and interpretations" (ibid: 36).

Also, HR, as had been propagated since the 1960s in North America, has not been the only way of treating menopause and in fact, not even a safe and infallible way of doing so. There are alternative and natural methods to deal with this issue without unnecessarily medicalizing the issue. However, it's not as black and white as it appears to be i.e. one cannot simply say that there is medicalization in 'the West' and not in 'the Rest'. In conjunction with the drug companies, biomedicine has marketed a particular picture of menopause and the menopausal woman (Ramirez 2006). With globalization, the increasing influence of the medical community, the changing nature of the doctor-patient relationship and the pharmaceutical giants making their presence felt all around, societies in 'the Rest' are feeling the pressure of medicalization. And moreover, the question of what is 'natural' and 'safe' also needs to be interrogated further.

The management of menopause was seen as the medical dilemma of the twentieth century (Brennen cited in Callahan 1993) and there were only a few other therapeutic regiments which have generated as much debate and controversy as HRT has since the time of its inception. Although the false promises of HRT have been exposed by the studies conducted by feminists over the years, women still face the dilemmas until now as they hear conflicting reports about the potential benefits and risks of this so-called treatment for menopause. Physicians with the liberal approach recommend HRT on a routine, long-term basis even in the absence of menopausal symptoms. And then there are physicians who with their conservative approach (similar to the WHO) recommend HRT for a short-term with the lowest possible dose only in the presence of certain

specific symptoms such as hot flashes, night sweats or vaginal dryness. The dilemmas that women face are to do with HRT and three primary problems – endometrial and breast cancer, osteoporosis and cardiovascular diseases. (Callahan 1993)

It is not as if HRT has absolutely no benefits, but as the WHI study shows the risks outweigh the benefits, especially in the longer run. Coney (2002) suggests that women who decide to stop using HRT should do so reducing the dose gradually over six to twelve weeks, so as to avoid withdrawal symptoms such as 'rebound' hot flushes. She also goes on to suggest that rather than blindly using the prescribed medication, one should look for alternatives. . The question at the present moment is that on what parameters should women weigh the pros and cons of using estrogen, as the current advises and scientific research findings are uncertain and speculative at best (Rothenberg 2005). While most health professionals agree that the risks of the hormone therapies should be put on the table for the female patients, it was only a minority of women who were aware about the risks. In a two year long project undertaken on health technologies aimed at midlife women in United Kingdom, when asked about HRT, half the women participants of the project said that the decision lay with the health professional (Innovative Health Technologies at Women's Midlife: Theory and Diversity Among Women and Experts 2001-2003). With the research findings of studies such as WHI demonstrating conflicting recommendations and results - potential benefits on the one hand and harmful consequences on the other hand - what the woman actually needs is the right kind of information to weigh the risks involved in choosing HRT and the choice to make an informed decision as to how she wants to handle her time of menopause and the subsequent years (Harding in Peterson and Bunton 1997). As National Women's Health Network activist Cindy Pearson puts it:

> "The right to choose is meaningless without the right to know." (Pearson cited in Coney 1994)

# Chapter Four

# Menopause in the Life Course: Engaging with Sexuality, Ageing and Anti-Ageing

## 4.1 Introduction

The foray of research into the sexuality of midlives of men and women has been quite recent and sparse when compared to the other stages of the human life span and most of the conducted research focuses on heterosexual women (Winterich 2003). The prime focus of this chapter will be to investigate what the menopausal transition, situating it in the larger canvas of the ageing process, means for women's sexuality. The first half of this chapter will entail a sociological discussion on how the sexuality of menopausal, middle-aged women has been conceptualized using the life course perspective– a theoretical framework which has been discussed in an earlier chapter. Following which the chapter will be concerned in examining how the menopausal woman's sexuality and body has been 'constructed' in a certain way by the different actors of the society such as the medical community, the media and the advertising industry. And, the second concern of the chapter will be to analyse the aspect of ageing and the anti-ageing discourse with respect to the menopausal, ageing woman. But first, let's take a look at the paradigm this chapter employs as its theoretical foundation.

## 4.2 The Life Course Paradigm: The Theoretical Underpinning

The life course theoretical framework/paradigm and/or perspective on sexuality has been a growing field among scholars since the 1990s. Rossi's edited volume in 1994, *Sexuality Across the Life Course,* was the pioneering work in this emerging field and it advocated the use of a bio-psycho-social approach. This approach integrated "biological and social-behavioural variables" to explore sexual "scripts" across the "full age range of sexual life" (Rossi 1994 cited in Carpenter 2010; emphasis not mine). But Rossi and the other scholars then did not discuss concepts from life course sociology such as transitions and trajectories and instead, presented a generic conceptual framework to study sexuality, points out Laura Carpenter (2010) in her article entitled 'Gendered Sexuality over the Life Course'. It is since the mid-1990s that scholars have started recognizing the importance of *trajectories* and *transitions* in an individual's life course (emphasis not mine). Carpenter writes that every individual life course is composed of

multiple, simultaneously occurring trajectories such as family, work and sexuality and each trajectory can be divided into a series of transitions such as the loss of virginity in the sexuality trajectory or retirement in the work trajectory. However, this is not to say that every individual experiences the same transitions and it is possible that most transitions have more than one potential outcome. For example, not every heterosexual individual will get married or one who gets married might end up getting divorced (Sussman, Steinmetz, and Peterson 1999 cited in ibid).

Clausen (1995 cited in ibid) points out that there are certain events which markedly change a trajectory's direction and those transitions can be understood as *turning points*. Because of the number of different transitions that a particular trajectory can go through in a life course, life course trajectories can be understood in terms of cumulative advantages and disadvantages (O'Rand 1996 cited in ibid). While positive transitions produce advantageous transitions in later life stages, negative transitions generate further disadvantages. There are some trajectories, argues Carpenter, which differ by gender – for instance, virginity loss as a trajectory is where men and women largely differ on how they choose to view it as well as how the society views that particular trajectory for either of the gender.

The transitions in an individual's life trajectory which are related to family and sexuality represent points at which individuals might adopt new ways of negotiating his/her sexual life. Developed by sociologists Gagnon and Simon (1973 cited in ibid), this approach to understanding sexuality is known as the '*sexual scripting approach*' or the '*sexual scripts framework*'. This approach proposes that an individual's sexual life and sexuality is governed not by biological imperatives as much as it is governed by socially learned sets of sexual desires and conduct. Simon and Gagnon (1986 cited in ibid) explain that sexual scripts exist at three interrelated levels (in no fixed order) – first, at the societal level are the *cultural scenarios* which are created and reinforced by social institutions like the mass media. These cultural scenarios act as 'sexual roadmaps' which people can refer to for guiding their choices about when, how, why and with whom to be sexual. To illustrate, widows having to be faithful to their deceased husbands is an example of a cultural scenario. Second, is where people write their *interpersonal scripts* at the level of social interaction when one individual influences the

other and vice versa in terms of sexual behaviour and sexual conduct for instance during sexual intercourse. The third is the *intrapsychic* or the individual level of sexual scripting which is to do with one's sexual desires, fantasies and intentions and this level is influenced by both the cultural scenarios as well as interpersonal scripts.

Lastly, as people accumulate life transitions, not only are they growing older in *sociological* (italics mine) terms i.e. acquiring new social roles but they are also growing older physiologically and biologically (which is closer to the health trajectory) as well as psychologically (Riley 1987 cited in ibid).

The crux of this chapter is based in the theoretical discussion above wherein using a life course perspective I argue that:

a) Menopause can be seen as a transition and as well as a major turning point in a woman's life course in her sexuality (and family) trajectory.

b) How a woman manages her sexuality, sexual desire and sexual conduct at different stages (in this case her midlife) depends to a large extent on her relations to the family and other actors of the society in which she lives.

And,

c) Ageing of a menopausal woman needs to be understood in more ways than one and the different types of ageing need to be considered for a complete understanding.

### 4.3 Sexuality and the Midlives of Women

Linda Gannon in her book *Women and Ageing: Transcending the Myths* (1999) argues that while historically the construction of sexuality was driven by religion, in today's day and age, science is the new religion. The view of women's sexuality and of ageing women in particular is not only constructed by the social morals, beliefs and values "but the construction is sanctioned and perpetuated by today's priests – the scientists" (Gannon 1999: 112) and one's devotion is towards the physicians. With scientific and medical control having replaced religious control,

> "...sex has been reduced to the content of science – biology, the methods of science – unitary, linear causal models, and the interpretations of science – there is one and only one healthy way to be sexual. And the consequences, not surprisingly, are ideologically consistent with patriarchy: the definition of healthy sexuality for ageing woman is to have sexual intercourse with her husband; her refusal to do so is interpreted as a hormonal deficiency, and the solution is to modify her biology" (ibid: 113).

Most discussions of middle-aged women and their sexuality is done quite exclusively in a context of "married woman, husband present", writes Greer (1993) in her widely popular book, *The Change: Women, Ageing and the Menopause.* Such a context and categorization does not apply to the section of women who are not partnered (as divorcees, widows or as single women) or those who partnered with a woman. Additionally, much of the existing literature and research is based on white, middle-class, heterosexual women who have asked for assistance in the form of medical intervention for their sexual problems and concern. Very little is known about the sexual lives and expressions of those middle-aged women who do not experience their menopausal changes as being sexually problematic. Gannon (1999) claims that "today's priests decree that sex is good and sex is healthy" (1999: 113). Thus, as per this diktat, a person who is not sexually active keeping in line with the heterosexual norm is deemed unhealthy and sick and have to face a great deal of stigmatization (ibid). Greer (1993) does not deny the important role that science, medicine and psychology play in treating those who do need that treatment, but

> "...helping a woman restore health to her vagina or helping a woman through the aftermath of a traumatic sexual experience does not then give the expert the right to tell her how, when, how often and with whom she may have a sexual experience" (ibid: 114).

### 4.3.1 Sexual Changes

There are a few common sexual changes that are reported by the menopausal and postmenopausal women which are dealt with in this section. Although it should be noted here that the changes discussed below are generalizations, not exhaustive, and these changes would be applicable to menopausal women in 'the West'. In other words,

these are not changes applicable universally and in fact, the latter half of this chapter would engage with these changes for women in 'the Rest'. As American biologist Alfred Kinsey, one of the pioneers in sexology, pointed out six decades ago:

> "...there is nothing more characteristic of sexual response than the fact that that it is not the same in any two individuals..." (Kinsey 1953: 167 cited in Daniluk 1998).

**a) Vaginal Changes:**

Due to the abundant and regular supply of estrogen to the vagina, the vaginal lining remains lubricated and pain-free. With the onset of menopause, the estrogen levels decline resulting in the thinning of the vaginal lining and decreased elasticity of the vaginal walls. The consequence of the thinning and decreased elasticity is the dryness of the vagina known as vaginal atrophy in the medical literature. These factors lead to an increased time for the menopausal women to lubricate when they are aroused sexually. These changes in the genitalia result in reduced sensitivity of the clitoris, painful sexual intercourse especially with deep penetration (primarily for heterosexual women) and a considerable decrease in orgasmic intensity and frequency. (Cole and Rothblum 1991 cited in ibid) Some of the complaints by women are wherein they compare their vaginas to "the Sahara desert", "fragments of cut glass" and "sand paper" (Cole 1988: 162 cited in ibid). Some women even complain of a greater urgency to urinate after engaging in sexual intercourse. And there are some who even complain that inserting a tampon is a painful process - a common complaint by both heterosexual and homosexual women. (ibid).

**b) Orgasmic Responsiveness:**

According to Gannon (1999) there is some evidence which suggests that the duration of an orgasm and the number of vaginal and uterine contractions are reduced as women begin ageing. Even though women are capable of multiple orgasms, with increasing age there are women who report of declining orgasmic responsiveness. The common notable changes are taking more time than earlier to reach an orgasm, having less frequency of orgasms and lesser intensity of the orgasms (Barbach 1993; Kahn and Holt 1987 cited in Daniluk 1998). However, there are a few women who reported having an enhanced orgasmic responsiveness

in their menopausal and postmenopausal years (Cole 1988 cited in ibid). The reasons attributed to this positive change was the increased time and energy that women had for sex once their children had left home, experienced a greater sense of intimacy with their partners and free from the fear of pregnancy. There are many factors responsible for the changes in orgasmic responsiveness. Some of them are (in no order of importance) decreased levels of estrogen, changes in the genital tract, slackening of the pelvic floor muscles. Moreover changes in the vagina is not solely responsible for the changes in reaching orgasms – the changes are spread across other parts of the woman's body such as her breasts, clitoris, outer and inner labia and Bartholin glands (Masters and Johnsons cited in ibid). On the other end of the spectrum are studies such as that of Kinsey et al (1953 cited in ibid) where women under the age of sixty reported no decline in their orgasmic responsiveness when involved in sexual activity which didn't require a partner, such as masturbation. In fact the decreased responsiveness might only be present in certain forms of sexual activity such as vaginal-penile sexual intercourse (ibid).

**c) Sexual Frequency and Desire:**

Greer (1993) pointed out that to determine whether and how women experience a decline in sexual desire (or not), sexual interest or responsiveness during and after menopause, it is first of all necessary to establish how much sexual pleasure they expect to get. According to Greer, a woman who has never had any sexual pleasure before cannot in all fairness experience a decline in it during and after her menopause. The results of a survey done by Kahn and Holt in 1987 (cited in ibid) suggest that the sexual activity and experience of women during their premenopausal years determines/predicts postmenopausal sexual activity and satisfaction thus corroborating Greer's view. It's important to understand that women in their midlives may be experiencing their sex lives in different ways than before because of a number of reasons, but just because it's different does not mean it's less satisfying. The existing literature on this issue is as equivocal as the literature on the issues mentioned earlier. It remains a challenging task to garner a complete account for the wide range of variation in the levels of sexual desire and interest experienced by midlife women. While on the one hand there are many women who fear that they will lose their sexual desire as well as desirability during

and after their menopause. On the other hand, there are as many women who report no change at all or an increased level of sexual desire and activity. (ibid) The current state of knowledge regarding the issue of midlife women and their sexual desire and sexual interest perhaps can be summarized in the words of Kaplan:

> "Whilst some women report a decrease in sexual desire, many women actually feel an increase in erotic appetite during the menopausal years. Again, the fate of libido seems to depend on a constellation of factors which occur during this period, including physiological changes, sexual opportunity and diminution of inhibition" (Kaplan 1989: 129 cited in ibid).

### 4.3.2 Sexual Relationships and Sexual Concerns

Gannon (1999) writes that broadly there are two theories regarding a woman's sexuality and her midlife. According to one theory, the onset of menopause will result in a dwindling of her sexual interest and sexual activity as the true identity, self-esteem and purpose of a woman lies in her ability to reproduce. This idea that sexual interest in a woman during or after her midlife wanes or is ideally supposed to wane has been present historically. In the nineteenth century for instance, only young women were expected to approach or engage in sex with enthusiasm but if ageing women did the same, it was seen as a sign of illness as well as imprudence. American physician Edward Tilt wrote,

> "My experience teaches me that a marked increase of sexual impulse at the change of life is a morbid impulse...Whenever sexual impulse is first felt at the change of life, some morbid ovario-uterine condition will be found to explain it... It therefore, is most imprudent for women to marry at this epoch without having obtained the sanction of a medical man" (Cited in Smith-Rosenberg 1985: 192 in ibid).

And the second theory argues that menopausal and postmenopausal women will enjoy sex more as they will no longer have to harbour the fear or anxiety of an accidental or unwanted pregnancy. It is the former theory which leads to the common

(mis)conception among the medical community that there is a major decline in the sexual interest and sexual activity of menopausal and postmenopausal women. They believe that as women become older, they become sexually abstinent (Youngs 1990 cited in Coney 1994). Coney (1994) claims that gynaecological and psychiatric literature shows no clear evidence for women having a decline in their sexual activity and interest in their middle years. Instead, the literature showed that for a large number of women in this age group, sex was an important activity. In cases where the sexual activity did decline, it was due to reasons such as the lack of an available partner. In fact, an Oxford study (cited in ibid) showed that when middle-aged men and women were compared, a similar number of both (and the numbers weren't high) had problems regarding sexual intercourse. If women faced problems, men also faced problems regarding erection and arousal. Thus the implication was that sexual problems in midlife had more to do with the process of ageing rather than with hormones. It is surprising, or not that surprising, that the libidos of midlife women are on the wane according to the medical practitioners as well the society at large considering the sociocultural ideas of what it means to be a woman and the prescribed norms of (hetero) sexuality. (ibid) And not just medical literature but feminist Simone de Beauvoir in her book *The Coming of Age* (1996) also states that with age, the frequency of coitus decreases. Greer (1993) argues that Beauvoir's discussion of the sexuality of the aged is male-oriented and doesn't consider the woman's sexual desire(s) and whether the male is able to sexually gratify his partner.

While most of the studies on the sex lives of menopausal women base themselves on the first theory dealing with negative aspects such as vaginal dryness, vaginal itching and decreased libido, very few studies are concerned with the second theory, i.e. the positive and liberating changes that menopause brings about in a woman's middle age and the subsequent years. Julie A. Winterich's (2003) qualitative study (unlike most other studies which base their results on surveys) is one of those few studies which based on in-depth interviews of thirty heterosexual and lesbian menopausal and postmenopausal women show as to how these women have positively embraced their postmenopausal sex lives. Although it would be incorrect to say that the biological and hormonal changes brought about the menopausal transition are insignificant, as a feminist sociologist, Winterich argues that how women experience changes surrounding sex is influenced to

a great extent by the cultural expectations about menopause, gender and heterosexuality.

The few studies that have been conducted on menopause and sex offer conflicting results as to whether there are significant changes in women's sexual activity and whether ageing is an important factor for predicting those changes before, during or after menopause. These studies are limited in their approach and scope as they assume that menopause results in problems for the women and consequently fail to investigate women's own views on this issue. Moreover, the existing studies rely on heterosexual samples of women thus assuming that for all women sex is defined on the basis of vaginal-penile intercourse opposed to those women for whom sex can also be defined on the basis of hugging, kissing, touching and masturbation (Conway-Turner 1992; Barbach 1993a cited in ibid.) The findings of Winterich's study demonstrated that although her study was framed around menopause, most of the women in her sample did not refer to menopausal changes while discussing their sexual activity. The emphasis was more on the social changes rather than the biological, bodily changes due to menopause. Rather than simply discussing the changes that menopause brought about in relation to their sex lives, the participants of the study spoke about the cultural ideas that associated middle aged women to the normative views about gender and heterosexual sex. Several women reported that they had an active and fulfilling sex life, and in fact, much more fulfilling than before as no longer did they have to worry about issues such as contraception, pregnancy and having little kids around the house. Problems like vaginal dryness didn't pose an obstacle to these women who made use of lubricants and unlike before, some women enjoyed the new found spontaneity in their sex lives. For instance a 56- year old Caucasian married for 35 years said:

> "He was very happy [that she talked to the nurse practitioner about her vaginal dryness] because it has made it much better and actually sex is great...I think it's better a lot of times now than it was...when we were younger...You don't have to worry about getting pregnant...[or] someone coming in and finding you" (ibid: 634).

Those women who reported not having a fulfilling sex life, or no sex life at all, blamed it on their current relationship status, past abusive relationships or health complications

brought about by ageing rather than blaming it on menopause in particular. Gannon (1999) suggests on a similar note as does Winterich that women experience little or no predictable changes as such in their sexuality as a result of menopause. Rather, those postmenopausal women who experience reduced sexual desire and sexual activity are affected more so by factors other than the menopausal status – factors such as the availability of a partner, psychological problems such as depression, mid-life crisis, marital discord, insufficient emotional support from the husband and/or alcoholism in husband. Thus, the fact is the sexual lives of women (and men for that matter) have to do with much more than merely the physiological aspect as reiterated by Szasz below,

> "Sexual pleasure is not merely reducible to sexual physiology than is pleasure in listening to music reducible to auditory physiology" (Szasz 1980 cited in ibid: 110).

However, the second theory which supports that women in their midlives can have fulfilling sex lives and instead of declining there's a surge in their sexual desire, has also been in some contexts pushed to an extent wherein the belief is that "menopause can turn virtuous women into sex maniacs" (Greer 1993: 282) These middle-aged women are seen as having an uncontrollable sexual desire to a point of "frenzied promiscuity" (Mankowitz cited in ibid.) There are a few who argue that middle-aged women with their increase in sexual desire might just become more like their male counterpart regarding the ideas of being direct and sexual aggressiveness:

> "Middle-aged women, having perforce cast off the narcissism of younger women, are quite likely to be more direct in their sexual advances and to make quite clear what it is they are after, especially if, for the first time in their lives, what they are seeking is not a love but a fuck. If this is the case, it will be the first time in their lives that they have understood the male pattern of arousal and the male search for release." (Hallstorm cited in ibid: 283)

### 4.4 Menopause and Ageing

Chadha (1999) writes that ageing, a natural phenomenon is not a uniform phenomenon, nor does it inevitably mean that it is a process of deterioration or decrement. He defines ageing as

> "...the process of growing older, it involves a multidirectional change involving the physical, psychological and social spheres of a person's existence, the key work is change or process" (ibid: 1).

Chadha (1991) describes four categories of ageing in humans and the various aspects of each category. *Biological ageing* refers to the physical changes in the body systems during the later years of an individual's life span[19]. This process of ageing might begin long before the individual begins to age chronologically i.e. *chronological ageing* as the second category which refers to ageing in number or years. The third type, *psychological ageing* refers to the "adaptive capacities of individuals as observed from their behaviour, but it may also refer to subjective reaction or self awareness" (ibid: 1). *Social ageing* refers to the individual's social habits and roles with respect to his culture and society wherein with the increase in social age, the individual experiences a decline in meaningful social interaction. Lastly, *affective ageing* refers to the individual's reduced affective capacities in relation to a changed environment. Willigen et al (1999) add yet another category of ageing which is *cultural ageing*. This category according to the authors is related to chronological ageing but yet, has its own distinct characteristics. The cultural age of a person can be defined as "possessing the knowledge that is expected for a specific period of their life" (ibid: 23). The authors point out, using Riley's (1979 cited in ibid) argument, how using the life course perspective is essential when trying to conceptualize cultural ageing because this perspective views the ageing process multidimensionally and it has a central premise wherein ageing is seen as a lifelong process – starting with birth and ending with death. They argue that a life course is culturally constructed and needs to be seen as a cultural unit. Thus, an individual's life course in a western society will in all probability be different from that of an individual's life course in a non-western society, owing largely to the differences in the cultural settings of the societies. Regarding cultural institutions and ageing, the authors note how

[19] The author being a psychologist himself uses the term life span – a term which is used by developmental psychologists instead of other terms such as life course or life cycle.

> "...ageing processes are expressed through the cultural institutions of a person's community and consist of changes in a person's relationship with others in society (ibid: 25)."

Also, there exists age norms and age status in each society and each society has its own cultural timetable for a person's apt social progress through his/her entire life course, and his/her behaviour corresponds closely to those very norms (Kertzer and Keith 1984 cited in ibid).

In any society which places great emphasis on a achieving or maintaining a certain body image and a standardised ideal of thinness (Chrisler and Ghiz, 1993; Tiggemann and Lynch, 2001 cited in Rubenstein and Foster 2013), women's anxieties about reaching menopause and their ageing years might be exacerbated and could ultimately have negative consequences for both physical and psychological health. Although it is clear that women's bodies will change and do change during menopause – they might gain weight, change body shape (Conboy 2001 cited in ibid), have a change in their skin tone or notice an increase in their facial hair (Papalia 2007 cited in ibid). Such changes, and more, might mean that these middle-aged women might not be able to match up to the ideals of youthfulness, beauty and slimness as is portrayed/reflected in the media (ibid). Thus, in such a situation, menopausal women might feel pressurised to conform to those ideals and as a result may be constantly dissatisfied with the way they look. However, some studies (Tiggemann and Lynch 2001, Hvas 2006 cited in ibid) suggest that with increasing age, there are some women who start feeling more confident about themselves and the concerns about their body image may diminish in comparison to their younger selves.

Locating menopause within the larger canvas of ageing (and anti-ageing), the following subsections will look into menopause with regard to a few of the types of ageing, primarily focusing on the contributions and work of one of the recent prominent feminist scholars who has worked on reproductive ageing with an emphasis on menopause, Heather Dillaway (2006; 2005).

### a. Menopause and Chronological Ageing

Dillaway's (2006) aim in one of her other papers entitled 'When Does Menopause Occur, and How Long Does it Last? Wrestling with Age- and Time- Based Conceptualizations of Reproductive Ageing' has been to reiterate her previous findings to some extent and to explore how "women's experiences illustrate yet demystify the equation of particular chronological ages and menopause" (2006: 38). In this paper, Dillaway makes three main arguments based on her in-depth interviews with sixty-one women, making it one of the largest qualitative projects on women's meanings and experiences of reproductive ageing in the United States. Firstly, there is a distinction between chronological age i.e. how women are in actual number of years and menopausal age as women do not believe that reproductive ageing begins or end as per a predetermined set of ages. The second argument Dillaway makes is that when doctors link menopause to chronological age, women's treatment choices are affected and their larger health concerns are neglected. And the final argument is that since menopause is understood and diagnosed via chronological age and operationalized within a biomedical framework, "there are definitional issues that surface within qualitative research on menopause" (ibid: 42). In summary, Dillaway's analysis based on her collected data is that menopause does not occur or cease at a particular chronological age and women report varying ages of onset and duration (a discussion on the variation in age at menopause has been covered in the previous chapter).

### b. Menopause and Reproductive Ageing

Defining menopause has been one of the major stumbling blocks in the studies on menopause as discussed in an earlier chapter. Along with the difficulty in defining menopause, there is also difficulty in determining a particular age for the onset of menopause as well as the length of this transition. In such a scenario,

> "...researchers, doctors, and women sometimes fall back on chronological age as a proxy for reproductive ageing, using it to diagnose or operationalize menopause. That is, we still rely on questionable links between chronological age and reproductive ageing." (Dillaway 2006: 36).

Dillaway (2005) claims that while there has been some work on gender differences and inequalities in ageing in general, there is a glaring gap in the knowledge about women's

experiences of ageing and reproductive ageing in particular. She argues that an understanding of women's experiences at midlife (or any other stage in their lives) cannot be limited by using the parameter of chronological ageing. By using chronological ageing to define menopause, while on the one hand lies the potential of inadequate medical treatment, on the other hand lies the narrow conceptualization of the experience of reproductive ageing. Also, women themselves suffer from uncertainty and frustration as they themselves tend to define their own menopausal experiences through the lens of chronological ageing. Instead, Dillaway argues that researchers need to continue working towards a broader conceptualization of ageing vis-a-vis women's midlife experiences. Feminist scholars have until recently focused on women prior to their middle years and those working in the field of gerontology have focused on women in their sixties and above. In this context Dillaway writes,

> "...feminist scholars have failed to contradict their own ageism, in that younger women and other reproductive processes have (e.g. pregnancy, childbirth, or contraceptive use) have overwhelmingly been their focus until recently (Calasanti 2004; Ray 2004; Twigg 2004). Furthermore, no research problematizes a general equation of menopause and chronological ageing (Fausto-Sterling 1992; Gannon 1999). Ageing scholars typically study individuals aged 65 and older (Kaufman and Elder 2002), forgoing the study of menopause as an ageing process. While menopause is both a reproductive and ageing expreince, research on its reproductive and ageing contexts is lacking." (2005: 400).

The existing definitions of menopause and reproductive ageing need to be challenged and the link(s) between the two needs to be understood much more broadly, so that the health requirements of midlife women can be met recommends Dillaway (2006). However, one cannot ignore the important work that has been done by feminists in this field. The work of feminist scholars such as Germaine Greer (1993), Margaret Lock (1993), Joan Callahan (1993), Sandra Coney (1993), Susan Sontag (1997) and Linda R. Gannon (1999) have definitely helped in understanding the menopausal phase, midlives and ageing and they have also presented a strong critique of the biomedical industry which end up 'medicalizing' all aspects in a woman's life course. Contemporary literature on ageing, writes Dillaway (2006), shows the distinctions between

chronological ageing from ageing experience and ageing identity. And it is from this point that feminist scholars need to pick up to build up their own research on the issues of the importance of chronological ageing in women's midlife or the distinction between chronological and reproductive ageing or the experiences of women regarding reproductive ageing. The existing literature on ageing distinguishes between "chronological ageing, how old individuals feel i.e. what age do they identify with and their bodily or experiential age" (2006: 37) i.e. what is the status of an individual's physical health. The scholars working in this field have illustrated how people depending on their physical well being can feel older or younger, and thus the experiences of chronological ageing and experiential ageing rarely match. However the problem occurs when scholars don't reflect on how chronological ageing figures into particular processes of ageing such as menopause. And the midlives of women (their personal narratives and otherwise) in regards to this have received sparse attention from the ageing scholars.

In her paper 'Menopause is the "Good Old": Women's Thoughts about Reproductive Ageing', Dillaway (2005) writes the following lines to justify her use of the term reproductive ageing:

> "...I often use the term reproductive ageing to conceptualize menopause as a process that (1) denotes biological maturation or ageing of some sort; (2) suggests that women's gendered, reproductive experiences create different experiences for women compared with men; and (3) illustrates how menopause may be distinct from other ageing processes. This term implies that menopause cannot be analyzed one-dimensionally and allows an exploration of multiple social contexts that may make it unique" (2005: 401-402).

Thus in Dillaway's understanding, menopause, or reproductive ageing, is unique and distinct from other ageing processes as it entails a reproductive context. To understand menopause in its entirety, the social background of the women, their use of contraceptive technologies, their feelings about sexual activity and the connections they make between menarche, menopause and the other reproductive events in their lives - all these factors need to be considered. The forty-five middle-class, heterosexual

women of the study (2005) reported that on entering their menopause and midlives, they did not feel old and in fact, suggested that this phase in their lives represented the "good old" – a phase where they enjoyed a greater amount of sexual activity. Having discussed earlier in this chapter, one can see that exists a considerable section of women who see the menopausal and postmenopausal phase positively.

### c. Menopause, Cultural Ageing and Social Ageing

The following discussion of anti-ageing is located within the larger framework of cultural and social ageing where I argue that it is the social and cultural values of a society which influence when a woman starts feeling 'old' and the constant pressure of living up to socio-cultural ideals of being 'young' makes a woman tread on the path to try and 'fight' ageing. I refer here to societies in 'the West' as well as 'the Rest' and to illustrate the latter, I will look at the image of the ageing woman in India. Desai (1999) explains that until recently, ageing or rather the elderly in India have enjoyed a high status and power in the family and the society. Consequently, it is often assumed that the matters of the aged in India is not a problematic area and thus, doesn't deserve much attention. Gerontology, like most other disciplines, was not devoid of androcentry and until the 1970s women's issues did not get any importance in this discipline. Even the women's movement in India until then did not define ageing as a feminist issue. It was failed to recognize that many of the problems faced by ageing women were shaped by the patriarchal controls and the subordinate status that they had been under all through their lives even before they started ageing (Hooyman 1987 cited in ibid). Along with sexism, Indian women also have to face ageism, starting from their menopausal stage – an issue I will briefly look at by the end of this chapter. But before that, we will see how the ageing woman is located within the anti-ageing discourse in 'the West' focusing on the work of de Beauvoir (1997), Foucault (1990) and Sontag (1972).

## 4.5 The Anti-Ageing Discourse

One of the crises stages in a woman's life history (along with puberty, sexual initiation and so on), menopause brings along a "dangerously abrupt" transition which is much more decisive than any transition in a woman's life history according to de Beauvoir (1997). With the loss of a woman's fertility, her femininity and erotic attractiveness – the points of justification for her existence in the society – the woman has no future and

yet, many years of her adult life are left. For de Beauvoir, this crisis of the menopausal transition is felt more by women who are not engaged in work, either inside the household or outside it. The woman, unlike the man, faces "the horror of growing old" (1997: 587) and "she feels the fatal touch of death itself" (ibid: 588). No longer seen as the attractive, sexual being that she once was, the ageing woman comes face-to-face with her anxieties. Now that she no longer has any hold on the man/men in her life, what will become of her? With the onset of menopause and the "dangerous age" having passed, the ageing woman "becomes a different being, unsexed but complete: an old woman" (ibid: 595).

Writer, cultural critic and a feminist, Margaret M. Gullette (2004) argues in her book *Aged by Culture* that age is culturally constructed and it's important that scholars and activists work towards dragging ageing away from nature and toward culture. Gullette claims that age is a powerful form of difference and identity just like race, class, gender and sexuality and "no other construction concerns every one, or concerns each one so nearly" (2004: 97). In the American culture where ageing is seen as the "social name for bad alterations" (ibid: 130), the burgeoning commercial anti-ageing market is one such arena which pushes for solutions to ageing and the midlife crisis. Calasanti (2007) critically examines the commercial and clinical anti-ageing industry as being involved in the regulation of bodies and claiming to forestall or even reverse ageing.

The ideology behind this ever-increasing market/industry (Gullette 2004), prolonging years of youth, de Beauvoir's (1997) views about the 'horror of growing old' and 'the fatal touch of death itself' are the basic premises which concern the anti-ageing discourse. The anti-ageing discourse would refer to the current popular understanding and discourse on ageing that prevails in the Western society but has made inroads into the non-western societies as well. The Indian society as an example of the latter will be discussed later in this section. Anti-ageing would primarily refer to the reversing of the ageing process, both in terms of bodily appearances and the desire to live longer.

Mortas (2008) asks whether it can be said that the anti-ageing discourse is merely an innocent aspiration to bring about eternal youth. It would be safe to say he writes that there has been a sharp increase in the popularity of anti-ageing since the 1990s, which is not to say that the desire to live longer among human beings is only a recent trend.

Although the endeavour for human longevity can be regarded as old as human existence itself, what makes the recent anti-ageing discourse different are certain notions and perceptions regarding ageing which are quite peculiar to the modern times (ibid). With liberalism making its way quite aggressively since the 1990s and the markets making their presence felt all around, the discourse around anti-ageing took newer, bigger leaps. The dissemination of this discourse can be seen through various channels such as the books, magazines, advertisements and so on[20].

Mortas writes that the main aims of the anti-ageing discourse are first, to operate in a way that it can control, regulate and shape the individual's body. And the second aim is to reproduce the meaning of age and ageing wherein ageing is reduced to a biological understanding and the social or psychological understanding of it becomes secondary. Eternal youth is presented as a possible alternative to ageing and with the discourse emphasising on the idea of living a longer life without ageing, the emphasis is on life over death and thus it becomes difficult for individuals to show complete resistance or indifference towards it (ibid). In such a context, the body becomes a crucial platform where this discourse gets played out and the body is seen as "a platform of performance for the practitioner" (ibid: 4).

Although Michel Foucault did not directly write about anti-ageing, according to Mortas, Foucault's writings on power-knowledge relations can be employed in this context to understand how power seeps into the daily lives of individuals without being coercive or violent but rather through a discourse which on the face of it comes across as a simple, voluntary acceptance of remaining young for as long as possible. Mortas claims,

> "The importance of the conceptualization of bio-power for examining anti-ageing is that it helps us to understand the logic which makes individuals a part of power mechanism through their bodies. The possible linkage and similarity between the logic of power in managing the life of human through controlling her body and the popular appeal of applying anti-ageing

[20]The last section of this chapter will focus on three such channels through which women receive the messages of this discourse: the media, the medical community and family and friends.

strategies can be understood in the light of Foucault's theory of bio-power" (ibid: 28).

The main concern of this section entails the examination of how the body is controlled and disciplined by the prevalent power relations in a society, specifically within the context of the anti-ageing discourse. To gain a complete understanding of the concern as mentioned, one first needs to look at the conceptual category by Foucault which he terms as 'bio-power'. Foucault describes bio-power as the mechanisms and tactics of power that are employed to control the life of humans. He writes,

> "Different from earlier forms of power, bio-power constitutes itself on controlling the population by exercising certain techniques on the conditions of life and well-being of individuals" (Foucault cited in ibid: 11).

In the first volume of his book, *The History of Sexuality* (1990), Foucault elaborates on the concept of bio-power and looks into the question of how certain kinds of knowledge and power relations control and also 'produce' the human body. According to him, power is not exercised through a top-down approach, but is rather exercised from different points and can be seen at all levels. Before the emergence of bio-power, the main deterministic character of sovereign power was holding the right over the life and death of people. The sovereign could use the right of death in certain situations, thus protecting an individual's right of life by holding their right of death. But 17th century onwards, Foucault argues that it became more important for power relations to manage the right of lives of people rather than their right of death. Giving life to the individuals became the main motive of this new form of power and thus new techniques and mechanisms were being produced by power to improve, maintain and conduct surveillance over the lives of its subjects. After this turn of events, bio-power began developing in two ways: first, the 'anatomo-politics of human life' and second, the 'bio-politics of human body'. The first form of politics was where the human body was to be treated like a machine and the goal was to build its levels of skills, productivity and obedience. The second form of politics, appearing in the mid-18th century, described the human body in terms of its biological processes and its focus was on the productive capacity of the body. In this form of politics, power was exercised in such a way that human lives could be controlled at the level of statistical knowledge. Thus based on the

bio-politics of power, Foucault argues that the biological processes of human life such as birth, death, longevity, fertility, health matters etc. became the object of knowledge and power – an object which needed to be controlled, disciplined and regulated so as to maintain the power relations.

According to Foucault, institutions in the society such as medicine and religion are institutions which practice their power not through coercion in the form of violence but rather in the form of normative coercion which disciplines individuals and exercises forms of surveillance in one's daily life (Turner 1997 cited in Mortas 2008). Such institutions are voluntarily accepted by the society as being normative and legitimate as they "exercise moral authority over the individual by focusing on their problem and providing solutions for them" (ibid: 75). In such a context, the practices propagated regarding anti-ageing can be seen as an institution of normative coercion where the anti-ageing discursive practices are being accepted by individuals without much opposition (ibid). Using Foucault's conceptual category of bio-power and the techniques employed by this form of power, anti-ageing as an institution uses a similar form of power and focuses on the body of the individual (ibid). Within the Foucauldian framework, anti-ageing can be understood as one of the practices and mechanisms which controls, regulates and disciplines the individual's body in the current times (Dumas and Turner cited in ibid).

The main target of the anti-ageing discourse has been the middle-aged and ageing woman[21], the following discussion will look into how practices of the anti-ageing discourse have managed to control and regulate the body of the middle-aged women.

### 4.5.1 'Forever Young' (?): Targeting the Menopausal, Middle-aged Woman

> "For ageing women, invisibility is both a feeling and a reality, and the silence of not being addressed is deafening" (Sontag 1972: 3).

The desire to look a certain age is especially predominant among the current generation of middle-aged women who want to look a certain age by regulating their bodily conditions, by preserving a certain appearance and body image and by disciplining their lifestyle choices (ibid). The way a middle-aged woman experiences and interprets her

[21] Although this is not to say that young women are not the targets, but since the subject matter of the present dissertation is the menopausal, middle-aged women the focus will be on the latter.

body within the ageing process needs to be understood within the domain of a youth-oriented culture (Daniluk 1998), a domain especially visible in the Western society where the 'altar of youth' is worshipped (Lock 1993). Women are subjected to ageism in such a society much before men (Ussher 1989, 1992a, 1992b; Wolf 1991 cited in Daniluk 1998) where women are perceived as being "over the hill" when they reach their midlives (Banner 1992 cited in ibid). This harsh discrimination between men and women in regards to ageing is referred to by Susan Sontag (1972) (and others such as Bell 1989 cited in ibid) as the *"double standard of ageing"*, where ageing according to Sontag meant a humiliating process of gradual sexual disqualification for most women. In other words, she argues that in a society where women are most desirable as lovers, young wives and mothers, the women's sexual value fades away once she starts ageing. Also, as women live within an inimical nexus of deep-rooted sexism and ageism, they are disempowered as they age. According to Sontag, ageing was much more of a social judgement than a biological eventuality. She believed that the society limits the ways in which women can imagine themselves and in such a society there is bound to be anxiety, fear and depression related to ageing. Even if women themselves do not want to feel old, the messages received by the society affects the women in both overt and subtle ways. In a world primarily ordained by men, Sontag argues that it is a particular type of normative male heterosexuality which defines and determines the messages about a woman's value and where her value lies. And unfortunately, the definition of a woman's value based on her appearance is largely visible and even more prominent in today's times. The loss of youth would necessarily imply the loss of femininity and as discussed before since women's experiences are understood largely within the boundaries of chronological ageing, the onset of menopause in a woman's life course is the time when she is no longer in her youth. With the end of fertility, comes along a woman who is sexually undesirable, unattractive and someone who is assumed to be hosting a range of psychological problems such as depression, mood swings and emotional instability (ibid). The understanding of menopause in its limited context makes menopause seem like "a major design fault that leads inevitably to diminishment, alienation and invisibility" (ibid: 31).

Thus with such an understanding of menopause in the western cultural context, it is not much of a surprise to see women being obsessed about their physical appearance and

body image. Let's now discuss how in 'the West', middle-aged women and ageing women's body image gets affected and how these women make attempts to stay 'forever young'.

### 4.5.2 Changing Body Image/Body Esteem of the Menopausal Woman

> "...we live in a society in denial about ageing; a denial fuelled by an obsession with image and style, with youth and physical beauty, and the illusion that we can keep making ourselves over to hold old age at bay. And although we are not all obsessed with the desire to stay young, resistance is frequently interpreted as deviance or failure..." (Sontag 1972: 29).

To reiterate, the main aim of the anti-ageing discourse is to tell individuals, especially women, that ageing as a process can be reversed and one can stay eternally young. Menopausal, middle-aged women and ageing women at large seem to have become the primary targets and the discourse has become so normalized that women of this age group find it normal to "fight" ageing and the assumption is that they should try to retain a certain body image and appearance (Winterich 2007). The 'certain' body image and appearance prescribed is that of a woman who is young, thin and sexually attractive. Body image is one such important factor for all middle aged women in the context of women's sexuality as they age. While there can be various definitions for body image, the definition below fits coherently with the present discussion:

> "Body image refers to the attention to and evaluation of an individual's own physical attractiveness and overall appearance" (Kelson, Kearney-Cooke, and Lansky 1990; Silberstein, Striegel-Moore, Timko, and Rodin 1988 cited in Koch et al. 2005)

Another term used synonymously with body image is body esteem which has three components: sexual attractiveness, weight concerns, and physical attractiveness (Crose 2002 cited in ibid). There are very few empirical studies which have investigated the relationship between ageing women's sexuality and physical attractiveness even though the links between the two "make conceptual sense and are supported by everyday observation" (Wiederman and Hurst 1997: 568 cited in ibid). Winterich (2007) also writes that the existing literature on body image and the body in general of ageing women is sparse and the available literature is mostly limited to white, heterosexual,

middle class women. An important point to note here is that as ageing (like other concepts and phenomenon) is given meaning within a socially constructed context, individuals experience and perceive their changing, ageing bodies as a response to the 'Other' i.e. to the others' perception of them becoming old (de Beauvoir 1970 cited in Banister 1999). Studies such as that by Frida- Ke Furman (1997 cited in ibid) show that heterosexual women who feel stigmatized as they age is because they lose out on the male gaze (i.e. the Other) wherein they are no longer seen as being young and as an implication, no longer attractive and (sexually) desirable.

Most studies on ageing seem to find that as women age they start having negative images of their bodies, primarily due to the negative socio-cultural ideas that the women have internalized over time; ideas which are based on the normative and dominant beliefs in the society about the connection between femininity and the need to look young (Winterich 2007). Koch et al (2005) argue that there is also a dearth of research more specifically on midlife women's body image and their sexual responses. Their own study, '"Feeling frumpy": the relationships between body image and sexual response changes in midlife women' is one those few studies which looks into this link and even though it has its own set of limitations (such as a homogenous sample of White women in the United States), the study highlights some important findings. For instance, about half the middle-aged women in the study found themselves less attractive than they were a decade ago and this decline in self-perceived attractiveness was consistent with a decline in sexual activity or response. The findings of this study, write the authors, were consistent with the central themes of an important ethnographic study conducted by Elizabeth Banister (1999), as discussed below.

How an individual perceives his or her self is located within a certain socio-cultural and historical context and the self perception is also based on his or her own knowledge and/or understanding of gender, sexuality and ageing, writes Banister in her article titled 'Women's Midlife Experience of their Changing Bodies' (1999). Her article was based on a detailed ethnographic study in Canada around the narratives of eleven midlife women to analyse how their views about their changing bodies was affected by the sociocultural and physiological factors. In her study, Banister outlined four central themes as sense-making markers which helped in integrating the diverse meanings of the women's experiences within the particular contemporary sociocultural and

historical context. The first theme was that of '*sensing incongruence*' according to which most of the women interviewed were sensing a certain, uncomfortable ambiguity with their changing bodies. And this ambiguity was to do with the fact that women in their midlife have great difficulty in adjusting to the fact that they are no longer as physically attractive as they were in their younger days (Halprin cited in ibid). The women participants of Banister's study were facing difficulties in coming to terms "with a changing body that was becoming less valued in terms of societal and, to a degree, personal standards of youth and fertility" (ibid: 526). Based on the cultural prescriptions imbued with sexism and ageism, prescriptions which devalue ageing women, women had negative experiences to narrate regarding their body weight, figure and physical appearance in general. The second theme was to do with women '*having more questions*' about their changing bodies. The answers to these emerging questions were sought by the women from women their age and to a great extent from medical experts as well. Banister writes,

> "Because looks are personal but are defined socially, the influence of social structural factors were embodied and thematicized as sensing incongruence between the women's life stories and larger cultural processes. As the women spoke of their changing bodies, more and more questions emerged. The questions arose as a result of their ambivalence but also because of a lack of knowledge, itself the result of cultural avoidance of the issues facing midlife women" (ibid: 527).

The third theme Banister discusses is that of '*sensing loss and longing*' – a result of the heightened awareness among the ageing women that they were no longer their former, younger self and had less years to live than before. Midlife becomes that stage of one's life when one shifts from a focus on the time lived to the time that one has left to live. In such a context, one's perception of one's self changes as Rossan explains,

> "...an important influence on one's identity is one's interpretation of the physical changes occurring at various points in life. The awareness of diminished youthful appearance confirmed by photographs and mirrors was at odds with most of the participants' self-images. Indeed, the observed

> physical changes of midlife challenged many of the participants' sense of identity and self- esteem" (Rossan 1987 cited in ibid: 530).

The final theme that Banister talks about is *'caring for self'* i.e. a theme involving the regeneration and emergence of the self. For some of the women in the study, ageing meant being able to step out of the social roles that had been ascribed to them and develop as an adult. With children growing up, leaving homes, parents passing away, women in their midlives are able to have a perspective transformation wherein they are now able to focus the attention on themselves for a change, gradually moving towards an increased individuation and autonomy. For a few women, this change of life crisis gave them the opportunity to connect with their inner selves and see it as a spiritual connection.

In the following section, the focus is on the messages that menopausal, middle-aged women receive from various social avenues and how within this social context, ageing women live and attempt to make sense regarding their changing bodies, about their sexuality as well as about menopause.

### 4.6 Messages Received Within the Society

> "When we're constantly surrounded by messages that tell us that young is sexy, it needs an imaginative leap to believe that middle-aged or old is sexy too" (Coney 1994: 111).

Carpenter (2010) writes individuals might adopt new ways of negotiating sexual life when faced with transitions related to either family or sexuality. Looking at menopause as a transition, this section is based on the *sexual scripting approach* or the *sexual scripts framework* (ibid) which is a useful tool to explore the messages that women receive and have to negotiate with in the society. As one will see by the end of this discussion, a woman's sexuality, sexual desire and sexual conduct is governed much more by the social messages on these issues which reveal some of the significant social impediments to midlife women's sense of sexuality, sexual desirability and entitlement than simply being governed by biology. The two main sexual scripts that I will closely examine here are firstly, the *cultural scenarios* at the societal level which act like 'sexual roadmaps' for women to refer to and include institutions such as the medical community, the media,

the beauty and fitness industries and secondly, the *interpersonal scripts* at the level of social interaction with the significant others in the women's lives such as the husband/partner, other family members and/or peer group.

In Judith C. Daniluk's book, *'Women's Sexuality across the Life Span'* (1998), Daniluk explores these social messages that women receive within the social context across their life span – messages which give out problematic and contradictory signals to women as a result of which many women feel disconnected and disempowered in matters regarding their sexuality, body and health among other things. Although the context of Daniluk's work is largely regarding women in 'the West', it can be argued in my opinion that her work can be applied to societies in 'the Rest'.

### a) Messages for Menopause

As has been discussed in one of the earlier chapters, the medical community views menopause as pathological, associating it with a wide range of symptoms. The menopausal women are seen as deviant, diseased, hormone deficient and sexless. The medical literature is replete with terms regarding menopause such as "vaginal atrophy", "degenerative changes", "estrogen starvation", and "senile pelvic involution" (Kitzinger 1985: 237 cited in Daniluk 1998). With medical treatment seen as a necessity to treat this disease, hormone replacement therapy is seen to be the obvious choice for curing women of this debilitating stage that women go through. Even in the 21st century, a considerable fraction of the medical literature sees menopause as a period of deficit and loss for the woman. To this, Daniluk asks whether it is of any surprise that even now women

> "...approach menopause with less than overwhelming enthusiasm? After all, who would want to rush into such a "rite-of-passage" when the destination of the journey is portrayed as one of physical and mental decline...?" (ibid: 274).

Since the 1990s, rather than shunning it aside as a taboo topic, there has been an increase in the public emphasis on menopause (Ahsen 1996 cited in ibid). In recent times, one would find a rise in the number of self-help books and magazines available advising women on the best ways to deal with the uncomfortable period of menopause and the associated symptoms. Although there are a few books (Germaine Greer's *The*

*Change: Women, Age and Menopause* [1993], Janine O'Leary Cobb's *Understanding Menopause: Answers and Advice for Women in the Prime of Life* [1993], *or Lonnie* Barbach's *The Pause: Positive Approaches to Menopause* [1993]) which aim at presenting menopause as a natural transition to the readers, the bulk of the available literature is giving advice and suggestions to women as to how they can eliminate the symptoms of menopause, the benefits of hormone replacement therapy and how to successfully 'fight' the signs of ageing.

Even in the visual media, the popular portrayal of menopausal women is of a woman who is on an "emotional roller coaster" (Barbach 1993: 27 cited in ibid.) and someone who is

> "...exhausted, irritable, unsexy, hard to live with, irrationally depressed, and unwillingly suffering a 'change' that marks the end of her (re) productive life" (Lindemann 1983: 103 cited in ibid).

There is rarely any television show and movie, writes Daniluk, where both middle-aged men and women are seen experiencing changes as they age. Rather, the natural conclusion is that it is the ageing woman who is going through a rough and tumultuous period in her life and it's this change of life that she's undergoing which is rustling in certain mannerisms and behaviour. A good example here would be that of the popular Hollywood movie, Sex and the City 2 where one of the lead characters is going through her menopause and she is someone who is highly dependent on her hormonal pills and in much fear of ageing. In one of the scenes where she in unable to have those pills, she starts throwing a fit and tells her friends how she would become an unattractive haggard without these pills. There are advertisements as well such that of the smoothie called Jack in the Box which shows that how menopausal women to remain sane need to consume this particular brand of smoothie, barring which they would "go cuckoo"[22].

Nevertheless, Daniluk also states that it is not as if all women are passive recipients of any and every message the media is dishing out to them and the agency of some women cannot be ignored. However, what also cannot be ignored is the fact that women do rely on the sources of written and visual media and the overt and covert messages of the same which suggest that menopause is usually associated with physical and mental

[22] Refer to advertisement on YouTube: http://www.youtube.com/watch?v=kKCpmz6Eccg

degeneration and it is a "condition" which requires medical intervention or attention in terms of lifestyle changes in general - especially in the light of studies such as those by Kaufert (1980) and Mansfield, Theisen and Boyer (1992) which show that a large number of women depend on the media much more than their health care providers on information regarding menopause (cited in ibid).

As far as the significant others in a women's life are concerned, Daniluk states that most women found it difficult to openly communicate about their menopausal experiences with their family members including their husband/male partner primarily because of two reasons. Firstly, by communicating about this phase with the other people in their lives, the women are acknowledging that they have reached this period of 'change' and due to the social stigma and secrecy attached to it, they themselves feel a certain sense of shame and do not want to talk about it in the first place. As Greer (1993) writes, the menopausal women "simply have to tough it out and pretend that nothing is happening" (1993: 35). Women are embarrassed to even discuss it with their own mothers as they seem to find it a taboo topic to discuss with their mothers just like any other aspect of their sexual lives. Most of the women were unaware of how their own mothers negotiated with their own menopausal experience. The second reason for the difficulty in communicating (a reason not mutually exclusive from the first) is that the family members have themselves internalized "the largely negative social perceptions of menopause" (Daniluk 1998: 276). For a lot of middle-aged mothers, going through their menopausal transition, the transition itself became an acceptable rationale for any of her mood swings, depression or frustration or discontent. The male partners or husbands also, as research shows, viewed their menopausal partners/wives as going through some major life crisis and thus, had largely negative attitudes towards menopause (Bowles 1986 cited in ibid). In a poll commissioned in 1991 (Gallup poll cited in ibid) by a company which manufactures estrogen-replacement patches, for many male respondents, menopause was a convenient scapegoat for understanding and interpreting the disagreeable behaviours being displayed by their wives. In fact, many of the men were reluctant to admit openly that their wives were going through menopause, as Daniluk argues that to admit that would also be to admit that the men themselves were getting older.

### b) Messages for the Body and Body Image

> ""The underlying message in the news stories about women's health is always the same: whether it's raging hormones, or ageing hormones, women are ultimately the victims of their bodies" (Katha Pollitt 1992 cited in Ferguson and Parry 1998).

The message present and promoted in virtually all forms of the media, argues Daniluk (1998), is that for a woman her most important asset is her body image and physical appearance. Persistent efforts are made by the media to make women believe and gradually internalize that they need to "fight" ageing so that they don't lose out on their most important asset. The popular media such as films rarely represent images of ageing women – in fact, the diversity among middle-aged women regarding physical aspects such as shape, size and appearance are few. Advertisements all around are constantly promoting products which would help middle-aged women to not grow older, to enhance their physical attractiveness and in the process preserve their youth and (implied) femininity. For Daniluk, the implicit message in these advertisements selling anti-ageing products (wrinkle-free creams, blemish-free moisturiser, skin toning moisturiser etc.) is to seduce the reader into thinking and believing that by using these products they too can look like as fabulous as the younger looking woman who's advertising the product. It seems that such attempts are "aimed at capitalizing on women's vulnerabilities about their ageing bodies (ibid: 296). One of the ways catching up fast to promote anti-ageing is in the field of cosmetic surgery and botox in aims of 'rejuvenating' the looks. In Virginia Blum's book *Flesh Wounds: The Culture of Cosmetic Surgery* (2005), Blum discusses how the feminine identity is shaped by the male gaze in such a way that the woman becomes both an object and a subject to herself. When it comes to ageing women and their bodies, undergoing surgeries and botox goes on to show that women would be willing to exchange a fair amount of risk for gaining a certain standard of beauty. Blum explains how for women, their image and beauty becomes coextensive and cosmetic surgery ultimately transforms the woman's image as much as it transforms the body.

The feelings of insecurity among the middle-aged women are enhanced by the messages promoted by the beauty industry - the innumerable cosmetics, fitness regimes, diet plans - all contribute into women buying into the belief that they should make all possible efforts to remain young and maintain a youthful appearance, which includes a lissom figure and perfect radiant skin. Women are made to believe that they need to look a certain way and the phenomenon of ageing needs to be controlled for as long as possible. Kilbourne (1994 cited in Daniluk 1998) notes how these beauty products are marketed not as beauty luxuries but rather as necessities for every woman for their health. It is argued by writers and researchers (such as Fallon 1990; Faludi 1991; Wolfe 1991, and Kilbourne 1994 cited in ibid.) that much of the marketing of these products for the women are motivated by economics and the actual needs and gains of the consumers are secondary. The writers and researchers go on to claim that.

> "...while the overt message may be one of good health, the hidden agenda is to capitalize on women's feelings of insecurity and shame about their ageing bodies" (ibid: 298).

In fact, the socialization process for women is such that being physically attractive is one of the most important aspects of growing up as a woman - an aspect that affects both heterosexual as well as homosexual women, although the former is more affected as shown by research (Faludi 1991; Ussher 1989 cited in ibid). It seems that the phrase "ageing gracefully" is applicable much more to the women than the men. While it is socially acceptable for a middle-aged man to partner with a younger woman, middle-aged women are for the most part not accorded that privilege (Barbach 1993; Katzinger 1985 cited in ibid). For a lot many women, argues Daniluk, it becomes a prerequisite to preserve a youthful appearance, which includes shedding off the extra body fat around her stomach and hips, getting rid of the lines on her face or to not have sagging breasts among other things, to continue with their intimate, sexual relationships - an aspect discussed next.

### c) Messages for Sex Lives and Sexual Relationships

Until the mid-1990s, the medical community argued for procreation as the raison d'être of sexual activity for women in general (Ehreneich and English 1978; Hubbard 1990; Martin 1987 cited in ibid) and thus sex and menopause were seen as anathema.

However, in the current scenario, the medical professionals support the idea that sexual activity is absolutely normal for a menopausal woman and in fact, older women should be engaging in sex for the sake of their vaginal health and not to be sexually active can be considered as the woman being sick (Gannon 1994). Women are encouraged by the physicians to do whatever is necessary to ward off the vaginal atrophy which is a result of the cessation of estrogen at menopause. Daniluk (1998) argues that while some might think that this new medical ethos is liberating for the woman, it actually is a double-edged sword. The assumption(s) of such an ethos is that there should be someone in the lives of these middle-aged women who wants to have sex with them and the desire to engage in sex should be mutual. For Daniluk such an assumption is not only unrealistic and largely invalid but also a prescription of sexual intercourse as a prescription for proper sexual and psychological health (as masturbation is not sufficient and intercourse is still seen as the *sine qua non* of sex) is "probably experienced by women as a series of rather mocking demands on them" (Greer 1993: 303 cited in ibid).

Porcino refers to ageism and sexism as "the twin prejudices of most health-care professionals" (1983: 162 cited in ibid). On the one hand, ageism is apparent in the sexual and general health concerns of ageing women being disqualified. And on the other, sexism is apparent in the differential attention paid to the health care needs of middle aged men and women. The kind of language used in the medical literature, as mentioned earlier, also contributes in reinforcing the negative, sexist stereotypes surrounding midlife women's bodies and sexual health. For instance, while terms such as vaginal atrophy, ovarian senility and estrogen deprivation are common in the medical literature for middle aged women, there are hardly any comparable terms such as penile incompetence or testicular failure when it comes to middle-aged men, writes Daniluk.

The popular media has also largely failed in portraying middle-aged or ageing women in general as sexually vital human beings. Daniluk writes that in the West, when it comes to television shows, movies or advertisements in either visual or print media,

> "...it would appear that there are only two types of women. There are those who are young, beautiful, and therefore sexually desirable. And there are

> those who are too old and unattractive by today's standards to be considered sexually appealing. Sandwiched between these extremes are the few middle-aged 'celluloid' women who have managed to maintain the appearance of youth (e.g., Goldie Hawn, Jane Fonda). These are air-brushed images of women in their 40s and 50s who, through the beauty rituals and services available to economically advantaged women, continue to look remarkably 'young'. Therefore, they continue to be portrayed as sexually desirable. Juxtaposed to these are the middle-aged women who, in their attempts to hang on to their fading youth and sex appeal, are caricatured as sexual buffoons..." (ibid: 319).

Very rarely do middle-aged women get portrayed by the media as women who are much more individuated, freer and liberated sexually than they were when they were younger. There are few, if any, female role models in the media who are shown to be sexually attractive after having passed their so-called 'prime' days. With beauty and youth having become synonymous, the middle-aged woman is largely absent from the media portrayals. (ibid)

As for the messages middle-aged women receive from their significant others, Daniluk writes that it is not uncommon for women to believe (because of the social perceptions of them at large) that as their ageing bodies are no longer sexually desirable, their sexual relationships are consequently on a downhill. Few women however, believe that with increased knowledge and experience over the years about what gives them the maximum pleasure sexually, they find their sexual relationships during the middle years to be much more enriched than before. But the picture is not as simple as it seems as by the time women reach their midlives, the situation regarding their partners might be different as compared to before. For instance, women who have been partnered for many years might commonly report of reduced frequency and desire of sexual activity (Barbach 1984, 1988 cited in ibid). There are women who are either divorced and single and very satisfied with their sex lives, although finding sexual partners might be quite the challenge (Anderson and Stewart 1994 cited in ibid). Some midlife single women don't feel the need to find themselves partners as they either find outlets for releasing their sexual energy through masturbation, fantasy, dance, art and music or they have no real desire for sexual intimacy and are content being on their own (Cline

1993 cited in ibid). Daniluk explains that the problem can also arise when middle aged women try finding men their own age as most middle-aged men prefer turning to women younger than them. So the middle-aged women are either left to choose from the older or the younger group of men, where both groups have their own set of problems. Daniluk concludes by stating that it is undoubtedly not an easy task for middle-aged and ageing women in general to reclaim their sexuality and sexual entitlement in a culture which disqualifies sexual desirability at that age. But it's important for women to be able to write "poetry of [their] own eroticism" (Fleming 1994: 247 cited in ibid) i.e. they should have the space and opportunity to "turn their creative energies and sexual wisdom towards the task of envisioning and living more sexually self-affirming and satisfying lives" (ibid: 338).

### 4.7 Moving beyond 'the West': The Complexities and Changes

Let us now look at the scenario in 'the Rest' and how sexuality, body image and ageing issues are dealt with for middle-aged women in these societies. As there is a paucity of literature on menopausal women, their sexuality and the issue of reproductive ageing and anti-ageing in the non-western societies, this section is in no way exhaustive and will be looking at India as a prime example where anti-ageing in recent times has made unexpected inroads in a society where ageing never seemed to pose any problem (Desai 1999).

...

As discussed previously, in the North American and European society, menopause is believed to be an important reason causing decrease in sexual interest and sexual activity. The situation seems to be quite similar in many other societies as well as demonstrated by studies albeit studies which are few in number and which were conducted not too long ago. For instance, a study by McMaster et al (1997 cited in Hallad and Khan 2010) in Zimbabwe shows that in some African cultures the widespread belief is that sexual intercourse after menopause is quite impossible. Such a belief stems from the fact that menstrual blood is considered to cleanse the body from semen but if a menopausal or postmenopausal woman engages in sexual intercourse then the semen will remain in the body causing the body to bloat and an eventual death of that woman. However, the researchers of the study argued that the belief was actually meant to protect the women from any menopause-related sexual problems. In a

study conducted in India by Mahadevan et al (1982 cited in ibid.), a higher proportion of postmenopausal women as compared to premenopausal women reported that they had ceased sexual relations with their husbands. The study found that many of the men whose wives had attained early menopause, engaged in extra marital sexual relations which led to marital discord in many cases. In another study in Uttar Pradesh, India (Misra and Saseendran 1988) women reported a lack of urge when it came to sexual intercourse leading to sexual dissatisfaction among the husbands. Chowdhary and Alam's (2000 cited in Hallad and Khan 2010) study in Bangladesh also showed a similar result – majority of the postmenopausal women reported a decrease in their libido, stating that sexual intercourse seemed inappropriate after the children grew up and thus resulting in tension between the married couple.

However, there are other studies in non-western societies which hold a contradictory view. For instance, the study by Yahya and Rehan (2003 cited in ibid.) in Lahore, Pakistan shows that 72% of the postmenopausal women reported an increase in libido, 6% reported a decrease and 24% reported no change. In the study conducted in Nigeria by Odum et al. (1999 cited in Ibid.), none of the women complained of loss of libido. In another example, Chen and Ho's (1999 cited in ibid.) study in China showed that women of a higher socio-economic class and higher level of education had a lower risk of decreased sexual functioning. Hallad and Khan's (2010) own study in Karnataka, India showed that most postmenopausal women discontinued their sexual activity while there were a few who continued to engage in sexual intercourse but only until a few years after their menopause. So with such contradictory views on the sex lives and sexual desire of women, it becomes impossible to have one universal understanding regarding these issues. Thus, there lies a great amount of scope to examine these connections and relationships further, especially in the non-western societies.

...

Menopause, writes Desai (1999), marks the beginning of ageing for women. Along with the physiological changes which are a result of the cessation of the menses combined with other social and cultural factors, asexuality is also assumed to replace the passive sexuality among the women post-menopause (Golub 1992 cited in ibid). Sylvia Vatuk (1975 cited in ibid) on similar lines writes that sexual activity is particularly not

considered desirable once the son gets married. For instance, the Indian society also equates attractiveness in women with youth, the media also portrays women in their post-menopausal stage as being neither sexually active and neither sexually attractive whereas ageing men largely don't have to face a similar kind of portrayal. Studies in India, such as the 1980 study by Prakash and Murthy show that a higher number of menopausal women and those women who had undergone hysterectomy were found to be psychiatrically ill when the Standard Psychiatric Interview was administered. However, such studies have been countered by other studies (for instance the 1995 study by Davar cited in ibid) which shows no such co-relation between menopause and psychiatric illness. Thus Desai concludes by saying that such observations need further investigation.

In a country like India where menstrual blood is seen as dirty and polluting, a menopausal woman once rid of this blood is no longer seen as being impure. She is no longer under any restrictions when it comes to religious rituals and has an elevated status than before. If the woman is mother of a son, then she has especially elevated status and gets to exert control over the young bride(s) of the household. Unlike before, with increasing age women can participate more in social activities and communicate more with the male members, both inside the household as well as outside. However, the aforementioned lines hold true for the most part for women belonging to the rural parts of the country or for women who belong to lower socio-economic strata. Marcha Flint's (1975) pioneering study among 483 Rajput women of Himachal Pradesh and Rajasthan highlighted these very facts as stated that with the onset of menopause, these women undergo a role change as per the socio-cultural norms. The Rajput women who until their menopause were veiled and secluded in *purdah* could post-menopause come down from the women's quarters and mingle with the men. These menopausal women were no longer considered contaminative as their menstrual cycle had come to a halt and they could no longer bear any children. Thus, in the Indian scenario, menopause and the ageing of women is not seen in a negative light and consequently, even women's ageing is not perceived negatively.

However, the scenario seems to be different for the urban, economically at an advantage, ageing woman as compared to her rural counterpart. As Desai (1999)

explains that until recently, ageing or rather the elderly in India have enjoyed a high status and power in the family and the society. Consequently, he writes, it is often assumed that ageing in India is not a problematic area and thus, doesn't deserve much attention. Gerontology, like most other disciplines, was not devoid of androcentry and until the 1970s women's issues did not get any importance in this discipline. Even the women's movement in India until then did not define ageing as a feminist issue. (ibid) Sarah Lamb's (2000) work in the field of ageing women in Bengal, India has been one of the landmark studies conducted. The few studies on menopause in India[23] show that menopausal, ageing women welcomed the event as it was a sign of their increasing social status and freedom from restrictions. It was failed to recognize that many of the problems faced by ageing women were shaped by the patriarchal controls and the subordinate status that they had been under all through their lives even before they started ageing (Hooyman 1987 cited in Desai 1999). Along with sexism, Indian women also have to face ageism, starting from their menopausal stage. Moreover, when dealing with ageing, it is not easy to ignore the massive boom in the beauty market that has occurred in the last few years to 'fight' ageing by using the plethora of anti-ageing products available in the Indian market today.

...

Although there are English magazines (such as Femina and Woman's Weekly in India) which have promoted a certain lifestyle for women before the rapid pace of globalization (Johnson 1981 cited in Talukdar 2012), Talukdar (2012) argues that the influx of western labels (such as Cosmopolitan, L'Oreal, Christian Dior etc.) drastically affected the idea of beauty and fashion in societies beyond the west. The impact was seen largely in the print and visual media when actresses of a certain body type would be cast in the leading roles. Thus, in an age of rapidly increasing globalization and western ideals and products being imported to non-western societies, the altar of youth is being worshipped more than ever before. However, this is not to say that women across the world, especially in the non-western contexts are indiscreetly adopting the western conception of the ideal body as this would fail to capture the complex negotiations that women are dealing with within their own cultures with respect to the ideals of femininity, sexuality and the body (Mohanty 1991 cited in ibid). Notwithstanding that, for a large part, the western medical community, the western

[23] For instance: Flint, Marcha 1975; Aaron, Rita et al. 2002; Singh, A and A.K. Arora, 2005

media, the fashion and beauty industry have made a considerable impact in the non-western societies in promoting the young woman with the fair complexion, thin body and flawless skin as being the ideal feminine and sexually attractive woman.

The title of an article in an online magazine, 'From Beijing to Bali, Tokyo to Thailand, Asia Embraces Anti-Ageing medicine' (June 2008), suggests the theme of the report itself. Writer Lindsay Steel reports that throughout the world today, anti-ageing and regenerative medicine has become the fastest growing medical specialty. The goal of this is not just to bring about an increase in an individual's longevity but to ensure that the later years are enjoyed in a productive fashion. The anti-ageing movement was spearheaded by American physician co-founders, Dr. Ronald Klatz and Dr. Robert Goldman in 1992. They formed the American Academy of Anti-Ageing Medicine, which is one of the fastest growing medical societies in the world today making a global impact. Steel's closing remark is that the huge number of anti-ageing clinics around the world is largely responsible for the mushrooming of the many anti-ageing products in the market.

Combining Steel's comment about the huge number of anti-ageing clinics around the world along with the social anxieties and fears about ageing particularly in the context of ageing women (as discussed earlier) leads one to understand why women feel the constant need to preserve their youthfulness. To illustrate with an example, one can look at the current Indian context where there is a plethora of anti-ageing products aimed at rejuvenating the ageing skin and letting the urban Indian woman reverse the process of ageing. Calasanti (2007) writes,

> "As a profit-seeking industry, advertisements for the anti-ageing industry draw on cultural constructions thought to resonate with the most potential customers; they can thus be seen as both reflecting and reshaping cultural constructs about ageing, bodies and gender" (2007: 339).

Although Calasanti made the above statement keeping in mind the American context, this can be held true for the current Indian context as well. The anti-ageing industry in has been one of the fastest growing industries, making a huge profit not only in the United States but also in India as is evident from the wide ranging anti-ageing products available in the Indian market today. Such anti-ageing advertisements writes the author,

reifies the real world discrimination regarding ageing individuals (especially ageing women) and ageing bodies and "urge the consumption of products to delay consumers' entrance into that stigmatized group" (ibid: 339). The common message underlying these advertisements is that one can not only control ageing by using these products but *should* control ageing by using the products (ibid). In India today, one of the most popular of these products is the Olay Total Effects Anti-Ageing cream which claims to "fight" the seven signs of ageing which according to the advertisement are the appearance of lines and wrinkles, loosening of the skin, loss of radiant skin, rough skin, larger facial pores, dark spots and dehydrated skin. This particular product gets endorsed in the media by popular Indian celebrities such as Madhuri Dixit, Kajol and Sushmita Sen – midlife women who claim to have younger looking, blemish free, supple facial skin by using this product. Needless to say in a country like India where the Hindi film industry has a huge following and various beauty and fashion trends get followed by the audience, the endorsement of this (and other similar products by reputed companies, both western and Indian, such as Lakme's *Youth Infinity*, Ponds' *Age Miracle*, Garnier's *Wrinkle Lift/Firming Cream*, Revlon's *Age-Defying Collection*) by such film personalities is bound to influence women to a large extent. A visit to any of the websites or print media offering beauty and fashion tips and it is not uncommon to read lines such as "ageing being every woman's worst nightmare" or "nobody wants to grow old especially when it comes with wrinkles, age spots and sagging skin". Thus, it seems that the obsession to look young and have firm, supple skin is for the most part, or rather completely, a phenomenon among the economically well-cushioned urban women who can afford to purchase these highly expensive anti-ageing products. But it would it remains to be seen if, how and to what extent the other socio-economic classes of the society get affected as well.

### 4.8 Conclusion: A Word of Caution

The entire scenario becomes complex when the matter of translation of certain terms and the serviceability of the same terms or concepts get employed in different socio-cultural settings. For instance, how does a word like orgasm or libido get translated in a society like Pakistan or India or in those parts of the world where English is not the first language? More importantly, there lies a contested problem of meanings as in, who defines these terms/concepts and decides that the meaning decided on is the final

meaning. Also studies need to be undertaken on a range of matters which are at most speculative until now. For instance, what constitutes sexual desire and sexual pleasure for women? If all aspects of one's daily life are getting medicalized, then how can one's sexual life be far behind? For example, how a woman experiences orgasm – is that a medicalized definition as well? Additionally, one cannot ignore pornography and the role it can play (or plays) in defining how a woman perceives sexual pleasure and sexual desire. This point could perhaps be associated with the idea of the *intrapsychic* or the individual level of sexual scripting which is to do with one's sexual desires, fantasies and intentions with regard to pornography (Gagnon and Simon 1986 cited in Carpenter 2010). As Greer (1993) points out it is first necessary to see how much sexual pleasure women expect to get and as I argue, how much of that is influenced by external factors such as the desire of men or viewing pornography?[24]

Hinchliff et al. (2010) argue that there is no doubt that menopausal women undergo biological changes which affect their sexual function to some extent, but whether or not these changes are experienced problematically/negatively will depend upon whether those women are/have been sexually active and the types of sexual activity they engage in. When issues of menopause and sexual activity, sexual interest and/or sexual desire are understood from a biomedical perspective (which is mostly the case) then the assumption is that the biological changes at menopause negatively affect the woman's sex life, thereby denying the experiences of those women who undergo positive changes or no changes at all. Using the scientific language of medicine, the biomedical understanding of menopause "decontextualizes health and illness from its social context and does not account for the complexities of experience" (ibid: 725). Thus, questions about what it feels to be a woman with sexual desire and on external factors like pornography need to be raised. Regarding the matter of body image, the scenario is no less complicated. Who defines what is a normative body image and how can the description of body image in one cultural environment be applied to another? For instance, in a society where the women wear hijaabs or burkhas, how does one define body image in such a society?

[24] I will not go into further detail here as a discussion on pornography could be the subject matter of a dissertation in itself and that would be beyond the scope of this dissertation.

The danger lies in firstly, applying perspectives (such as the biomedical perspective where research emanates from focusing exclusively on reproductive problems and medical treatments) which treat women as a homogenous group or menopause as having universal affects on sex. And secondly, in looking at the various issues which affect a menopausal woman's sex life as distinct instead of looking at their complex interplay. There is enough available evidence to demonstrate that social, psychological and interpersonal factors (such as relationship quality with one's partner or low levels of social support) have an impact on women's sexual experiences as much as do biological changes, if not more (Gannon, 1999; Goberna et al., 2009; Hartmann, Philippson, Heiser, & Ruffer-Hesse, 2004; Hawton, Gath, & Day, 1994; Hess et al., 2009; Ling et al., 2008 cited in Hinchliff wt al. 2010). Thus it's not surprising to see that factors (other than biological changes) which include taking on more responsibility and add stress and tiredness, may affect a woman's sexual desire (HInchcliff and Gott 2004a in ibid)

To conclude, it seems that every study discussed in this chapter, or even otherwise, considers there to be "a tacit before and after switch with regard to menopause". As discussed in the beginning of this chapter, the need is to consider menopause as being a part of a woman's entire life course in a way that it is not de-linked from the other stages of her life course.

# Chapter Five

# Conclusion

## 5.1 Concluding Remarks

The central idea of this dissertation was to investigate how the midlives of women are getting 'constructed' from the standpoints of various actors 'through menopause', "an ostensibly private experience that is painless and presents no obvious threat to life" (Lock 1993: xviii). The larger question addressed in this sociological comparative study has been the analysis between 'the West' and 'the Rest' of the different dimensions of women's middle years of adulthood viz. menopause, sexuality and ageing. Each of the three core chapters dealt with broadly three themes respectively – the discourses, contested definitions and paradigms of menopause research; the medicalization of menopause in western societies through hormone therapies vis-à-vis the de-medicalization of it in non-western societies through 'alternative' methods and; the changing sexuality and changing body of the menopausal woman situated within the larger canvas of ageing and anti-ageing. And within each chapter, the attempt has been to highlight the variations (or similarities) between the different societies such that the universal views about the biology of menopause can be teased apart from the subjective views - views which have emerged through research in societies beyond 'the West'.

The *first* chapter of this study began with certain hypotheses and a set of research questions on the issue of menopause and the midlives of women. Through the examination of secondary literature, the attempt throughout the dissertation has been to build a case to test the validity of those hypotheses as well as to answer the research questions. The main aim of the *second* chapter was to build a theoretical edifice for the rest of the dissertation. In this chapter, I discussed the various discourses that exist in the society and the knowledge that is produced through these discourses affecting how menopause is defined and interpreted by women and in the society at large. The different paradigms of menopause research, influenced by the different discourses, have also been discussed and I have tried to substantiate each paradigm with the seminal studies conducted over the years. In the *third* chapter I critically examined the 'construction' of menopause as a 'disease' by the biomedical community in 'the West'

and the widespread recommendation of HRT for the 'cure' of this 'disease'. The trajectory of what were the roots of the medicalization of menopause was mapped out, tracing it back to the synthesis of estrogens in Europe. The critics of the biomedical and pharmaceutical discourse argue that by blaming the woman for her menopausal discomforts, the medical community individualizes the problem, thus deflecting responsibility from the social structure at large which is primarily to be held responsible for the maligned and precarious status it confers upon the menopausal woman. The 'alternative' method(s) of dealing with menopausal discomforts has also been critically discussed and thus concluding that it becomes imperative for women to ensure that ultimately they take informed decisions on their own. In the *fourth* chapter I was concerned with the changing dimensions of sexuality and the body, ageing and anti-ageing of menopausal, middle-aged women. I looked at the manner in which the stereotypes around ageing influenced the stigmatization of menopausal women in societies which have an unhealthy obsession with being young, resulting in the 'medicalization' of appearance. The literature review in this chapter demonstrated that menopause was seen as being synonymous to ageing among the prevalent discourses in the society as well as among a majority of the women in the western societies - a phenomenon being eventually imported into the non-western societies as has been illustrated by the example of the changing Indian scenario.

To sum up, this dissertation gives the reader an insight into how menopause, a ubiquitous event in the life of women, never received the attention it should have until the 1970s, barring within the medical purview where there was "a laissez-faire attitude regarding menopause and there was a reliance on physician's subjective 'experience' in managing menopausal 'cases'" (McKinlay and McKinaly 1973 cited in Prakash 1999). The encoding of misogyny in medicine was apparent throughout the review of the available medical literature on menopause and a discussion of how feminists and women's health activists try to grapple, negotiate and critique the formidable forces of sexism along with misogyny was also delved into. Here, I would like to point out the dialectical relationship between the knowledge produced through discourses and culture, with regard to the first hypothesis of this study - how women define and understand menopause and their midlives are based on the existing discourses in the society and each of these discourses are based on cultural assumptions and

interpretations of menopause, gender, female sexuality and women's ageing. Also, employing the theoretical framework of the life course perspective as well as the sociocultural and feminist perspective, I validate the second hypothesis of this study by stating that the menopausal phase of a woman can be best understood and researched when the women's own subjective experiences and all external socio-cultural, medical factors are taken into consideration, situating the entire experience within the larger canvas of ageing and anti-ageing. The merging of these different theoretical frameworks provides a comprehensive means of analysis, allowing a different kind of investigation of data which wouldn't have been possible by using one theoretical framework individually (Guillemin 2002). The final hypothesis of this study which stated that women's bodies have served as a socio-cultural-medical canvas where the larger questions of the nature of women, their social roles and their concerns (regarding health or otherwise) have been played out as per the convenience of different actors in the society gets validated throughout this dissertation. The medical community, the pharmaceutical companies, the media, and the advertising industry – all these different actors have used women's bodies as their primary targets (middle-aged women in this case) for their own motives and benefit. And quite smartly, these profit-oriented industries (which make assumptions largely from the Freudian belief that biology is destiny and women are supposed to be 'victims' of their own changing bodies) make the women feel responsible for being a 'victim' of their own biological bodies.

It is not to say that the knowledge about menopause is stable and an unchangeable biological fact, and in fact the knowledge is a result of the contingent social, cultural and historical factors (Guillemin 2002). These contingent factors on which the knowledge about menopause is based is produced through the discourses and discursive practices of a handful of actors, as discussed in the second chapter. Based on the corpus of literature analysed, it can be seen that menopausal, middle-aged and ageing women in general are the (involuntary) '*victims*' (emphasis mine[25]) of a certain hegemony in the society to a great extent, a hegemony which is male-dominated to a great extent, dominated largely by the medical community, the pharmaceutical companies and the media – the actors in the society who as discussed in the previous chapters have the

[25] I emphasise the word victims as I am uncomfortable using this term which according to me is offensive and seems to portray the women negatively as being powerless and as lacking any agency.

position and power to prescribe how these women should be, how they should look and how they should conduct themselves. This is also a hegemony which has a double standard of ageing (as rightly pointed out by Susan Sontag, 1972) and one which demeans ageing women and most importantly, doesn't take into account women's own subjective (and non-clinical) menopausal, ageing experiences. And such a hegemony and double standard of ageing is no longer limited to 'the West' as illustrated by the example of India in the previous chapter.

However, work by biological, social and medical anthropologists, feminists and women's health activists since the 1970s has portrayed an alternative scenario where women are not merely 'passive victims' of biomedical power and pharmaceutical conspiracy and may actively resist medicalization or sometimes even benefit from it (Women's Health Council 2008; Guillemin 2002). Thus, I would be slightly wary of relying too much on the biomedical discourse as therein lies the risk of reinforcing and essentializing the image of women as passive 'victims'. Whether women actually see themselves as passive and submissive 'victims' or as women with agency who are active and willing participants of the entire process, especially women in the 'the Rest', remains to be seen. Certain other themes of research which can be explored in this field have been discussed in the following section.

## 5.2 Directions for Further Research

The effort throughout the dissertation has been to remain open to the different avenues opening up on the subject of menopause and the different aspects of the midlives of women. The dissertation raises as many, if not more, questions than it answers and one of the main reasons for conducting this study was to dig up further questions. Thus, this concluding chapter would at best be suggestive in outlining and proposing possible directions and themes for further research in this field.

There are many unanswered questions in the Indian context regarding middle-aged women. The few studies that have been conducted have been done among rural women where one can apparently see an elevation in social status. But, what does one make of the absence of women's subjective experiences and their own voices? Does a woman with age truly gain social status? And what about the urban Indian woman - where does

she figure in the entire scenario? With her new needs to 'fight' ageing and preserve her youthfulness, with the recommendation of HRT for her symptoms, what are her experiences of the middle years of her life? Thus, there is a major gap in research when it comes to looking at such issues and one hopes, that a study of the present kind would open up directions for further research in this area.

In her article titled 'Femininity and the Orientation to the Body', Veena Das (1988 cited in Bulbeck 2001) suggests that there is no conceptualization of the 'female menopausal body' in India. She writes,

> "...the Indian female body exists in five states: that of the child, that at the onset of menstruation, the body in sexuality at marriage, the maternal body and the body at death. Although there is a passage from the child to the woman's body in sexuality and a passage to the maternal body (pregnancy), no passage between the maternal body and the state of the death is identified or discussed" (Das 1988: 194 cited in Bulbeck 2001).

In partial agreement with Das's point, while I would agree that there is still an absence of the 'female menopausal body' in India, it would be incorrect to say after twenty five years of Das having made her observation that menopause as a subject of research or general discussion in the popular media is absent. Instead, I would like to argue here that the present research would be particularly significant in the current Indian scenario where menopause has 'arrived' in a big way since the 1990s (a result of Westernisation perhaps?). Uberoi and Bahadur (2000 cited in ibid) explain the increasing discussion of sexual issues and women's health as being prompted by the women's movement as one reason and the western influenced magazines being the second reason for this 'arrival' that I speak of here. Since the late 1990s, articles about menopause have shifted from popular women's glossy magazines or as an advertorial to serious magazines and newspapers. Unlike in the case of rural Indian women, among the urban women in India one can notice an increasing pattern of the delinking of menstruation from ritual practices in the name of science and secularity. While on the one hand taboos and restrictions may not be observed for a large part among the menstruating urban Indian woman, menopause and the postmenopausal phase is

gaining recognition as a medical problem. Through the medical community and media, women are being told that entering menopause and midlives does not imply getting one step closer to old age. Whereas earlier the medical practitioners told the women who complained of menopausal problems that it's a natural transition, with the pharmaceutical companies looming over the medical community at large, the situation has altered. The Indian Menopause Society[26] (IMS) which was launched in 1995 had two primary goals – one, to provide a forum for discussing menopause and its related issues and second, to promote awareness of menopause and HRT. The Indian Council of Medical Research which is the premier government-run research agency also supports HRT. This ever burgeoning promotion of HRT needs to be questioned and as consumers of the society one needs to have adequate information about what is being advocated or prescribed to them. (ibid)

Statistical projection for the year 2025 shows that the ageing population in India would increase to 12% of the total and approximately half of this population will be ageing women. IMS[27] reports that while the average age for menopause is 48 years, Indian women can begin their menopausal transition as early as 30-35 years. (Puri, Sonia et al. 2008) The quality of life of the increasing ageing population is becoming an important issue in India (Aaron et al. 2002). Although there have been a few scattered studies from India in estimating the mean age at menopause and to find out what menopausal discomforts do Indian women experience, there has been no in-depth, published literature on menopause and broadly, the reproductive ageing and midlives of women. Very few Indian studies have attempted at determining the differences in the menopausal experiences between the rural and the urban women (Dasgupta and Ray 2009) and hardly any studies have been conducted on the effects of menopause on Indian women. While in most of the developed countries, HRT is recommended by the medical practitioners to prevent the symptoms associated with menopause, the feasibility and impact of hormone replacement therapy in preventive health care in the Indian context is yet to be determined (ibid). It is generally believed that for Indian women, especially rural Indian women, menopause is a favourable event unlike for their Western counterpart. But it cannot be merely assumed that Indian women or for that

[26] http://www.indianmenopausesociety.org/
[27] http://www.indianmenopausesociety.org/

matter, women in other non-western societies do not face any problems brought about by the menopausal phase in their lives. Although late in the day, but there are few studies which have been done, for instance in India, where the menopausal problems of Indian women are being highlighted. For example, the study by Aaron et al. (2002) in rural south India shows that a significantly high proportion of tmenopausal women suffered from vasomotor symptoms and other somatic symptoms such as backaches, pains, dizziness and lack of concentration. Their sexual lives were also getting affected due to the physical complications brought on by menopause. The authors write that a large number of these women go unnoticed by the health care system in India. So even though there is a sizeable cohort of menopausal and postmenopausal women in the country, there exists no health care programme meant to cater specifically to their health vulnerabilities (Mishra 2011).

Thus, it would be wrong to say as suggested by some of the literature on menopause that the silence around menopause in India reflects an absence of menopause and menopausal symptoms so to say. Rather, the socio-cultural taboos surrounding menstruation, sexual issues, expressing any change from the usual behaviour, lack of awareness and information and the lack of access to required health care facility – these could be among the reasons as to why Indian women prefer maintaining a silence around midlife issues. But now that the popular media has started talking about these issues in public, women, especially urban women, are gradually beginning to discuss these issues out in the open. Efforts should be made to understand the process of ageing among women in relation to the period of menopausal transition in their life courses to ensure a healthy post-reproductive life for the ageing women– an understanding which is currently inadequate and remains speculative at best.

### 5.2.1 Looking Beyond "Married Woman, Husband Present"

Taking cue from Greer's (1993) argument that most discussions of middle-aged women are done in the context of "married woman, husband present", I would like to ask what about women's experiences of menopause where the women are not partnered as either divorcees, single mothers by choice, single by choice and on the path of renunciation or are lesbians. How do these women perceive their menopausal phase and their midlives? Does the menopausal transition have a different meaning for them?

Are there any discourses around the midlives of these women? Would a comparative analysis between the midlives of heterosexual and homosexual women reveal different results? Let us take a brief look at women who by choice; or otherwise, do not fall within the normative boundaries of (heterosexual) wifehood and motherhood.

Denton (2004) writes that in India, within Hinduism, there are some women who tread the path of asceticism, celibacy and renunciation, either willingly or unwillingly. Based on his study in Varanasi writes that these Hindu female ascetics usually fall into two age categories – one category is in young, unmarried women and the second category is that of mostly old, widowed women. The path of renunciation (considered to be the highest of religious paths) is such that it requires a complete break from the ordinary household interests and activities, writes Meena Khandelwal (2004). Thus household concerns such as getting married, having children, earning money and being defined by parameters such as gender are not a part of this religious path (ibid). About single mothers, Mannis (1999) writes that single mothering by choice might be a concrete example of women demonstrating their agency and not becoming mothers because society tells them to. As a researcher interested in women's midlives and ageing, it would be interesting to delve into questions of menopause and other aspects of the midlives of single mothers by choice who don't adhere to the ideal norms of the society regarding motherhood and the two-parent heterosexual family. How do these women interpret their middle-age, changing sexuality and the ageing process? Such questions and more need to be raised and probed into instead of accepting the dominant discourses which have been making their presence felt in a large number of societies, discourses which are no longer limited to 'the West'.

I hope that this dissertation has addressed the set of fairly modest objectives that it had started with, within the limited time frame and constraints and has also been able to raise further unexplored questions on this subject.

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# Appendix A

**Historical Timeline of Menopause[28]:**

- **300 B.C** – Hippocrates observes and associates breast cancer with menopause
- **1400-1750** – A European medical textbook in the Renaissance period advised women having problems with menopause to combine a "decoction of myrrh and apples" along with taking a walk.
- **1686** - Of the fourteen women accused and executed for being "witches" in Salem, thirteen of those women are menopausal women.
- **1809** - Ephraim McDowell performs the first successful removal of ovaries in a female patient in Kentucky, USA. Fifteen years later in 1824, it becomes the treatment of choice in "curing" menopause.
- **1821** - A French physican named de Gardanne publishes his book "De la ménopause, ou de l'âge critique des femmes" using the term menopause to describe the phase in a woman's life. This is a century prior to the isolation of the hormone estrogen. Thus begins the search for the 'cure'.
- **1824** – Surgical removal of ovaries i.e. ovariotomy is used excessively to "cure" anything that is believed to be a mental disorder – be it sexual desire, hysteria or menopause.
- **1866** – Isaac Baker Brown, a member of the Obstetrical Society of London recommends the surgical excision of the clitoris i.e. clitorectomy to cure the symptoms of menopause including hot flashes, dry skin, sleeplessness, and heart palpitations.
- **1872** - Physician and surgeon to Birmingham Hospital for Women and a Fellow of the Obstetrical Societies of London, Dublin and Edinburgh, Lawson Tait considers menopausal women at high risk for mental derangement and incurable dementia. He writes the worst tendency is for menopausal women to abuse alcohol. In Tait's opinion, the relief of nearly all menopausal symptoms can be achieved by the use of an occasional drastic purgative and 'removal from

[28] This is the timeline in the Western part of the world only. Refer to: http://tuesdayshorse.wordpress.com/2012/03/05/trace-the-history-of-the-premarin-family-of-drugs-with-this-revealing-timeline/.

home at frequent intervals' , making a demand for them to be sent to the mental asylum.

- **1876** - Mass marketing of Lydia Pinkham's Vegetable Compound, used for menstrual pain and menopause, begins. With main stream medical cures being ovariotomies, clitorectomies and the asylum, her formula becomes one of the best-known patent medicines of the 19th century.
- **1890** - By the late nineteenth century, Merck Serono suggests medicating menopausal women with, among other things, wine, cannabis, opium, and a product made out of the powdered ovaries.
- **1891** - Many doctors assume that once a woman reaches menopause her sexual drive and physical attraction will cease. Indeed, some warn that menopausal sexuality is a sure sign of disease.
- **1893** – Dr John Harvey Kellogg, from Michigan, USA, says women who 'transgressed nature's laws' will find the menopause 'a veritable Pandora's box of ills, and may well look forward to it with apprehension and foreboding'. Kellogg is rabid against masturbation, often mutilating both sexes - circumcising young boys and applying pure carbolic acid to a young woman's clitoris without the benefit of anaesthetic for either procedure so that the pain "can be connected with the idea of punishment." He also covers their genitals with cages, sews the foreskin shut and applies electric shock to the genitals. His advice on menopause and masturbation are to be taken with more than several grains of salt today.
- **1895** - Described in medical literature as a terminal illness, menopause becomes viewed as the "death of the woman in a woman."
- **1899** – An idea was emerging that sex hormones might be involbed in menopause. A Parisian woman medicates herself with liquids derived from pigs' ovaries with positive effects.
- **1903** - According to George Savage, writing in The Lancet, the very nature of a women's physical make-up predisposed her to insanity. Even women who were not mentally ill were likely to offer "insane interpretations" of their menopausal symptoms.
- **1929** - The first American doctors to attempt to treat menopause symptoms are Drs. E. L. Severinghaus and J. Evans. Their treatment of choice is a derivative

from the amniotic fluid of cattle. Also, estrogen is isolated and identified by Edward Doisy at Washington University in St. Louis.

- **1930** - Water soluble estrogens are discovered in pregnant mares' urine by a German doctor, Bernhard Zondek. Other researchers reveal that decomposed and hydrolyzed pregnant mare's urine contain estradiol.
- **1933** - The first estrogen replacement product marketed in the US is developed – Emmenin, a product made from the urine of pregnant women. However, it is costly and the search continues for a cheap alternative.
- **1939** - Diethylstilbestrol (DES) is marketed as a more potent form of estrogen than Emmenin which had been marketed as a hormone replacement product for curing menopause.
- **1942** - Wyeth's predecessor Ayerst receives approval for the patent of Premarin, formulated from the urine of pregnant mares, and is approved by the FDA to market. Initial approval was based on a "replacement" therapy to "replace" a woman's depleted estrogen levels.
- **1943** - Wyeth merges with Ayerst, McKenna and Harrison, Ltd. Of Canada. With this came Premarin®, the world's first conjugated estrogen medicine.
- 1965 - The growth in use of estrogen replacement therapy (ERT) and the HRT concept is supported by a book written by Dr. Robert Wilson titled "Feminine Forever". Unknown to the general public, he is a consultant for Wyeth.
- **1973** - The belief that estrogen was beneficial for the heart in women led to a trial in which men took Premarin® for the prevention of heart attacks and strokes. The trial was abruptly halted since the men receiving the treatments had increased incidences of heart attacks and blood clots. Instead of a wakeup call to the deleterious side effects, they simply attributed this to dosage issues and continued to praise the drug for its use in relieving menopausal symptoms in women.
- **1975** - The New England Journal of Medicine publishes two articles that indicate a four to fourteen times increased risk of endometrial cancer with post-menopausal use of ERT.
- **1976** - Ayerst sends a "Dear Doctor" letter to every physician in the country regarding the use of Premarin®. The FDA reprimands the letter maintaining it is misleading and minimizes the risk of the association of CEEs and uterine cancer.

In turn, the FDA issues a drug bulletin underscoring the increased risk of uterine cancer with prolonged use of estrogen products. The New England Journal of Medicine publishes the first report of a link between estrogen use and breast cancer.

- **1977** - Ayerst Laboratories Premarin® is definitively linked to uterine cancer. Ayerst responds by adding a warning to the label but Hill and Knowlton, a public relations firm, simply attribute the cancer risk a "public relations" issue. Premarin® becomes the fifth most frequently prescribed drug in the US with more than 30 million prescriptions written.
- **1989** - A Swedish study indicates that women on a regimen of estrogen or estrogen-progestin had a slightly increased risk of breast cancer when on estrogen yet when on the combined drug therapy their risk more than doubled (New England Journal of medicine).
- **1990s** - Premarin® becomes the most frequently dispensed drug in the US.
- 1991 - The Women's Health Initiative (WHI) is launched. The clinical trials were designed to test the effects of postmenopausal hormone therapy, diet modification, and calcium and vitamin D supplements on heart disease, fractures, and breast and colorectal cancer.
- **1995** - Prempro® is the first estrogen-progestin HRT drug approved by the FDA. NAERIC (North American Equine Ranching Council) is established. An organization engaged in the collection of pregnant mares urine (PMU) that reportedly is dedicated to the progressive science-based horse management techniques to ensure the highest possible care standards are utilized in the equine ranching industry. NAERIC is heavily funded by Wyeth and supports horse slaughter.
- **1997** - Premarin® becomes Wyeth-Ayerst's first brand to reach $1 billion in sales. The FDA rejects an application for a generic version of the drug Premarin®. Both the FDA and Wyeth-Ayerst want the public to believe it was in their best interest to protect and safeguard the public. In reality it was motivated by scores of lobbyists, fraught with conflicts of interest, and epitomized by questionable surreptitious political manipulation. Data from 51 epidemiological studies is published in The Lancet (a UK medical journal) further implicating an increased risk of breast cancer with post-menopausal estrogen use.

- **1998** - The first major placebo controlled trial of HRT indicates no benefit to women who have had heart attacks, in fact, increasing their risk and advises them to withdraw.
- **2001** - First results of the WHI study are released spreading bad news to not only doctor's offices but also Wall Street. Although physicians remained ambiguous about the results of increased cancer risk and heart attacks, shares of Wyeth fell 19%. The company responded by emphasizing it was the combination therapy of estrogen-progestin Prempro® and not Premarin® that was at fault.
- **2002** - Government scientists abruptly end the WHI HRT study – the nation's largest – which states that long-term use of estrogen and progestin significantly increases women's risk of breast cancer, strokes and heart attacks. After the government's announcement, millions of women discontinue the use of HRT – down from about 6 million users for Prempro® to 3.3 million. FDA announces it will more thoroughly evaluate HRT use – the first official response from the government. Prempro®'s sales plummet 32% for 2002.
- **2003** - Further studies indicate there were increased incidences of cardiovascular events, and breast cancer in women taking the combination therapy drug Prempro®. FDA orders that both medications – Premarin® and Prempro® – carry warning labels advising users of the increased risk of heart disease, stroke, breast cancer, pulmonary embolisms and blood clots. Additional results from the NIH study indicate that HRT contributes to dementia.
- **2004** - As a result of falling sales of Premarin® and Prempro®, Wyeth introduces a lower dosage estrogen-progestin drug claiming it is safe. The estrogen-only (Premarin®) division of the WHI study continues to 2004 but it also is terminated prematurely due to indications of increased risk of stroke, deep vein thrombosis and without benefit in terms of coronary heart disease. Sales of Premarin® and Prempro® freefall from $1.3 billion in 2002 to $880 million in 2004.
- **2005** - Wyeth closes a manufacturing plant and eliminates 15% of its sales force as sales of Prempro® falls 76% and Premarin® 47%. Wyeth asks the FDA to investigate independent pharmacies producing bio-identical hormone replacement therapy (BHRT) claiming there are potential risks to women's health and possible violations of manufacturing practices. In October of 2005,

Wyeth files a "Citizen's Petition" demanding the ban of bio-identical hormones which coincidentally compete with their synthetic hormones.

- **2007** - A report in The Lancet found that HRT increases the risk of ovarian cancer by 20%. FDA declines to approve Pristiq – a non-hormonal drug for menopausal symptoms produced by Wyeth – without further testing due to some indications that the drug causes serious heart and liver complications. After years of research, analysis, and debate, the International Agency for Research on Cancer, the U.N.'s cancer research agency, has reclassified HRT from "possibly carcinogenic" to "carcinogenic."
- **2008** - Wyeth announces that it plans to meet with the FDA in February to discuss product formulation, bioequivalence and clinical study efforts to support the planned NDA filing of Aprela – a new drug containing certain hormones for menopausal symptoms and a selective estrogen receptor modulator, for the prevention of postmenopausal osteoporosis.