Menopause: the need for a paradigm shift from disease to women's health

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Southern Cross University

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Menopause: The Need for a Paradigm Shift from Disease to Women’s Health

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Doctor of Philosophy

School of Health and Human Sciences
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Declaration

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for a degree at this or any other University.

I acknowledge that I have read and understood the University rules, requirements, procedures and policy relating to my higher degree research award and to my thesis.

I certify that I have complied with the rules, requirements, procedures and policy of the University (as they may be from time to time).

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Abstract

Through a postmodern/feminist exploration of postmenopausal women’s textual narratives this research revealed women’s menopausal and postmenopausal ageing life cycle journey as a women’s adult developmental process. Based on the method of creating conceptual meaning, I argue that emerging from women’s narratives, the phenomenon of menopause is limited by a reductionist paradigm. Exploration of the narratives further revealed that a paradigm underpinned by a wholistic philosophy is more appropriate for women as they negotiate this significant ageing life cycle process to postmenopausal status.

The positive conceptualisation of menopause is set against a backdrop of a discourse analysis of seminal and pivotal biomedical texts, which revealed the marginalization of women’s adult developmental processes. Menopause, a normal life cycle process has been diagnosed by Western scientific reductionist methods as a deficiency disease and an endocrinopathy. This reductionist biomedical diagnosis, which is underpinned by Descartes’ philosophy, is the dominant paradigm in our Western culture. The discourse analysis also revealed the power of biomedicine to define menopause as a pathological process only, thereby also marginalizing other aspects of the phenomenon such as the interactions of body, mind, soul and spirit, and the acknowledgement of context.

The research revealed the necessity for policy development on menopause and menopausal women to be designed by postmenopausal women informed by their embodied experiences, perspectives, and theories. This is a gender equity issue. Therefore, I propose that the Social Model of Health would enable a fuller understanding of this women’s health issue. The social model is underpinned by the social determinants of health. Particularly, the determinants of social justice, gender equity and sustainability are explored as I believe they inform the proposed redesign and development of women’s health: policy and practices, educational and health promotion programmes for menopause, menopausal and postmenopausal women. In addition, this social model of health forms the framework for a proposed paradigm shift to a wholistic model. The research supports an urgent call for the employment of a social model of health as directed by the World Health Organisation.
Finally, positive evidence presented from cross cultural and multidisciplinary research supports the increased status of ageing postmenopausal women. This, together with the evidence from the published texts of postmenopausal women’s wholistic experiences, an argument is presented for a shift from an alternative to the biomedical paradigm, to an integrated wholistic paradigm that raises the value and status of ageing women. Finally recommendations and strategies are proposed for menopause health promotion including complementary and alternative medicine, multidisciplinary conferences, and an enhanced multidisciplinary health care programme accompanied by local group follow up.
Dedication

To my dear mother, Chrissie, my grandmothers and
great grandmothers.

This thesis is also dedicated to all those
women who have gone before,
all who are here now

and

all who are yet to come.
Acknowledgments

I am very grateful to all those who have assisted and supported me through this PhD research project and my sincere thanks go out to them.

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To my dearest friend and colleague, Linda Bradbury who has shared with me the ups and downs of this journey we travel. Thank you especially for adding depth to my life. To my special friend Lyn, thank you for your encouragement and the enjoyable times we spent together. Thank you also to my two housemates, Delia and Lorna, who had nutritious meals waiting for me during the most testing time of this journey. Special thanks to colleague, Julie.

Lastly but not least, to the members of my family who stood with me and encouraged me in my decision to take up academic study in later life, particularly my children. And to my niece Emma also, who showed continued interest in my studies.

Finally, I would like to gift this thesis to my children, Lisa, Sally, Matthew, Rebecca and Sarah, and daughter in law Joni who have helped me along the way. I gift it also to my granddaughter, Rhea and my grandsons, Darcy and Ptolemy and future grandchildren and great grandchildren (yet to arrive).
List of Publications


Conference Presentations

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Byron Bay. NSW.

2008 December Australian Psychological Association
Women and Psychology Conference,
University of Sydney.
Sydney. NSW.

2008 July Activating Human Rights and Peace Conference,
Centre for Peace and Social Justice,
Southern Cross University.
Byron Bay. NSW.

2006 May International Congress on Women’s Health Issues,
(ICOWHI),
Sofitel Hotel,
Sydney. NSW.
Table of Contents

CHAPTER ONE – INTRODUCTION

- Description .................................................................................................................. 1
- Aims/Objectives ........................................................................................................... 2
- The Use of the Term HRT/HT .................................................................................... 3

Perspectives that informed the research ........................................................................ 4
- Methodology ................................................................................................................. 4
- Background .................................................................................................................. 4
- Multi Methods .............................................................................................................. 6

Overview, justification and connections regarding methodology .................................. 7
- Interdisciplinary, Multidisciplinary Dialogue and Research Methods ......................... 9

Significance of the Project ............................................................................................... 11

Negative Constructions of Menopause ........................................................................ 12
- Medicalization, Medicalization of Women and Menopause .................................... 15

The Contribution of this Research Project to Previous Critiques .................................. 19

Representation within the thesis .................................................................................... 25
- Stylistic Features of the Thesis .................................................................................. 26
- Unsettling Writing Strategies ..................................................................................... 28
- Overview of Thesis Chapters .................................................................................... 29

New Paradigm Required ............................................................................................... 31

Summary, Conclusions and Recommendations ................................................................ 32

CHAPTER TWO - METHODOLOGY AND METHODS: THEORETICAL PERSPECTIVES AND HOW THEY INFORM THE RESEARCH .................................................................................................................. 34

- Introduction ................................................................................................................ 35
- Connection with Critical Theory ................................................................................. 38
- Guiding Themes for Methodology ............................................................................. 40

Feminism ......................................................................................................................... 42
- Introduction to Feminism ........................................................................................... 42
- Three Basic Principles of Feminism .......................................................................... 42
- These Three Principles in Relation to Research ......................................................... 43
- Key Terms - Embodiment, Empowerment and Emancipation .................................. 43
- Feminism and Philosophy ......................................................................................... 45
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feminist Literary Criticism</td>
<td>45</td>
</tr>
<tr>
<td>Feminist Epistemologies</td>
<td>47</td>
</tr>
<tr>
<td>Elements That Inform Feminist Research &amp; Writing</td>
<td>48</td>
</tr>
<tr>
<td>1. Valuing Women’s Experience</td>
<td>49</td>
</tr>
<tr>
<td>2. Recognising Systematic Conditions That Oppress Women</td>
<td>50</td>
</tr>
<tr>
<td>3. Transforming the World for Women</td>
<td>52</td>
</tr>
<tr>
<td>Feminist Perspectives in Research</td>
<td>54</td>
</tr>
<tr>
<td>Methods - Feminist Ethical Perspective</td>
<td>55</td>
</tr>
<tr>
<td>Philosophy of Science</td>
<td>58</td>
</tr>
<tr>
<td>Postmodern</td>
<td>60</td>
</tr>
<tr>
<td>Postmodern/Poststructural Philosophies</td>
<td>60</td>
</tr>
<tr>
<td>Lyotard</td>
<td>60</td>
</tr>
<tr>
<td>Foucault</td>
<td>64</td>
</tr>
<tr>
<td>Derrida</td>
<td>68</td>
</tr>
<tr>
<td>Criticism of Derrida’s Deconstruction</td>
<td>72</td>
</tr>
<tr>
<td>Affirmative Postmodernism</td>
<td>73</td>
</tr>
<tr>
<td>Postmodernism and Poststructuralism</td>
<td>74</td>
</tr>
<tr>
<td>Postmodernism Explored</td>
<td>75</td>
</tr>
<tr>
<td>Postmodern – Concern with Content</td>
<td>80</td>
</tr>
<tr>
<td>My Concern</td>
<td>82</td>
</tr>
<tr>
<td>Affirmative postmodernism and the return of the new subject</td>
<td>84</td>
</tr>
<tr>
<td>Methods as driven by my methodology</td>
<td>85</td>
</tr>
<tr>
<td>Feminism and Women’s Health</td>
<td>87</td>
</tr>
<tr>
<td>Discourse Analysis as Method</td>
<td>89</td>
</tr>
<tr>
<td>Women’s Texts – Search for a Second Method</td>
<td>92</td>
</tr>
<tr>
<td>Feminist Critique of the Traditional Method</td>
<td>93</td>
</tr>
<tr>
<td>The Importance of Understanding</td>
<td>94</td>
</tr>
<tr>
<td>Creating conceptual meaning</td>
<td>102</td>
</tr>
<tr>
<td>Introduction</td>
<td>102</td>
</tr>
<tr>
<td>Definition of Creating Conceptual Meaning</td>
<td>102</td>
</tr>
<tr>
<td>The Process of Creating Conceptual Meaning</td>
<td>102</td>
</tr>
<tr>
<td>Benefits of Conceptual Meaning</td>
<td>103</td>
</tr>
<tr>
<td>Concept Definition</td>
<td>104</td>
</tr>
<tr>
<td>Empiric and Abstract Concepts</td>
<td>104</td>
</tr>
<tr>
<td>Constructs</td>
<td>107</td>
</tr>
</tbody>
</table>
Method for creating conceptual meaning .................................................. 108
1. Concept Selection ............................................................................. 108
2. Clarifying my Purpose ...................................................................... 109
   Clarification for my project ............................................................... 109
3. Sources of Evidence .......................................................................... 109
   Sources of Evidence for my project ................................................. 110
4. Popular and Classical Literature ....................................................... 110
   My literature Sources .................................................................... 110
5. Contrary Cases .................................................................................. 111
6. Criteria for Concepts ........................................................................ 111
Creating Conceptual Meaning – A Brief Summary .................................. 112

Rigour in relationship to my project ....................................................... 113

CHAPTER THREE – DISCOURSE ANALYSIS: THE BIOMEDICAL GAZE ____ 116
Introduction .......................................................................................... 117
Discourse Analysis of the Biomedical Model ....................................... 117
Considering the Dominant Paradigm .................................................. 118
Objective/Subjective Divide ................................................................. 119
Objects of Perception ........................................................................... 122
Summary ............................................................................................... 123

Text One: Feminine Forever ................................................................ 123
My Introduction .................................................................................... 123
   Foreword .......................................................................................... 125
   Chapter One: A Woman’s Right to be Feminine ............................... 131
   Chapter Two: Must Women Tolerate Castration? ........................... 134
   Chapter Three: A Woman’s Chemistry .......................................... 137
   Chapter Four: A Woman’s Body ..................................................... 138
   Chapter Five: Menopause – The Loss of Womanhood and the Loss of Good Health ........................................ 145
   Chapter Six: Feminine Once More and Forever ............................ 148
   Chapter Seven: Plain Talk about Sex .............................................. 151

My Conclusion ....................................................................................... 154

Text Two: The menopause manual ........................................................ 155
Preface and Chapter One: Introduction ................................................. 156
Chapter Two: Historical Perspective .................................................... 161
Chapter Three: Changing Populations and Vital Statistics .................. 163
Chapter Four: The Social, Cultural and Emotional Aspects ............... 163
Menopause: The Need for a Paradigm Shift from Disease to Women’s Health  Margaret T.C. Harris
Contrary concepts and images from Marian McCain’s story .................................. 243

Women’s Text Three: Journey Through Menopause: A Personal Rite of Passage – Christine Downing ................................................................. 245
  Author Background ................................................................................. 245
  Christine Downing’s Narrative ............................................................... 245

My Final Image .......................................................................................... 263

Contrary Concepts and Images from Christine Downing’s Story .................. 264

Women’s Text Four - Menopause Matters: A Practical Approach to Midlife Change – Judy Hall ................................................................. 266
  Author Background ................................................................................. 266
  Introduction ............................................................................................ 266
  Judy Hall’s Narrative ................................................................................ 267
  Chinese Medicine and Menopause .......................................................... 282

My Summary .............................................................................................. 286

Contrary Concepts and Images from Judy Hall’s Story .................................. 289

THE VALUE OF POSTMENOPAUSAL WOMEN AND THEIR TEXTS - EMERGENT SIGNIFICANT REVELATIONS ...................................................... 295
  Women’s Texts – Revelation 1. Wholistic Processes ................................ 296
  Women’s Texts – Revelation 2 – Adult Developmental Process ............. 299
  Women’s Texts – Revelation 3 – New Naming and Terminology ............ 301
  Women’s Texts - Revelation 4 - The Postmenopausal Woman as Liability or Valuable Asset ............................................................. 303
  Important Contradictions between Wilson, Utian and the Women’s Narratives ................................................................. 304

The World Health Organisation Gender Policy ............................................. 309

Summary and Wholistic Revelations from Women’s Texts .............................. 310

Conclusion ................................................................................................. 311

CHAPTER FIVE – POLITICAL SIGNIFICANCE OF REVELATIONS FROM WOMEN’S TEXTS: WHOLISTIC, HEALTH, SYSTEMS THINKING & THEORY, COMPLEMENTARY & ALTERNATIVE MEDICINE, GENDER, EQUITY, WOMEN’S RIGHTS, SOCIAL JUSTICE, PARADIGM SHIFT AND SOCIAL MODEL OF HEALTH ........................................................................ 313
  Introduction ............................................................................................ 314
  Significance of Wholistic (Including ‘W’) ................................................ 315
  Health ...................................................................................................... 316
**Multiple Meanings of Health**

1. Health as not ill/diseased: 316
2. Health as a reserve: 316
3. Health as behaviour, health as ‘the healthy life’: 316
4. Health as physical fitness: 317
5. Health as energy, vitality: 317
6. Health as social relationships: 317
7. Health as function: 317
8. Health as psycho-social well-being: 317

**Optimal Health**

Health and Growth for Menopausal Women 319
Aboriginal Perspective: An Optimal Model of Health for Menopause 320
Health as Health-Education 322
Health as Wholeness 323
Women’s Health 324
Philosophy of Women’s Health 325
Impediments to Health and Wholeness 326

**Wholistic Model**

Health and Wholeness – The Need for Balance 327
Holistic & Holism 329
The New Holism 330

**The Reductionist View, Mechanism, Self-Organization as Opposition to the Cartesian Paradigm**

Machines and Organisms 332
Organismic Thinking and Systems Thinking 333
Systems Thinking, Interconnectedness and Evolution 334
Interdependence and Self-Organisation 337
Linkages 339
Summary and the Value of Systems Thinking and Theory 340

**Contrary Viewpoints - Complementary & Alternative Medicines (CAM) and Unconventional Therapies**

Four Perspectives on Unconventional Therapies 341
Gray’s Biomedical Perspective 342
Gray’s Alternative Perspective 343
Gray’s Progressive Perspective 344
Gray’s Postmodern Perspective 345
Tataryn’s Paradigms of Health and Disease 346
Tataryn’s Body-Based Paradigm .............................................. 347
Tataryn’s Mind-Body Paradigm .............................................. 347
Tataryn’s Body-Energy Paradigm .......................................... 348
Tataryn’s Body-Spirit Paradigm ............................................. 349

Relevance of Tataryn’s Paradigm for Menopause: Body-Energy and Homeopathy ______ 350

Conclusion ........................................................................... 353
The body .............................................................................. 353
The body-energy .................................................................. 353
The body-mind .................................................................... 353
The body-spirit .................................................................... 353

PARADIGM SHIFT .................................................................. 356
The Emerging Paradigm in Health-Related Research ............... 357
Relationships as Primary ..................................................... 358

Relationships - Social Model of Health ................................. 360
Social Policy and the Need for a Social Model ....................... 360
Women’s Health and Feminist Spirituality ......................... 362
Ethical Consideration ......................................................... 364

Summary ............................................................................ 365

Political Significance of Revelations from Women’s Texts: Women’s Rights, Social Justice
and The Need for a Paradigm Shift ...................................... 367
Menopause as Gender Issue ............................................... 370
Gender, Equity and Inequity ............................................... 373
Discrimination and Disempowerment .................................. 375

The Ottawa Charter, Holistic Perspective and Systems Thinking ........................................... 376
Systems Thinking and Health Promotion ............................. 377
Systems, Enabling Environments and Community Development ............................................. 378
Health Promotion and Health Equity ................................... 379
Social Justice – Reform Required ........................................ 380
Determinants Approach ....................................................... 381
Reform in Action .................................................................. 382

Conclusion ........................................................................... 383

CHAPTER SIX - FEMINIST PRINCIPLES AND PERSPECTIVES - POLITICAL
ACTION FOR AGEING WOMEN ........................................... 385
Introduction ......................................................................... 386
Part One: Feminist Principles ___________________________________________ 386
  Devoid of Recognition ______________________________________________ 388
  Women’s Human Rights _____________________________________________ 389

Part Two: The Process for Lifting the Status of Ageing Adult Women _________ 391
  Feminist Principles and Perspectives – Political Action ___________________ 392
  Ways of Knowing: Lay People and Communities of Knowing _______________ 393

Collaboration & Partnerships ___________________________________________ 396
  Visions and Directions ______________________________________________ 396
    Visions __________________________________________________________ 396
      1. Collaboration with Women Elders ________________________________ 397
      2. Education for Menopause by Women Elders ________________________ 398
      3. Wholistic Education for Women: Essential Aspects ________________ 398
      4. Wholistic Models – Developing a Wholistic Model _________________ 399
        Directions ______________________________________________________ 400

Part Three: Praxis – Action to Support Ageing Postmenopausal Women _______ 402
  From Interventions to Levels of Action – First Action – Submission ________ 402
  Other Practical Actions for Change: Advocacy, Enabling & Mediating _______ 403
    Advocacy in health promotion ________________________________________ 403
    Enabling in health promotion: ______________________________________ 403
    Mediating in health promotion ________________________________________ 403
  Creating Political and Social Change for Women: Where Shifts can occur ______ 404
  Primary Health Care _________________________________________________ 406
  Primary Health Care and Sustainability _________________________________ 408
  Distinguishing Points and Advantages of Primary Health Care (PHC) ________ 410
  Intentions and Orientation of Primary Health Care Practitioners ____________ 412

Part Four: Health Promotion, Partnerships & Collaboration - A Social Model Of Health, &
Determinants Of Health ________________________________________________ 413
  Comprehensive and Sustainable ________________________________________ 413
  From Interventions to Levels of Action – My Second Action ________________ 414
  Health Promotion Initiatives _________________________________________ 415
    • Empowering: ____________________________________________________ 415
    • Participatory: ____________________________________________________ 416
    • Holistic: _________________________________________________________ 416
    • Equitable ________________________________________________________ 416
    • Sustainable: ____________________________________________________ 416
    • Multistrategy: ____________________________________________________ 416
Conclusion ................................................................. 416

CHAPTER SEVEN – REVIEW AND FINAL RECOMMENDATIONS ........ 418

Introduction ................................................................. 419

Review, Results and Main Points of Chapters .................................. 419

Implications Emerging from the Research ................................... 423

A MORE COMPREHENSIVE MODEL .................................. 425

RECOMMENDED HEALTH CARE PROGRAM FOR MENOPAUSE – ENHANCED PRIMARY HEALTH CARE (EPHC) .................................................. 428

Health Promotion Strategy .................................................. 430

Details of the EPHC Program ................................................ 432

FINAL RECOMMENDATIONS .............................................. 434

1. Learning Opportunity: Health Promotion for Menopause: Conferences ..................... 434
2. Enhanced Primary Health Care Program: ........................................ 434
3. Seminars, Workshops and Forums: .......................................... 435
4. Local Group Follow Up available after all sessions: ........................................ 435

Implications of Lack of Status for Ageing Women .................................. 435

Final Conclusion ............................................................... 436

REFERENCES ........................................................................ 437

APPENDIX ONE ..................................................................... 459

Regarding Inclusion of Postmenopausal Women ............................... 462
Regarding the First principle underpinning the new NWHP – Gender Equity .......... 463
Sustainability and Collaboration .................................................. 464
Conference Program .............................................................. 466
Regarding the Second Principle underpinning the new NWHP – Health equity between women .......... 467
Regarding Fourth Principle underpinning the new NWHP – A strong and emerging evidence base .......... 467
Regarding the Fifth Principle underpinning the new NWHP – Life Course Approach .......... 468

APPENDIX TWO ..................................................................... 470

Conferences: ........................................................................ 471
Workshops: .......................................................................... 471
Groups: ................................................................................ 471
Counselling: .......................................................................... 471
List of Figures

1. Figure 2.1 105
2. Figure 4.1 219
3. Figure 4.2 244
4. Figure 4.3 265
5. Figure 4.4 290
6. Figure 5.1 353
7. Figure 5.2 365
8. Figure 6.1 401
9. Figure 7.1 424

List of Tables

1. Table 3.1 176
2. Table 4.1 218
3. Table 4.2 243
4. Table 4.3 264
5. Table 4.4 288
6. Table 4.5 291
7. Table 4.6 293
8. Table 4.7 306
CHAPTER ONE – INTRODUCTION
Description

This research project, through a postmodern/feminist multimethodology and a multimethod approach, aimed to explore factors which inhibit or support evolutionary thinking within disciplines and within individuals. My emphasis is on the phenomenon of menopause and the menopausal woman situated within the midlife transition of the ageing life cycle process. Menopause, the end of women’s reproductive life, is a process that involves the whole woman – body, mind, and spirit – and is inclusive of physical, mental, emotional, and spiritual aspects. Cavanaugh & Whitbourne have described menopause as a primary ageing process and “primary aging refers to the normal, disease-free development during adulthood” (1999, p. 4).

At the same time, the phenomenon also presents within the context of her life situation, time, place, and space, including society and culture. Therefore, women have connections with and are affected by external factors/variables. It is a phenomenon of multidimensionality and complexity, and it includes both negative and positive aspects and losses and gains of a normal life cycle adult developmental transition process toward ageing. In our culture, menopause has been diagnosed negatively and pathologically by Western scientific biomedical processes as a disease, an estrogen deficient disease (Wilson, 1966) and an endocrinopathy (Utian, 1987, 1990). Medicalization with hormone replacement therapy is the traditional prescribed approach. This can cause confusion for some women who are then led to construct this normal ageing process as a medical condition requiring treatment. Furthermore, this pathological diagnosis by scientific biomedical practices is the dominant paradigm in our Western culture/society. While this is so, it is important to acknowledge that in recent years the widely published association between breast cancer and hormone replacement therapy has tended to see a slight decrease in the use of this drug regime. It was only in 2008 that the Cancer Council of New South Wales Australia called on the Federal Government to review the policy of hormone replacement therapy (ABC Australia, 2008). This is significant in that it reflects the concern about the risks and benefits of HRT/HT, however, this thesis is concerned with the lack of attention to the complexity of biological changes and the marginalization of other aspects of the phenomenon rejected in the biological diagnostic process.
Chapter One: Introduction

**Aims/Objectives**

As already stated menopause is a process that involves the whole woman, mind/body/spirit, and is inclusive of physical, mental, emotional and spiritual aspects. At the same time, the phenomenon also presents within the context of her life situation, time, place and space. Therefore women have connections with and are affected by external factors/variables. It is a phenomenon of multidimensions and complexity. The research explored these aspects through a multidisciplinary approach highlighting how a woman’s life-cycle process can be interpreted from alternative and multiple perspectives, and from the woman herself, thus enabling wider perspectives within health care practices. Objectives are as follows:

1. Explore the construction of menopause within the biomedical model through discourse analysis.
2. Explore postmenopausal women’s perspectives for positive interpretations to enable creation of conceptual meaning.
3. Explore the underlying philosophical thinking that emerges from both the biomedical texts and also the postmenopausal women’s narratives.
4. From the above and drawing on a variety of philosophical discourses, construct a more inclusive paradigm and model to the dominant reductionist paradigm and biomedical model.

My research question is:

What knowledge constructions of menopause and ageing women more clearly reflect an alternative to a disease model?

**The Use of the Term HRT/HT**

Hormone Replacement Therapy (HRT), has been the common main term referred to for the treatment of menopause. However HRT is now referred to as Hormone Therapy (HT) in feminist social science, humanities, and epidemiological work on menopause. It is also highly recommended by feminist scholars as the term to use. However as the term HRT has been used extensively throughout time, and for all those who do not have feminist social science, humanities and epidemiological knowledge, I will refer to this medical intervention as HRT/HT to acknowledge that both terms have existed to describe the same intervention.
Also the term HRT/HT is more congruent with a postmodern feminist methodology and sensibility.

**PERSPECTIVES THAT INFORMED THE RESEARCH**

**Methodology**

In brief, a multi-methodology and multi methods were employed. Methodologies and methods are expanded upon in Chapter two. Multiple theoretical perspectives, postmodernism and feminism informed the methodology. The discourse analysis method was framed by both a postmodernist and feminist lens and based on values that I see as common to both. The search for alternative perspectives and the value of difference, diversity and plurality drove the research. Also, the inclusion of postmenopausal women’s experiences added to the body of knowledge.

Postmenopausal women, who through their own internal processes and experiences, their own particular feelings and thinking, depicted in their texts a reality, or an alternative perspective, were explored. Further, their texts highlighted various and different needs of women beyond medicalization, as they are women who have been connected to their own internal processes. Their realities cannot be ignored, as their own personal knowledge, whilst being subjective rather than objective is still a valid experience. However postmenopausal women’s subjective knowledge rather than being objective has not had a designated place within the accepted cultural definition of the phenomenon of menopause within western society.

Therefore the discrepancies, distortions and omissions that occur between these levels of knowledge, the biomedical model, other disciplinary perspectives, and perspectives of ageing postmenopausal women and therefore between multiple truths, were explored through a multimethodology that enabled a new paradigm that more positively validates ageing women.

**Background**

In accordance with feminist methodological approaches of transparency, subjectivity and focus on women’s lived experience, it is appropriate for me to state my position as a postmenopausal woman, whose experience of menopause has enabled many insights and feelings regarding this issue. I proposed this research as a result of my own lived experience
of midlife and menopause, which was both acute, and a challenge, together with knowledge gained through my academic studies to date. This dual journey has led me to a deeper search for what could inform the knowledge base that currently constructs the phenomenon of menopause pathologically, and what positive constructs could inform a necessary new paradigm shift. I propose that different thinking, different theories and different paradigms and a more positive framework are required to assist women to move towards ageing in a more healthy way. Also my path of study has confirmed for me that menopause as a disease is a diagnosis that has been portrayed in our Western culture through a limited construct, that of scientific biomedical practices and technology. Never the less, this limited and narrow diagnosis, and portrayal of the menopausal woman continues to dominate as the ‘truth’ and medicalization with hormone replacement therapy/hormone therapy is the prescription. This is promoted and prescribed for women as a result of the dominant scientific and medical perspectives within our society. An exploration of knowledges alternative to this limited and narrow diagnosis is required. The following quote is cited in support of my own thinking and also my own experience.

One of the more important outcomes of the modern critiques of medicine and its institutions has been the reassessment and reinterpretation of menopause. Out of these critiques many different perspectives have developed regarding medicine, the female body, femininity, aging, the temporality. Indeed, it is not an exaggeration to say that menopause has today become a major site, or battleground, for radical and innovative reflections on medicine, culture and society … A potential space thus emerges for other forms of subjectivity and of lived experience (Komesaroff, et al., 1997, p. 12).

This indicates that women’s experiences of menopause are not only important and need to be central in radical and innovative reflections rather than be minimized, trivialized or overlooked, but are the valuable and important instances of subjectivity and lived experience. And further to this women in the Boston Women’s Health Book Collective (1985) contend that:

If we overlook the changes of [m]enopause we run the risk of trivialising our experiences. Menopause is an important physical and emotional life transition, and we are different after we have gone through it. We can be strengthened and
empowered by acknowledging the reality of our experiences and giving one another support during this transition (p. 444).

It is to postmenopausal women’s subjectivity and lived experience that I turned as they have moved through the transitional time themselves. They are the ones able to reflect in more, and I believe inclusive and wholistic ways and levels, as to the changes that occurred for them. Regarding the value and importance of these lived experiences, I propose that it is the already ‘lived’ experience of the postmenopausal woman that holds the value and is also the glaring omission in our dominant cultural paradigm. Therefore through this thesis I use the words ‘postmenopausal’, as well as the words ‘menopausal’ woman, when referring to menopause. This also ensures the woman and women themselves remain a prominent feature of the discussion as much as the word menopause. It keeps the woman herself continually visible.

**Multi Methods**

First, discourse analysis was chosen to explore the paradigm of the dominant biomedical model and its diagnosis of menopause as disease.

Second, Chinn & Kramer’s method of creating conceptual meaning to enable the search for contrary concepts from within the narratives and perspectives of the postmenopausal women.

Third, my own method of ‘Without Interpretation’ to ensure that I did not distort, modify or interpret the postmenopausal women’s words. New perceptions and representations, through the use of my own images, although secondary to the women’s words, completed this exploration.

Fourth, my own additional method, Juxtapositioning as a method of representation became necessary to enable discrepancies between the biomedical model and the postmenopausal women’s perspectives to be highlighted.
OVERVIEW, JUSTIFICATION AND CONNECTIONS REGARDING METHODOLOGY

Because of the multi-leveled approach employed in the research, it is necessary to trace a thread through the various levels to image connections in the work. Firstly, a feminist approach has been chosen because menopause is a woman’s issue. Feminism views women as important, deals with women’s issues as important, and sees woman as central to her issues. Secondly, true to this value, feminism encourages, embraces and values diversity of experiences, and can be seen to celebrate ‘difference’. Thirdly, feminism encourages empowerment for, and in women, by encouraging them to voice their individual experiences. And fourth, feminism seeks to bring women’s issues to the fore where appropriate, and where necessary, aims for social change.

Therefore feminism allows for the woman herself to be central. It also validates her right to speak for herself, from her position. It is appropriate that one should be able to speak from one’s reality. Also, I see allowing postmenopausal women to share their realities, in their own voices, as opening up another way of accessing knowledge. To this end, encouragement of and support for postmenopausal women, speaking from their individual experiences, would not only be important, but also a critical part of an informed knowledge base. According to Bammer (1992) “[a]bove all, a feminist politics of language means resisting the use of language as a means of appropriating the right of others to speak for themselves, in their own voices” (p. 255 quoting Helene Cixous 1980). Furthermore, Bammer also refers to Trinh T. Minh-ha (1986/1987) stating “[t]his means shifting from the authoritative stance of a universalizing monologue (“speaking for and about”) to the interactive space created by dialogue (“speaking nearby or together”)” (p. 255).

Secondly, postmodernism permits more than one voice, which I see can also allow for dialogue. It is against this postmodern feminist backdrop, together with the employment of discourse analysis that I presented my multileveled approach. It is one that moves from the monologue of the dominant paradigm of the discipline of scientific medicine, to a dialogue. However for dialogue to occur one needs another, ‘another’. The other I refer to here is the philosophical underpinnings of the biomedical model together with those of a wholistic model which emerged from the postmenopausal women’s narratives, in other words a dialogue between contrasts. This enabled my second level of knowledge to be explored. Moreover the
particular writing strategy adopted in this thesis is one that reflects a commitment to this theoretical perspective of postmodernism, as it does not look for just one truth. This thesis aimed to search for many truths regarding the phenomenon of menopause. Within this project, these philosophical theories are examined and present as valuable and visible dialogue partners.

In addition, I would like to add to the above words of Minh ha of “speaking nearby or together”, the words of “speaking for oneself” (cited in Bammer, 1992, p. 255), the women themselves. This position shifts the authoritative stance once again from the hierarchical, to the third level, to the women herself, who is the author (originator of the condition), thereby allowing for another, more personal level of knowledge. I see this as an interactive practice, one that is important for my project because I was exploring menopause from three perspectives, ‘scientific/biomedical’, ‘multidisciplinary theories’ and ‘philosophical perspectives’. The philosophical space also allowed the woman herself to be her own theory. With regards to theory, Bammer has related that:

In theoretical terms, feminism presents itself as a radical critique of language, which it sees, on the one hand, as an emblem and tool of power and, on the other hand, as a means of social and self transformation. Feminism has secured a place in the domain of public discourse, and feminist insistence on the importance of language as a political reality has had a measurable, even if not yet revolutionary, impact on the general consciousness about, and use of language (p. 255).

Discourse analysis as method enabled me to explore and address specific biomedical texts authored by prominent medical practitioners who promoted the biomedical model and the powerful language that constructed the menopause research. The use of discourse analysis also allowed the exploration of the underpinnings of the biomedical model and to ascertain how language as an emblem was a tool of control and power. More importantly it allowed me to explore what effect this language had in repressing and oppressing other theories, realities and truths. Creating conceptual meaning as second method enabled a different process of gathering information that was not reductionist in nature and which is absent in the scientific objective process and which does not focus on the pathological and reductionist elements. The results emerging from this second method when juxtaposed (third method) with the
results of the discourse analysis highlighted the omissions and marginalizations that need to be reclaimed through the experiences of postmenopausal women, thereby enabling and resulting in a more wholistic paradigm. The women’s potential adult life cycle developmental process emerged as an omission. This omission has been hidden by the scientific diagnosis of disease.

Interdisciplinary, Multidisciplinary Dialogue and Research Methods

It is here upon reflection, that I considered interdisciplinary dialogue to be important. Lock (2001) has noted that “interdisciplinary turf wars” occur in academia. And she also stated that in her estimation “transcending disciplinary boundaries is one key to the advancement of knowledge” (p. 1). Lock does go on, however, to warn:

In sum, differences in local biologies partly account for but do not determine the cultural construction of menopause and, where relevant, its medicalization. There is no doubt that biological and genetic determinisms must be rejected outright. But it is also necessary to reject those equally deterministic arguments for the social and cultural construction of the body and related medical practices in which the material body is black-boxed. Truth claims about the body demand contextualization and critical appraisal, but to ignore the reality of biology entirely and its interdependence with history and culture is shortsighted in the extreme (p. 485).

Therefore, it is through both a postmodern lens, which allowed for interdisciplinary and multidisciplinary perspectives, and also a feminist lens that this research explored the powers and attitudes that are in place in our society that portray menopause and the menopausal woman negatively, thereby maintaining a negative representation of the ageing woman.

Firstly, seminal texts authored by medical practitioners were explored through the first method of discourse analysis. This method revealed the biomedical attitude towards the phenomenon of menopause. In turn the language revealed the negative pathological emphasis that is characteristic of the biomedical model. The theories and philosophy underpinning the biomedical construct of menopause were also addressed, together with critical exploration of the value of these philosophies and theories, and how they in turn connect with the client who presents with a health problem. A postmodern perspective on the phenomenon of menopause,
invites continuing interest and further interpretations by other disciplines, and calls forth to researchers to adopt multidisciplinary and interdisciplinary perspectives in addition to the dominant scientific perspective and orthodox medical gaze. Therefore, this multi-methodology approach allowed for the inclusion of multiple perspectives and insights from authors in different disciplines that present a positive representation of the menopausal woman. In accord with my own thinking Banister has stated that “there is a need for further interdisciplinary research of women’s midlife developmental issues to provide a broader, more comprehensive and balanced understanding of this important time of transition in women’s lives” (Banister, 1999, p. 534).

Obviously then, encouragement of diversity in philosophical perspectives, represented by different authors and other disciplines would be appropriate, as it would allow a more comprehensive and balanced understanding of the phenomenon. The phenomenon requires not only further exploration, but deeper and broader thinking of the philosophical underpinnings of the discourse. In particular, each discipline creates the partial truth of the embodied woman, thereby presenting a partial image only, whilst at the same time denying and omitting the reality of the adult life cycle process as has been experienced by postmenopausal women who have transited and lived through the experience, together with their perspectives, theories and philosophies. In addition, this research thesis builds on the work of multiple recent philosophers of our time, Lyotard and Foucault (postmodernism), and Derrida (poststructuralism). Their contributions are discussed in Chapter Two, and female, philosophers of our time, de Beauvoir, Irigaray, Cixous and Kristeva, in Chapter Four.

Moreover because I am a woman researching a ‘woman’s issue’, a feminist perspective was appropriate to enable further insights into this phenomenon. To this end women’s own stories were also explored through the narratives of postmenopausal women’s texts to address issues of broader and deeper experiences. For this exploration I utilized a second method, that of ‘creating conceptual meaning’, taken from Chinn & Kramer (1999). Therefore this project has added to the literature on a woman centered approach through the second method of creating conceptual meaning within the women’s stories. The contrary concepts that emerged were then juxtaposed to the medical terminology from the discourse analysis.
Juxtaposition was used as a method of representation. This method emerged as a natural progression of the research. It was by juxtaposing both the Western scientific medical diagnosis with the postmenopausal women’s narrative that the dramatically contrasting philosophies underpinning the experience of menopause were revealed.

In addition the creation of my new method of what I have termed ‘Without Interpretation’ was considered necessary. As I researched the words retrieved from the women’s texts I did not want to interpret their text through my own lens. In other words, this method allowed the original presentation of the text to remain as ‘data’, without any interpretation by myself. The data stands alone and the reader will interpret the text.

In defining the authentic voice in this research, whilst it is located within the inter-subjective lived experience of the body, there is no interpretation. In relation to the interpretive paradigm methodologies such as phenomenology, grounded theory and ethnography, the authentic voice is located in the inter-subjective lived experience of the body (Crossley, 1996; Williams 1996; Coryazzi, 2001). Further, authentic voice is the expression of inner thoughts and feelings that reveal the self (Cihonski, 2003). Specifically, in Lather’s (2001, p. 484), consideration of interpretive ethnography, the authentic voice is grounded in the “real experiences of everyday life”. In the deconstructive paradigm, postmodern/feminist methodology, the authentic voice is located also in the inter-subjective lived experience of the body, but in this research project the data stands alone without any interpretation.

My method ‘Without Interpretation’ differs from the interpretive paradigm as it enabled the words presented by the women authors to be presented as authentic ‘data’, to remain as originally noted within their texts without any distortion, alteration or misrepresentation due to my interpretation. This is further expanded on in Chapter Two of this thesis.

**SIGNIFICANCE OF THE PROJECT**

I believe this research project is positively significant for women themselves. It will offer alternative and inclusive positive representations of menopause and the menopausal woman to share with perimenopausal, menopausal and postmenopausal women in contrast to the negative biomedical construct of ‘disease’
In addition, an expected benefit of this project was a contribution of a broader and deeper understanding to the body of health care knowledge of the normal life-cycle process of menopause and of ageing women. This knowledge and discussion encompassing multiple perspectives and discourses was essential to enable this. As stated by Komesaroff (1997):

There is no single discourse of menopause…the concept of ‘menopause’ is itself a complex one, referring to a multiplicity of theoretical and cultural perspectives on a variety of issues, from the biology of aging to the philosophical understanding of death. Discussions of menopause may refer to biology or politics, hormones or feminism, psychoanalysis or social control, and when it comes to individual experiences, women provide widely varying accounts (p. 56).

The benefit of the research which has included multiple perspectives and women’s accounts has revealed a much broader, deeper and inclusive understanding of the phenomenon of menopause. The research revealed the need for a paradigm shift from a reductionist paradigm to a wholistic paradigm, and the necessity of a more inclusive model, that being a social model of health rather than a biomedical model.

NEGATIVE CONSTRUCTIONS OF MENOPAUSE

The socio/political constructions of menopausal women as diseased, deficient, dysfunctional, declining and marginalized in the political process has also been discussed by other researchers. It has been revealed by Margaret Lock (1993) through her research and her text *Encounters with Aging*, that the biological and the cultural are both involved in issues of health and that the social and cultural context can be instrumental in defining menopause as negative or positive for the woman. In addition, I believe the issue of relationships on many levels is also critical for health and well-being. This issue of relationships also became clearer as this research project progressed. However, Lock (1998) has extended the notion of relationships to think of both “biology and culture as being a continuous feedback relationship of ongoing exchange, and more importantly an exchange where both are subject to variation” (p. 410). It is within this context that I wish to refer to menopause, and how the political/social/cultural constructs of the menopausal woman can change to accommodate a
different and more complex transition, one that is more positive and does not delete, minimize, marginalize, deny, ignore or omit other meanings or variables that are critical to this normal process of ageing.

Historically, menopause has also been defined negatively. A very brief historical record of this negativity has been noted by Hunter & O’Dea (1997, p. 300). I present this directly from the words of Hunter & O’Dea, as I believe their presentation is useful in that it paints an initial picture of how women’s reproductive system and particularly menopause has been interpreted through generations.

Negative views of menopause date back at least as far as Roman times when menstrual blood was seen as poisonous. It was argued that after the cessation of menstruation, toxins previously excreted via menstruation were ‘retained’, destroying the body from within and causing physical, sexual and emotional decline. Blood-letting, by cutting veins or applying leeches, was a common treatment used to attempt to preserve well-being, physical and sexual attractiveness (p. 200).

In addition, The link between a woman’s reproductive capacity and emotional well-being, and even her sanity, was perpetuated by psychoanalytic, psychiatric and gynaecological thinking in the nineteenth century. Expressions of distress or dissatisfaction could be seen as sexual or ‘hysterical’ in origin and gynaecological surgery was used as a treatment (Showalter, 1987). Until 1980, when it was removed from the DSM-III (Diagnostic and Statistical Manual of the American Psychiatric Association) classification of psychiatric disorders, it was believed that the menopause was a cause of psychosis (involutional melancholia) (Krafft-Ebing, 1877 cited in Hunter and O’Dea 1997, p. 200).

Very importantly Hunter and O’Dea (1997) also cite how negative meanings of this normal life cycle process can affect women.
Historical examples clearly show how the female body can be variously constituted. It is usually defined as a problem or an illness, thus serving to maintain and reproduce inequalities in gendered power relationships. For example, if a woman’s menopause is assumed to signify inevitable loss and the body is imbued with negative meanings, then this construction of the menopause may well lead to depression and misery for women, thus reinforcing the link between loss and the menopause (p. 200).

Pathological definitions and scientific biomedical diagnosis of menopause highlight negative aspects of the phenomenon. Women are presented with ideas of decline, deficiency and loss and “the underlying message is that female biology makes women uniquely vulnerable to many physiological and psychological problems” (Rotosky & Travis, 1996, p. 300).

In addition, Ussher (2006) has noted that “[t]he ‘psychological turmoil’ is depression or anxiety, described as ‘Involutional Melancholia’ in DSM-I and –II, which reified it as a psychiatric illness, but omitted from DSM-III and IV as there was debate about midlife depression being associated with the biological event of menopause … [Ussher states further that] … there is no clear evidence that the body causes women’s physical or psychological distress” (pp. 130-131).

Further it has been stated that “[c]hallenging the authority of science and medicine - whose meanings are part of powerful and deeply entrenched social and historical codes, remains a significant and courageous action” (Treichler, 1988 cited in Rostosky and Travis, 1996, p. 304).

I believe that it is consideration of other meanings of menopause that can be instrumental in highlighting the conflict, confusion and controversy regarding the biomedical translation of normal signs and symptoms of a life cycle process into that of ‘disease’. Regarding menopause, “[a]mbiguity and confusion” has been referred to by Lock (1982, p. 264), and “Menopause misnomer” is admitted by van Hall (1997, p. 59). Furthermore, Komesaroff, Rothfield and Daly (1997) have stated “[i]t is not an exaggeration to say that menopause has today become a major site, or battleground, for radical and innovative reflections on medicine, culture, and society” (p. 12).
Medicalization, Medicalization of Women and Menopause

It has been noted that menopause and other women’s health issues have a history of medicalization. Whilst the main focus of this thesis is not only the medicalization of menopause it does, in part, address this issue in more recent years.

This research also explores in more detail the significant aspects of the underlying philosophy of the Western scientific biomedical model of disease which has resulted in medicalization of menopausal women. Extending this further, this thesis also identifies and uproots the denial of the hidden, positive aspects and gains of the phenomenon for women, which have been obliterated and deleted through the disease diagnosis. The following brief discussion of medicalization, medicalization of women’s health, and also medicalization of menopause enable an historical picture of what has been instrumental in creating confusion and the need for reflections, radical or otherwise as noted above, on medicine and its relationship with menopause.

Firstly, I present here, very early in the thesis, some of the researchers who have previously addressed the medicalization of human conditions, to enable the consideration of the cultural embeddedness in which women’s natural processes, including the life cycle process of menopause, have been diagnosed as pathological, and dysfunctional. It is within this discourse that the interventions of medicalization have their roots. Lupton comments that:

In westernized countries, menopause has become medicalized in the medical literature, treated as a deficiency disease which may be ‘corrected’ by HRT and defined as a generalized abstract concept which is independent of individual women’s social, cultural, racial and economic backgrounds and personal experiences (Kaufert, 1988 cited in Lupton, 2012, p. 149).

Medicalization in general has also been referred to by various authors such as Illich (1976, 1995). Zola refers to the medicalization of “much of daily living, by making medicine and the labels ‘healthy and ill’ relevant to an ever increasing part of human existence” (1972, p. 487). Expanding on this Riessman draws on Conrad & Schneider (1980) stating that in the past spheres of deviance and “human conditions such as alcoholism, opiate addiction,
homosexuality - which at one time were categorized as ‘bad’” have also been classified as sick (Riessman, 1983, p. 4).

Following on from the work of French philosopher Foucault in *The Birth of the Clinic* (1973), Riessman states, “[t]he medical model is used from birth to death in the social construction of reality… For women in particular, this process has had far-reaching consequences” (1983, p. 3). Regarding the medicalization of women and women’s health Riessman also names five areas of women’s human conditions that have come under the framework of medicalization, “childbirth, reproductive control, premenstrual syndrome, weight, and psychological distress” (1983, p. 5).

Further, the medicalizing of women’s health together with the medicalization of menopause, including the risks and benefits of hormone replacement therapy (HRT/HT) have been explored by various researchers, including Kaufert & Lock (1997), and Loppie & Keddy (2002). Lyons & Griffin (2003) critiqued and compared literature from a medical approach and compared it with a ‘woman centred’ approach in which a discourse of change and management rather than treatment or cure emerged. This critique is important for women, as all women who pass through middle age will experience this natural life cycle phenomenon that has been diagnosed medically as a disease.

With regards to medicalization birthed from a scientific mentality, Riessman highlights the following process, “… in the scientific mentality, complex, dynamic and organic processes are reduced to narrow cause - and effect relationships. Clinical science locates the problem of disease in the individual body” (Crawford, 1980, cited in Riessman, 1983, p. 5), whilst the “[s]ocial and emotional aspects of illness that do not fit a physiological model are likely to be ignored, and uncertainty is excluded” (Plough, 1981 cited in Riessman, 1983, p. 5).

Bell (1990) states that “alcoholism, homosexuality, hyperactivity, childbirth and menopause” as human experiences have been medicalized (p. 173). Importantly also with regards to medicalization, “pregnancy, conception, menstruation, menopause and breastfeeding are all reduced to biological or physiological events” (Brubaker and Dillaway, 2009, p. 34). Brubaker and Dillaway have also observed that “[s]cholars have not fully responded to …
calls for more complex biosocial analyses of gendered reproductive processes like childbirth, menstruation, and menopause” (2009, p. 44).

There are limitations to medicalization, some of which have been identified by Riessman who states that “[m]edicine attracts public resources out of proportion to its capacity for health enhancement, because it often categorizes problems fundamentally social in origin as biological or personal deficits …” (1983, p. 4). Importantly, regarding women themselves there are limitations to this approach. “As women visit doctors and get symptom relief, the social causes of their problems are ignored. As doctors acknowledge women’s experience and [treat] their problems medically, problems are stripped of their political content …” (Riessman, 1983, p. 16). Significantly:

… Finally, the medicalization framework emphasizes that the power of physicians to define illness and monopolize the provision of treatment is the outcome of a political process. It highlights the ways in which medicine’s constructions of reality are related to the structure of power at any given historical period (Riessman, 1983, p. 5).

And therefore according to Riessman, “[e]xperiences such as routine childbirth, menopause, or weight in excess of cultural norms should not be defined in medical terms, and medical-technical treatments should not be seen as appropriate solutions to these problems” (1983, p. 17). However, medical-technical treatments are appropriate in crisis situations such as acute psychosis or cardiac arrest.

Further there are risks to medicalization, particularly medicalization of menopause. Whilst this research project does not explore the risks and benefits of menopausal medicalization, it does explore, through the discourse analysis on medical texts, the philosophical underpinnings of the process that enabled menopause to be diagnosed and promoted to women and the public as a disease, particularly from the 1960’s onwards. To question how menopause became a diagnosis is important. Regarding diagnosis:

Diagnosis always intensifies stress, defines incapacity, imposed inactivity, and focuses apprehension on non-recovery, on uncertainty, and on one’s dependence upon future medical findings, all of which amounts to a loss of autonomy for self-definition. It
also isolates a person in a special role, separates him (sic) from the normal and healthy, and requires submission to the authority of specialised personnel (Illich, 1976, p.96).

Diagnosis of this natural life cycle process as a deficient disease within the framework of medicalization causes confusion for some women because “[t]he definition of the mid-life woman as deficient strikes a blow at her sense of completeness as a woman. It exploits her fears about ageing and is personally eroding” (Coney, 1993, p. 54). Koeske, (1983) reminds us that “researchers and practitioners alike must train themselves to systematically recognize and re-evaluate the basic assumptions of the biomedical world view” (p. 2).

The Psychiatrist Koeske (1981), in her article Menstrual Cycle: Research and Implications for Women’s Health has noted that “… traditional research on the menstrual cycle has been mostly atheoretic” (p.56), however it has assumed that the “disease model framework is appropriate for viewing cycle-related phenomena” (p. 56). This implies that:

Behaviour, moods, and even cycle phases and hormone levels can be arranged somewhere along a continuum of normality – abnormality. Since the context in which these behaviours, moods, cycle phases, and hormone levels occur is regularly ignored, these variables come to take on an aura of inherent normality or abnormality (Maitland-Schilling, 1978 cited in Koeske, 1981, p. 56).

I believe the scientific biomedical diagnosis of menopause as disease medicalizes a natural bodily change that all women experience. Therefore this thesis explores the experience of menopause from a postmodern/feminist perspective. By applying a postmodern lens of discourse analysis I reveal how the medicalization occurred, and through a feminist research lens I identify and focus on what has been marginalized, ignored, rejected and omitted in the process of diagnosis and medicalizing this natural adult development life cycle phenomenon and process. I concur with Duffy’s (1985) significant statement:

If feminist research is not conducted or published, potential knowledge is lost. What remains is the knowledge developed in the traditions of male science. Public policy formation, clinical practice, and subsequent research are dependent upon
communicated knowledge. An absence of a feminist perspective in the literature biases the data that influence decisions in practice and research (p. 345).

This research project then contributes to the production and dissemination of knowledge of women’s understandings, and also women’s knowledge.

THE CONTRIBUTION OF THIS RESEARCH PROJECT TO PREVIOUS CRITIQUES

This research project adds to and therefore contributes to the body of literature on women’s reproductive health as it explores in depth how the disease diagnosis was birthed, and specifically how medicalization of menopause was promoted to women in the 1960’s and 70’s. As Bell states: “[e]xploring the medicalization of menopause illuminates some of the special and complicated ways that women’s experiences are vulnerable to medical control” (1987, p. 535).

Bell’s research also reveals the intellectual roots of the medicalization of menopause in the 1930’s and 1940’s. She analysed papers published by 37 physicians, all of which were published in medical journals between 1938 and 1941 (Bell, 1987). Regarding these physicians published papers, “all of them investigated the possibility of using DES, a synthetic estrogen, to treat menopause, which subsequently became the first widely used estrogen replacement therapy” (Bell, 1987, p. 536).

Further Bell (1995) has related how diethylstilbestrol (DES) “initially appeared to be a benign and exciting reproductive technology but in the long run had profound and damaging consequences for women” (p. 469). This drug was initially used for regulation of menopause, and then in addition, was administered to pregnant women.

Many of us think of DES only as a drug prescribed to pregnant women to prevent miscarriages which put the girls born of those pregnancies at increased risk of vaginal and cervical cancer, the boys at greater risk of genital abnormalities, and the mothers at a slightly greater risk of breast cancer. But DES has an earlier and quite important and complex history in which it figures in what has been described as the ‘hormonalization’ of women. The regulation of menopause rather than pregnancy was
its first site of intervention. In addition, the usefulness of DES as a treatment for menopause was a matter of medical dispute (Bell, 1995, p. 470).

In addition, Bell also traces how and why a “medical vocabulary was constructed and used to define menopause as a ‘deficiency disease’ by a small, elite segment of American medical professionals in the 1930’s and 1940’s” (1987, p. 535). She states, “[t]his was made possible and shaped by developments in laboratory science and research medicine, as well as by the persistence of sexist values about menopausal women” (1987, p. 541). This thesis also, through the discourse analysis, contributes to this previous critique on language and vocabulary of biomedical processes by noting the language and vocabulary that Wilson and Utian have applied in their two medical texts in the 60’s and 70’s.

Rostosky and Travis (1996) also researched menopause in relationship to the dominance of the biomedical model through their exploration of journal articles from 1984 to 1994. This thesis adds to and extends these works as it also illuminates the functions of the medical control and the promotion of medicalization to women and the public through medical texts during the 1960’s and 70’s.

Other researchers’ studies as cited by Bell, such as work by Kaufert & Gilbert, (1986); Martin, (1987); and Lock, (1982), concerning the medicalization of menopause consider “how strongly this process actually affects women’s subjective experiences, women’s behaviour toward physicians, relationships between doctors and women patients, and physician’s behaviours towards women” (Bell, 1990, p. 173). My research also revealed and analysed how, through revealing the sexist images of the woman’s body, Wilson’s medical gaze in 1966, was used to advise women that by submitting to medicalization they could look younger and beautiful, thereby appealing to the image of the beautiful woman to influence the woman’s decision to medicate.

According to McCrea’s research, it was in 1943 that an “estrogen extract from the urine of pregnant mares” was developed. It was termed “conjugated equine estrogen and manufactured by Ayerst under the brand name Premarin” and by the early 1960’s “exogenous estrogen (that is estrogen originating outside the human body) was … inexpensive and easy to
administer … But if estrogens were to become the cure, what was to be the disease?” (1983, p. 112). McCrea elaborates further:

The moral entrepreneur who, during the 1960’s led the crusade to redefine menopause as a disease was the prominent Brooklyn gynaecologist Robert A. Wilson. As founder and head of the Wilson Foundation, established in New York in 1963 to promote estrogens and supported by $1.3 million in grants from the pharmaceutical industry (Mintz and Cohn, 1977), Wilson’s writings were crucial to the acceptance of menopause as a ‘deficiency disease’ and the large-scale routine administration of Estrogen Replacement Therapy (ERT). He claimed that menopause was a hormone deficiency disease similar to diabetes and thyroid dysfunction (1983, p. 112).

Further, Wilson, publishing in a prominent medical journal, Journal of the American Medical Association (1962) claimed that “estrogen prevented breast and genital cancer and other problems of ageing. Even though his methodology was weak, this article launched a campaign to promote estrogens for the prevention of menopause and age-related diseases” (McCrea, 1983, p. 112). According to Coney (1991), “Wilson was not just doctor but evangelist and entrepreneur” (p. 59).

A year later, Robert Wilson published another article in the Journal of the American Geriatrics Society (1963), with his wife Thelma Wilson. In this article he advocated that women be given estrogens from “puberty to the grave” (Wilson & Wilson, 1963, p. 347). Wilson then published Feminie Forever (1966), claiming HRT/HT as life saving for all women. McCrea (1983) relates that this widely read book of Wilsons was “[c]rucial to the popular acceptance of the disease model of menopause” claiming that menopause is a malfunction threatening the ‘feminine essence’” (pp. 112-3). This thesis critiques this particular text through a discourse analysis.

Specifically, Chapter Two of this thesis expands on research by McCrea and others as cited above, through a discourse analysis of Wilson’s text, Feminine Forever, together with Utian’s medical text The Menopause manual: A women’s guide to the menopause. These critiques add to and extend the works of the above previous researchers who have identified the limitations of the diagnosis of menopause as disease. The discourse analysis not only reveals
the limited reductionist, objectifying pathological process of the diagnosis of menopause but also the underlying philosophy of the western scientific biomedical diagnostic method. In addition it reveals that the purpose of these medical authors was to convince women that they are in decline that menopause is dysfunctional and by taking HRT/HT they will remain forever feminine. The dictate was that women should never change, but remain looking young and beautiful, to always identify with their previous roles and remain appealing to males. Given the dominance of the medicalization framework, critiquing and challenging this limited medical authority is urgent and highly relevant. I concur with the following statement by Rostosky and Travis and this thesis responds to the challenge articulated below:

In Western society, the broader issues of ageism, sexism, classism, racism, and ableism must be addressed to provide a comprehensive picture of women at midlife. A more balanced view, through increased interdisciplinary research and scholarship that is supportive of midlife women, is mandatory for adequately understanding the physical and symbolic nature of menopause. This view must be actively promoted both in the training of health professionals and in the education of women through media outlets to turn back the current tide of overly negative and unidimensional constructions of midlife women. As Paula Treichler (1988) stated: “Challenging the authority of science and medicine –whose meanings are part of powerful and deeply entrenched social and historical codes – remains a significant and courageous action” (Rostosky and Travis, 1996, p. 304).

Kaufert (1982) citing her examination of the views of ageing women, both by the medical profession and by the feminist health movement, found that there were competing descriptions of the menopausal experience. She challenged these descriptions stating that:

While not denying the existence of an underlying biological reality in which women age, lose their fertility and no longer menstruate, menopause is a social construct and not a separate, independent, biological entity. More accurately, there is a multiplicity of constructs parading under the same label: the feminist versions of menopause have little in common with the medical (1988, p. 331).
Chapter One: Introduction

Feminist versions of menopause require feminist research principles which include a woman centred approach. This project has added to the literature on a woman centred approach through the second method of creating conceptual meaning within the women’s stories. The contrary concepts that emerged through the women centred approach were then juxtaposed to the medical terminology from the discourse analysis.

Stating that the physical changes that occur in women are the first level of reality of menopause, Kaufert also identifies the second level of its reality. Drawing on her previous research (1979) and other scholars (Bart, 1971; Flint, 1975; Brown, 1979) Kaufert states:

‘Passage through the menopause’ is also an event occurring within a socio-cultural context. It is this – the cultural dimension of the menopause – which forms the second level of its reality. It is at this level that explanation has to be sought for cross-cultural variations in the menopausal experience. The available anthropological data suggest a relationship between a society’s definition of the menopause as a positive or negative event and its definition of a woman’s status as increasing or decreasing in middle age (Kaufert, 1982, p. 144).

Resulting from this research project is the recommendation for an increase in the status of ageing women.

Scientific evidence is important and distinguishes it from other information, but facts are always interpreted from one perspective. It is possible that reinterpretation from other perspectives can be insightful and hold value. Cobb’s (1990) following statement regarding the advantages of pathologizing menopause is worth of note: “Pathologizing menopause may make it more credible when seeking research funds or getting sponsorship for a clinic … but women should not have to be diseased to be interesting to health care providers” (p. 225). Further if funding for scientific biomedical processes depends on searching for pathology, what has emerged through this research is the need for equal funding in support of positive evolutionary processes to support postmenopausal women’s health and the positive status of adult life cycle development for women.
This thesis, by including the medical construction of menopause, together with women’s own experiences, then juxtaposing the two perspectives rather than excluding one or the other, the need for a paradigm shift emerged. The critical significance of the discourse analysis is the revelation of rejected, marginalized, deleted gains and the rejection of the natural positive aspects of these gains within the normal life cycle adult developmental process of menopause. Multidisciplinary researchers and feminists have also referred to a life cycle developmental process. As these were noted and addressed through the thesis, together with highlights and insights from the postmenopausal women’s narratives regarding these positive gains, the normal life cycle adult development process became very evident and which also directed the need for a paradigm shift. In addition, exploration of the social model of health revealed how to raise the status of postmenopausal women and the processes by which this can be achieved.

Psychiatrist, Koeske (1983) has recommended that feminist researchers and practitioners “turn their attention to developing a more sophisticated critique of scientific medicine - a critique which contains within it the seeds of an alternative paradigm” (p. 3). Also Riessman finally asserts that attending to, and addressing paradigms is required. “The real challenge is to use existing medical knowledge selectively and to extend knowledge with new paradigms so as to improve the quality of our lives” (Reissman, 1983, p. 17).

I am in agreement with Koeske’s recommendations (1983), together with Reissman’s (1983). In addition, this thesis extends their arguments by recommending a paradigm shift rather than just a new or alternative paradigm. The necessity for this paradigm shift became evident as the research progressed and the need for an inclusive wholistic paradigm emerged rather than an alternative paradigm to address the phenomenon of menopause. Importantly the research reveals the urgency for the paradigm shift to an inclusive wholistic paradigm and a move away from a limited predominately reductionist paradigm for the phenomenon of menopause. This thesis project also recommends the paradigmatic inclusions needed in the shift, which includes women’s narratives and experiences, and in particular the social model of health in addition to the biomedical model to improve the quality of ageing women’s lives, thus lifting the status of ageing women, and extending the knowledge base of the phenomenon of menopause.
This thesis is a critique of the medicalization of menopause and in addition adds to the feminist critiques by authors previously discussed above. The two seminal medical texts interrogated in Chapter 3 also promoted the medicalization of menopause and the diagnosis of menopause as disease, to women and the general public, and advertised the menopausal clinics as the appropriate places for treatment of hormone replacement for the menopausal disease. These two particular texts were chosen to initially address my research question as they presented the negative disease diagnosis. My original research question being ‘What knowledge constructions of menopause and ageing women more clearly reflect an alternative to a disease model’. In addition through the utilization of discourse analysis these texts revealed the limitations of the underlying method of Cartesian dualism, with regards to the phenomenon of menopause. Also when employed as a backdrop for the postmenopausal women’s published texts, their material provided an impetus for my new method of juxtaposition which in turn revealed the necessity for a Wholistic model that is inclusive, rather than an alternative construction that is also limiting. This necessity for a Wholistic model emerged as the texts were critiqued.

**REPRESENTATION WITHIN THE THESIS**

As I write this thesis, I will refer directly to the actual words emerging from within the women authors for two reasons. Firstly, as this research analyses texts, the words of the author become ‘data’. Secondly, it is my preference to make valid and visible each woman’s words rather than have them absorbed into the body of my work. I feel this is important, especially when I am writing about other women’s own life stories. People’s life stories are, I believe, their personal property. Therefore, to tell someone else’s story does not sit very easily with me as I realize I am not the originator of the words. I am very tentative in case I may skew the original author’s meaning, as it is possible to make incorrect interpretations about them unconsciously. The real meanings and words come from the narratives themselves, and I believe carry with them ‘life’, a unique life experience. Their words for me actually contain a life of their own, and deserve to be respected and acknowledged just as the author expresses them themselves. For me to attempt to retell this life experience is, I believe, a space where I could, intentionally or unintentionally modify, distort, reword or misinterpret the true essence of the story, and therefore of the life of the writer. To do so would give an interpretation of that story that may not reflect the writer’s ‘authentic voice’ but
rather the thinking of feminist philosophers, postmodernists or my own thinking, and in this way make a false authority claim to that knowledge. I want to avoid and prevent this.

Present in my mind is the case of Dora; Dora being the woman whom Freud (1905) interpreted incorrectly. However, he continued to use interpretation as the basis of his theory of psychoanalysis and many men have followed this path. In order to avoid this predicament I have chosen to repeat the woman’s words exactly, to do a reprint of the original print, so to speak. The use of this strategy will be more just, in portraying the reality without any distortion. My intention is to avoid interpretation and conduct a conversation. Rather than an observer, or a listener of a reader functioning to interpret, I believe only the one who experiences the reality can know and interpret the real meaning. Whilst I do this, I am also aware that this writing strategy does not allow me to reduce and summarize women’s stories. Therefore this prevents me from repeating the whole story of their experiences and explanations. Thus the story is partial and further explanations regarding these woman’s stories, can be found in a full reading of the chosen texts. This aspect of the research is further explained and justified in Chapter Four. In terms of copyright I have been careful to ensure that not more than ten per cent of each published work is quoted within the thesis.

**Stylistic Features of the Thesis**

Theoretical discussions of the text are represented in Times New Roman font 12 set at the left hand margin. For example: To this end, in postmodernism, local narratives are preferred to grand narratives.

In the main body of this text, direct quotes from the literature which support the conversations and arguments I presented, are represented in non-italicised block quotes, times new Roman 12 font, and are indented, and quotes less than 40 words are double inverted commas, non-italicised and remain in body of the text.

Regarding the Women’s narrative, the specific lines I refer to from within the women’s texts are in 12 font italicised and enclosed in double inverted commas. My own conversation with the text is non-italicised and directly follows the author’s words. For example: Times new roman, italicised and in double inverted commas and indented.
“The GnRH pulses associated with menopause prime the brain for new perceptions – and, subsequently, for new behaviour. It is very common for women to become more irritable, even downright angry, about things that were more easily overlooked before. Long before we begin to feel hot flushes from changing hormonal levels, our brains undergo changes in the hypothalamus, the place where GnRH is produced. This same brain region is key for experiences, and ultimately expressing, emotions such as anger” (Northrup, 2001, p. 53).

The following defines how my method of ‘Without Interpretation’ operated in this thesis. I created this method to ensure no distortion or misrepresentation that can intentionally or unintentionally emerge from myself as the researcher. This ‘Without Interpretation’ method includes Reflections, Images and Contrary Concepts and follows the story lines. This method also enabled the contrary concepts, required to create conceptual meaning, to emerge without distortion.

All reflections, images and contrary concepts are placed to the right hand side after the presentation of author’s original words.

The Reflections, presented underlined, italicised, in 12 point, are words taken directly from the author’s words that spoke to me of something significant. I did not change these words in any way at all as a result of my reflection, to ensure that neither my objectivity nor subjectivity contaminated the women’s own subjective choice of words. The words that I reflected upon, that spoke to me, struck me either as my image or a contrary concept but still remain the same as the author’s own words.

My Images, presented underlined, italicised, in 10 font rather than 12 font, as I wished them to remain smaller than the author’s original words to enable the author’s words to hold visible prominent importance and significance. The images emerged from within me from the words of the authors. They are not my interpretations but only my images.

Contrary Concepts, presented in 12 font, in capitals, bolded italicised and dot pointed to enable Chinn & Kramer’s method of creating conceptual meaning. These are also taken from
the author’s own words once again as I did not want to interpret the author’s original words. Therefore, they have not been interpreted, changed or distorted in any way.

An example of the stylistic representation from Christiane Northrup’s narrative, including the above, is provided below.

“By sharing both the joy and the pain of my own transition (my emphasis), I hope that I can help to illustrate and also demystify the surges of creative energy that erupt in so many of us at midlife. As we break this silence we are also breaking cultural barriers, so we can enter this new life phase with eyes wide open…” (Northrup, 2001, p. 6).

Reflection: Sharing one’s transition can illustrate and demystify the surges of creative energy that erupt in so many of us at midlife. And very importantly, Christiane says, that as we break this silence we are also breaking cultural barriers. This also enables us to enter this new phase of life with eyes wide open as this is a time of transition.

My Image 1: Demystification of creative energy changes through giving voice with others to the phenomenon.

**CONTRARY CONCEPTS**

- **OWN TRANSITION**
- **THIS TRANSITION**,
- **ONE’S TRANSITION**

**Unsettling Writing Strategies**

Throughout the thesis there is deliberate repetition of words and concepts as a writing strategy to unsettle the dominant discourse of scientific writing. Also when referring to menopause I
deliberately refer to menopausal and postmenopausal women as a strategy to keep the woman continually present.

This thesis is an unsettling text. It can be seen to unsettle the biomedical model of menopause. Also this thesis is written by an ageing postmenopausal woman. The text can be unsettling to the reader as it is not a tight academic text, clearly concise. Informing the unsettling aspect of writing and of texts are the words of Lather who in her article *Troubling Clarity* refers to the usual ways of making sense and giving sense, which she refuses in her chosen text. The refusal is against a “tidy” text, a “comfort” text that maps easily into our usual ways of making sense and “giving sense” (Lather, 1996, p. 529). Lather also asks “What is the violence of clarity, its non-innocence?” (p. 529). Rather than the violence of clarity this thesis also presents the opposite and also in Lather’s words it is “diverting it in a way that returns the question from reader to author, undercutting both authority and tradition and the reader and the author…” (p. 531).

This thesis is reflective of the author who makes her important and significant points through repetition. This text is authored by an ageing postmenopausal woman and is one which attempts to make a voice heard. Ageing women’s voices are barely heard in our episteme of knowledge, especially philosophy. And ageing women are barely there. Therefore this thesis repeats what is important and significant to this woman’s voice and hence a repetitive pattern.

**Overview of Thesis Chapters**

The following is a brief overview of explorations in relation to the research objectives.

**Chapter One: The Introduction.** This chapter has explored the background, significance, and aims/objectives of the research. Perspectives that informed the research have been explained and justified. Representation in the form of writing strategies of the thesis have been explained and justified. An overview of the findings together with the need for a paradigm shift has been recommended.

**Chapter Two: Methodology:** Explains in detail the multi methodology and multimethods employed in this research. The contributions of postmodernist and feminism that framed the
methodology, together with the methods of discourse analysis and the journey to creating conceptual meanings are explored.

**Chapter Three:** Discourse Analysis: The Biomedical Gaze. This chapter is a discourse analysis of two seminal medical texts. The discourse analysis revealed how the disease was invented to enable the medication to be administered in order to deal with the symptoms of menopause. It revealed the power of the dominant scientific paradigm of medical science, together with underlying philosophy that defined menopause as a physiological phenomenon requiring medical treatment. Historically, these two seminal medical texts were influential in defining the modern perspectives of the episteme of menopause with the pathological negative biomedical diagnosis of menopause as disease.

**Chapter Four:** Women’s Texts: This chapter explored four women’s narratives and revelations by Creating Conceptual Meaning from the texts. Revealing conceptual meaning and was central to this chapter together with the method ‘Without Interpretation’. Using reflections, images and contrary concepts enabled the revealing of the underlying contrary philosophies to the biomedical model.

**Chapter Five:** Political significance of revelations from women’s texts: wholistic health and CAM systems thinking & theory, gender, equity, women’s rights, social justice, paradigm shift and social model of health. This chapter explored the significance of the revelations and contrary concepts as linked to health, CAM, wholistic and systems thinking which were all more relevant to the phenomenon of menopause rather than the biomedical objective reductionist pathological approach. Women’s rights, social justice and the need for a paradigm shift were explored. This chapter highlights the social model of health as more appropriate for the phenomenon of menopause as are gender and equity significant within this model.

**Chapter Six:** Feminist principles and perspectives - political action for ageing women. Health is sensitive to social environments and political and social change are necessary to refocus the emphasis of menopause from a pathological philosophy, science and episteme of our time, to the positive and empowering aspects of this health transition for all women. The
chapter nominates primary health care (PHC) and enhanced primary health care (EPHC) as relevant women’s strategies, and presents visions and directions for a paradigm shift.

Chapter Seven: Reviews the thesis overall and explores visions and recommendations for a more comprehensive enhanced primary health care program within a new Public Health framework.

NEW PARADIGM REQUIRED
Regarding omissions and marginalizations, and drawing on the support of multiple scholars, Im, Meleis and Park (1999) propose that “[w]hen science is used to support the predominant androcentric views and interests, those who are not part of this dominant group are marginalized, and their issues are either not considered relevant for study or not reflected accurately in research” (p. 411).

A shift to a more wholistic paradigm rather than a reductionist paradigm is what has emerged from this research project as necessary and critical for conceptualizing menopause, and creating the space for menopausal and postmenopausal women’s experience to be framed as an adult life cycle process. In addition, a social model of health became obvious as the most appropriate model in which to address the issues of menopause. As the concepts of gender and equity emerged as relevant to the phenomenon of menopause so the social model of health rather than the biomedical model of disease emerged. Ultimately menopause was highlighted as a health issue rather than a medical issue.

The shifting paradigm not only relates to the changing face of public health and health promotion, but also to why and how health promoters change their practice and to the role of learning in that process. The shift involves moving from a conscious instructive level of adult education to one that facilitates learning (Davies, Colomer, Lindstrom, & Hospers, 2000). The facilitation of learning has also emerged from this research as appropriate for both menopausal and postmenopausal women to correct the previous imbalances. In addition to being instructed in medicalization as a result of biomedical philosophies and practices, women have a right to multidisciplinary learning regarding the phenomenon of menopause. In addition, learning through postmenopausal women’s knowledge, women who have published their narratives, perspectives, theories and philosophies regarding their own

Menopause: The Need for a Paradigm Shift from Disease to Women’s Health    Margaret T.C. Harris
experiences of the adult life cycle developmental process cannot be ignored. These women 
offer learning that is positive, valuable, rewarding and more wholistic for women, 
perspectives which has been lacking in the previous paradigm.

**SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

My final conclusion regarding the phenomenon of menopause, menopausal and 
postmenopausal women, is that a shift is required from a reductionist paradigm to a wholistic 
paradigm which is inclusive. A further shift from a biomedical model to a social model of 
health is required as menopause has emerged as a women’s health issue rather than a 
biomedical one.

In summary, this research revealed the positive aspects of the phenomenon of menopause that 
had been marginalized and deleted in the biomedical diagnosis, therefore highlighting 
menopause as a health issue rather than a medical one. It also identified menopause as a life 
cycle adult developmental process that has been hidden behind the disease diagnosis. In turn 
a paradigm shift from a reductionist paradigm to a wholistic paradigm became essential and 
urgent to enable a health perspective to be applied. This will allow and support the potential 
positive adult life cycle developmental process that has been ignored behind the disease 
diagnosis, and which has also emerged from this research project as an important and 
significant process. The ethical implication of this is that menopause would be addressed 
within a co evolutionary space.

An exploration of a social model of health revealed the social model as the more appropriate 
and essential model rather than the biomedical model. The shift is necessary so that the social 
determinants of health, such as gender and equity emerging as issues regarding menopause, 
menopausal and postmenopausal women can be accommodated and addressed appropriately 
as this cannot occur in the biomedical model.

My recommendations regarding dissemination of the various knowledges to all women from 
middle age, perimenopausal (42 years of age), to ageing postmenopausal women, which have 
emerged from the research, are also included in the last chapters. They include the 
importance, regarding perimenopausal, menopausal and postmenopausal women, of gender 
and equity as determinants of health within the social model of health, together with
recommendations in policy design and development, health promotion and enhanced primary health care and public health.

This concludes the introduction chapter of this thesis and an exploration of the methodology and methods follows in Chapter Two.
CHAPTER TWO - METHODOLOGY AND METHODS:
THEORETICAL PERSPECTIVES AND HOW THEY INFORM
THE RESEARCH
“On the basis of the premise that the concept of ‘woman’ and the codes and conventions of the cultures we call ‘patriarchal’ are social, not biological, in origin, feminists have insistently focused attention of the need for the cultural change that the women question raises. Long before Lacan or Derrida, feminists had established the connection between patriarchy and culture, pointing out that the subordination of women is inscribed as much in ‘our’ literature as in ‘our laws…The feminist agenda, therefore, is necessarily ‘committed to a politics of transliteration,’ as the poet Olga Broumas puts it. If, as a deconstructionist might say, woman has always already been written (or if, as Gertrude Stein put it, somewhat more cryptically, ‘patriarchal poetry is the same’), then the steps to be taken follow logically and implacably. First, she must refuse to be written (64) in the terms that have already been set. ‘Let her try,’ writes Stein, ‘Let her try./Just let her try./let her try./Never to be what he said./Never to be what he said./ Never to be what he said. (65). Then new ways of thinking, of constructing reality in language, must be found: ‘Like amnesiacs/in a ward on fire, we must/find words/or burn …” (Bammer, 1992, p. 257).

Introduction

Initially when considering the research process of this qualitative research project, a postmodern feminist methodology was chosen as the most suitable to enable the aims and objectives of the research to be achieved. However, as the research has developed, what has emerged is the importance of, and a need for, a strong emancipatory impulse which has been revealed as the thesis moved along. An emancipatory impulse overlaps as a concern with that of critical theory. Because of this overlapping, I will refer briefly in this chapter to some main points regarding critical theory, to enable hopefully a connection towards the end of the thesis with the urgency and critical need for the emancipatory impulse of a paradigm shift.

However the main focus of this chapter is on postmodernism and feminism together with the exploration for the most appropriate methods in relationship to these methodological perspectives I have chosen.

This chapter converses (or convenes) in greater detail, with the theoretical perspectives that inform the chosen multimethodology, these being postmodernism and feminism. It is also presented in the form of a discussion or conversation in an effort to explain and justify the methodology and methods I have employed for the complex phenomenon of menopause. Feminism and feminist research will be referred to firstly, and then an exploration of postmodernism will follow.

Notably, postmodernism and feminism are often considered to be an uncomfortable fit, where one is not acceptable to the other, or even more so, where they are very often seen to be in conflict. I have looked for the similarities in both, or the areas where they overlap rather than where they conflict. Firstly, I believe that both feminism and postmodernism ‘include’ rather
than reject. Also indicative of both a feminist and a postmodernist stance is that no one particular aspect is necessarily better or worse than the other, just different. Both allow for difference and diversity. Because there are no hierarchical levels where one rules over the other and rather than dualisms, many ideas and perspectives can sit side by side and all be of equal value. This then enables the consideration of the phenomenon of menopause in a more extensive and expansive way. This expansive image has emerged in greater detail also through the implementation of a multimethods approach. Because contexts are always crucial in defining realities, and because we are very often dependent on the ‘context’ within which life and realities are embedded, contexts have a significant part to play. This aspect of context presents as critical to the phenomenon of menopause. Both a feminist and a postmodern methodology allow and provide a space for this component to be included. Also most significant and critical, is that both feminism and affirmative postmodernism (Rosenau, 1992) have been instrumental in a wholistic picture emerging, where all of the above have been highlighted.

Therefore, I believe that viewing this phenomenon through the dual lenses of both feminism and postmodernism provides a more wholistic view. Whilst they are very different, and maybe seen in conflict, I am using the lens of both to enable the larger picture. This is advantageous. Regarding postmodernism and feminist research, in relationship to traditional feminist research, the following has been noted, “[w]hat holds apart postmodern feminist research from traditional feminist interpretation research is that attention is also paid to the function of social and cultural discourse in women’s lives” (Nosek, Kennedy, & Gudmundsdottir, 2010, p. 2). Therefore postmodern feminist research can be considered worthy, and I consider it very useful as a methodological framework.

Importantly, I believe a good description of feminist perspectives is important. Equally too, a good description of postmodernism is necessary. Because the main character and nature of postmodernism is to continually seek many and therefore multiple perspectives, and also for me to better understand and sense how a postmodern perspective extends, I refer particularly to, and in addition to others, the writing of Rosenau (1992) as I consider her writing in itself, a good example of the postmodern as it in itself enables an expanded sense of the extensive and expansive net of postmodernism.
Rosenau as a postmodern writer believes that this form of writing is more literary than modern writing that tends to focus on precision and exactness. True to postmodernism, her writing is also a delivery in the more literary mode. Included also, I have a brief reference to modernity, taken once again from Rosenau to enable a backdrop for the emergence of postmodernism. I then refer to a postmodern concern, which in turn is then followed by the concern that emerges for my research. Finally to enable an even clearer understanding of postmodernism for myself, I then refer to postmodernism in action.

This conversation will then explore various methods to enable a suitable multi-methods approach. I have employed discourse analysis as first method. This method was an obvious choice as it enabled the exploration of the historical seminal texts where the conception and birthing of menopause as disease by men only, was evident. Also through the discourse analysis the philosophy of the power structure underlying the biomedical dominant paradigm became obvious. An historical exploration is consistent with postmodernism, and therefore suitable for this research project.

This was followed by a search for the second method, before finally deciding to choose “creating conceptual meaning” (Chinn & Kramer, 1999, p. 49) as the most suitable second method to utilize for the women’s published narratives. This search includes a thorough exploration of various concept analysis methods and the reasons why these methods were not suitable for this particular project, thereby confirming for me the chosen method of creating conceptual meaning as definitely more appropriate for this project. This is quite an extensive search. Following this search, details of creating conceptual meaning (Chinn & Kramer) will then be presented.

Throughout the process of creating conceptual meaning I employed my own method which I have named ‘Without Interpretation’. In my method of “Without Interpretation” the texts have been presented as similar to that of an interview without any interpretation. This is a rather unusual and radical approach to the data but it has enabled me to stay true to the authenticity of each author’s own words. While this is so, there are scholars who have also tended to rely on the exact words of other scholars, narrators and practitioners and then abutted these against their own thoughts and reflections. As Lather (1996, p. 540) has suggested, “I have constructed a text whose significance will not be exhausted by the meaning
attributed to it by any one person, ourselves included.” See also Lather (Lather, 2001). In other words the narrative stands alone as the exact words of the author and can then be reflected upon and considered by multiple readers. Rather than abutting, I have chosen the term ‘juxtapositioning’. The juxtapositioning is with the exact words of the postmenopausal women together with those of the biomedical diagnosis. I believe this method of presenting the text as ‘data’ has value as it is more congruent with a woman centred approach as it honours and validates the postmenopausal women’s own word exactly, which is also a women’s health approach.

Last but not least my own method of juxtaposing or juxtaposition is included briefly. I say briefly as I had not planned for this method at all. It emerged from within the research process as the next practical thing to bring the results of the two previous methods together. It was this method that further made the contradictions very obvious and also further highlighted the revelations. The necessity and urgency to correct the limitations of the dominant paradigm through a paradigm shift then became extremely urgent.

Connection with Critical Theory

According to Baum (2008):

Feminist researchers (Keller and Longino, 1996) claim that science has been dominated by male vales and reflected a very skewed view of the world. These critical voices have been strengthened by those of critical theorists, led by Habermas (Cheek, Shoebridge et al., 1996, pp. 168-73), who have strongly challenged the view that science is the only form of research through which knowledge can be developed (p. 140).

The methodological process and choice of methods I have employed in this thesis has highlighted the urgent need for a paradigm shift. I now see this process as a critical theory. To justify this statement I refer briefly to critical theory as described by Judith Clare (2003).

Critical Theories have three distinguishing features.
1. They guide human action in that they enable people to determine what their true interests are (they are inherently emancipatory);

2. They have cognitive content (they are forms of knowledge);

3. They differ epistemologically in essential ways from theories in the natural sciences. “While theories in the natural (positivist) sciences are ‘objectifying’, critical theories are reflexive’. That is, critical theories presuppose interaction among theory and practice (action), people and social structures” (p. 128).

In these terms, according to Clare (2003), “a critical social theory is a reflexive theory which gives agents a kind of knowledge inherently productive of enlightenment and emancipation” (p. 128). In defining what critical theory is, Clare states that “[c]ritical theory is explicitly founded on an awareness of the ways in which conditions, such as hierarchical power relationships and other institutional regimes and ideas which support dominant ideologies, can generate certain beliefs, ideas and self-understandings” (p. 131).

Exploration of “hierarchical power relationships and institutional regimes and ideals which support dominant ideologies” (Clare p. 131), in this case the dominant paradigm of menopause as disease is critical. It is necessary firstly to raise consciousness, secondly to enable a vision that would be different and thirdly to define the constructs at the socio-political level that restrict new and different understandings. Also according to Clare “[t]he central aim of critical theory is action at the socio-political level” (p. 128). Finally,

Critical theory is not ‘critical’ in the sense of voicing disapproval of contemporary social arrangements. The critical character rests with its ability to focus attention on the irrational or oppressive elements within society, elements which take away or destroy people’s ability to make collective rational choices about their lives (Clare 2003, p. 127-128).

Therefore, Feminism can be considered a critical theory, in that; it is a theory that considers the oppression of women to be a central element within society. Emerging from this research
project are oppressive elements that have contributed to diagnosing menopause as a disease with HRT/HT as the magic bullet therefore excluding the need for more in depth studies of the phenomenon on various levels and from a diversity of perspectives. I will return to this in a much later chapter of this thesis.

Guiding Themes for Methodology

Finally I found the following specific guiding themes as listed by Worell and Etaugh (1994) as a useful check and balance for feminist methodology. My project addresses all these particular themes appropriately as follows:

1. Challenging the Tenets of Traditional Scientific Inquiry
   - Restructuring the polarity of objective-subjective.
     
     For my project - the polarity of objective-subjective will be neutralized, because the objective-subjective will stand side by side, included and valued equally. Therefore the polarity will no longer exist.

2. Focusing on the Experience and Lives of Women
   - Validation of women’s experiences.
     
     For my project - By the acknowledgment of women’s experiences through the inclusion of their own writings.

3. Viewing Power Relations as the Basis of Patriarchal Political Social Arrangements
   - Seeking strategies that lead to women’s empowerment.
     
     For my project - By validating, valuing and upholding women’s texts as legitimate and equally valuable. This also allows and enables women to speak for themselves rather than having ‘others’ speaking for her.

4. Recognizing Gender as an Essential Category of Analysis
   - Exploring the functions of gender as a stimulus variable that frames expectations, evaluations, and response patterns.
     
     For my project - By stressing that women’s body issues, are women’s issues, and should also be ascertained by women. Patriarchal constructions of women’s bodies are limited when created from men’s reasoning, limited interpretations, definitions
and diagnosis. These constructions are all very partial and lack the reality of the woman’s actual experience.

5. Attention to the Use of Language and the power to ‘Name’.
   - Initiating research on hidden phenomena based on the process of naming. 
     *For my project - My choice of ‘discourse analysis’ and ‘creating conceptual meaning’ as methods to enable a revealing of the hidden phenomena in relation to menopause.*

6. Promoting Social Activism Toward the Goal of Societal Change.
   - Reconceptualizing theories, methods, and goals to encompass possibilities for social change, toward reductions in power asymmetries and promotion of gender justice.
     *For my project - By including new methods, models and paradigms that are inclusive of alternative constructs of menopause, menopausal and postmenopausal women that empower and support emancipatory processes for each woman.*

     *Promotion of this information, by sharing it with other women, thus empowering women to claim their own constructions of their own menopausal experience as their reality and the necessity then, for various other appropriate interventions.*

     *Implementing social change through the social determinants of health, particularly gender equity and social justice, congruent with the social model of health as directed by the World Health Organization (2002).*

I now turn to the postmodern/feminist methodology in more detail. I now turn to the postmodern/feminist methodology in more detail. Then follows the detailing of my first chosen method, that of discourse analysis, together with a rather extensive journey and search for my second chosen method, that of creating conceptual meaning. Finally this chapter will address the question of rigour within this research project. I now turn firstly to explore feminism and feminist methodology, as appropriate for this woman’s only health issue, especially a health issue that involves all women moving from middle age to postmenopausal status.
FEMINISM

Introduction to Feminism

“From the Latin ‘femina-woman’,
originally meant ‘having the qualities of females’.
Feminism originates in the perception that there is something
wrong with society’s treatment of women”.

“Feminism has only working definitions since it is a dynamic,
constantly changing ideology with many aspects including
the personal, the political and the philosophical.
Feminism is a call to action. It can never be simply a belief system.
Without action, feminism is merely empty rhetoric which cancels itself out”.

The above first quote has been chosen as I believe menopause is a quality of females rather
than a disease. The second quote indicates the dynamic quality and action orientation of
feminism as it has a stake in the personal, the philosophical and the political.

Three Basic Principles of Feminism

“Feminism is concerned with women’s issues and lives…[and in addition]…there are many
kinds of feminism” (Chinn & Wheeler cited inRoberts & Taylor, 1998, p. 129) such Liberal,
Marxist and postmodern. These feminisms differ in terms of the explanations provided for
the cause of oppression and the strategies to be implemented to deal with that oppression.
However, “in general, feminisms share three basic principles: a valuing of women’s
experiences, increasing the awareness of factors that oppress women, and creating social
change through critique and political action” (Hall & Stevens 1991 cited in Roberts & Taylor
1998, p. 129). These three basic principles will be applied in this thesis.
These Three Principles in Relation to Research

Firstly, this research aims to value women’s experiences by incorporating women’s narratives and texts as important research material. To enable a valuing of women’s texts, these writings (the research data) will remain in the exact words as written by the women themselves. To this end they will not be interpreted by me but only imaged by me, thereby allowing each woman’s own ‘authentic voice’ to remain so there is no fear of unintentional or unconscious misinterpretation to any degree. This will allow the women’s words to stand for themselves. In other words, the ‘text’ becomes what is usually viewed as data within more (modernist) writing and the data will stand as is. This I believe is more effective in validating women’s own personal authentic voice.

Secondly regarding the awareness of factors that oppress women, and through a discourse analysis of the western scientific, biomedical model, the limitations of this model will be highlighted thereby enabling an understanding of how this limiting model functions to oppress women. By critiquing this biomedical model, areas where change is necessary can emerge. In addition, validating women’s personal narratives regarding menopause enables the personal to be revealed. This also serves as a reflection on a less pathological process, allows for positives to emerge as well as negatives, and highlights the need for additional appropriate interventions. This strategy enabled suggestions and recommendations for emancipatory actions related to menopause, menopausal and postmenopausal women. In turn, social change and political action will be required which is the third basic principle of feminism.

Key Terms - Embodiment, Empowerment and Emancipation

Of most significance to the present discussion on feminism is Roberts & Taylor’s statement that, “Feminisms are searching for ways that will make the lives of women more positive and liveable” (p. 129). Key ideas towards making the lives of women more positive and liveable are the following words “embodiment, empowerment, and emancipation” (p. 129).

Embodiment acknowledges the female body positively. I believe it requires valuing the sacredness of women’s bodies and acknowledging this in a positive way. Women hold within themselves, within their bodies, the secret of, and ability to incorporate, house, and
nurture the population of the world. To pathologize any aspect of this normal reproductive life giving and life cycle process of woman does not value her processes and her gifts, her continual life-giving processes, experiences and knowledge.

**Empowerment** means supporting women in the development of their own power. By naming the woman as diseased and deficient does not, I believe, support the development of the woman’s power, but only serves to interact with medication to correct the so-called disease. To be defined as ill and ailing does not acknowledge and value the power of the woman’s life cycle process but sees it only as a pathological deficiency indicating deterioration. It does not serve to positively validate or empower the ageing woman in our Western scientific society/culture. Through this pathological diagnosis and definition the woman’s positive status and value in the society/culture is deleted and excluded as the reductionist diagnostic process serves to pathologize and present to herself and also to one and all, the status of chronic patient. This in turn serves to create the ageing woman as a system gone wrong and one in need of control by medicalization.

**Emancipation** means working to assist and freeing women from any negative, destructive, confining or unjust elements that maybe oppressive or controlling. With regards to the phenomenon of menopause, emancipatory processes, I believe, would act to support women through their natural life-cycle transition process by supporting, enabling and encouraging women to have access to, and the ability to tap into their own new energy and power. In short, this means to name and supply emancipatory strategies, rather than just medicalization, to assist women to experience the freedom of the process of accessing their own untapped power that is creating a change within, and therefore a new self. The awareness of this new self and emerging power can propel women to be active and creative and therefore valuable contributors to the society/culture, rather than chronic patients as diseased, deteriorating and deficient. Emancipation can be viewed as freeing one from ethical and intellectual bonds.

In the case of menopause this would be setting free from intellectual discourses that have a negative and pathological connotation towards menopausal and ageing postmenopausal women. Positive constructs are conducive to health and are also health supporting and therefore are required for the optimal health of ageing women. In addition, I believe that searching for the positives within women is also important to enable support for women’s
strengths, gifts, creative impulses and positive developmental energies as this can result in more sustainable health. Medication indicates disease and sometimes disease cure, but not sustainable health potential.

**Feminism and Philosophy**

The following statements by Barker (1997, p. 209) regarding feminism and boundaries, I consider particularly relevant to my project as it allows for diversity, difference and change: “Feminism lacks the boundaries that would serve as a means for the exclusion – of people, principles, and practices – that definition traditionally demands”. Barker continues:

> With respect to its relation to definition, feminism stands on the same ground as philosophy itself. All philosophical theorization employs and projects interpretations and reinterpretations of the terms of its debate; all philosophical theorization defines and redefines the terms of philosophy (p. 210).

The statement that philosophical theorization reinterprets the terms of its debate is appropriate and necessary from a feminist perspective, especially if the terms of the debate are not empowering and emancipating for women themselves. This is even more so where validation of postmenopausal women’s texts have not been acknowledged as having value for a wholistic understanding of the phenomenon of menopause, where body/mind/soul/spirit aspects occur but are ignored, dismissed and remain invisible in policy recommendations designed through the scientific biomedical model. Other terms, and another model is possible.

Therefore, a feminist philosophy regarding menopause, I believe would require wholistic definitions and a redefining of the terms of the phenomenon, to include body, mind, soul, spirit interactions, and in addition would need to acknowledge her context as either inhibiting or supporting in the process of empowering, together with the emancipation of women.

**Feminist Literary Criticism**

More wholistic explorations are also implied by Jackson, Clare & Mannix (2003, p. 208) who have stated that “feminist literary criticism is an interdisciplinary mode of enquiry”.

Borrowing from Jackson et. al., from a feminist perspective more than one definition or exploration and enquiry is required. Regarding the phenomenon of menopause, a call has been made by various other researchers also for multidisciplinary and interdisciplinary perspectives rather than biomedical science only (Andrist & MacPherson, 2001; Komesaroff, et al., 1997). Komesaroff et.al. support this notion suggesting “[t]his process of questioning has drawn on a variety of theoretical traditions and perspectives, including feminist theory, politics, philosophy, sociology, psychology and anthropology” (p. 3). In this way a more wholistic understanding of the phenomenon, together with a more wholistic range of interventions, equally accessible and affordable to all women, can be envisaged. Regarding this women’s health issue Andrist & Macpherson state:

Women’s health, including menopause cannot be divorced from social, political, economic, and cultural forces that impact women’s health. There is much to gain by exploring and using theories from other disciplines. We could do well to follow feminist academic scholarship on menopause that has emerged from various disciplines, including philosophy, anthropology, sociology, history, psychology, psychiatry, and English (2001, p. 52).

Therefore, fundamental to and emerging from this project is my belief in the value of highlighting other philosophical theories and methods and multidisciplinary perspectives as alternatives to the empirical scientific/biomedical model to describe and illustrate the phenomenon of menopause. Various other theories can offer more life giving, untapped positive aspects of the phenomenon that have not been acknowledged and promoted as significant in our society beyond the biomedical model. They deserve to be promoted equally. They can be of benefit to the reflection and thinking of menopausal women and postmenopausal women. The significant benefit would be the additional perspectives that would be brought forth that challenge the limited reductionist knowledge construct currently defining menopause and the menopausal woman in our culture pathologically. According to Loppie & Keddy (2002):

Knowledge is temporally, culturally and contextually constructed. Although most scholars acknowledge the limitations of biomedical information, there exists an almost universal dominance of scientific reductionism that has contributed to difficulties in
our appreciation of complex processes such as the climacteric. The whole of menopause is not simply the sum of its parts (p. 98).

In addition and most important for this research is the call for inclusion of various postmenopausal women through their own textual narratives as participants in relating their own embodied experiences defining the phenomenon. A call for women’s experiences and perspectives is fundamental to feminist research. This in turn also brings forth their reflections on a variety of interventions rather than just HRT/HT. When included in policy design and development, postmenopausal women’s narratives would stand to empower women by allowing other women to define their particular needs from within their own context, and their specific required therapies, thereby providing various levels of choice which can be emancipatory for women.

I believe it is relevant that women’s contending philosophies, as well as various other philosophies are equally significant and worthy underpinnings out of which emerges the need for a new paradigm and a different model. In addition, out of these will emerge the various different perspectives which according to postmodern thinking will stand equally with, and alongside, the biomedical perspective of the dominant paradigm of menopause as disease.

**Feminist Epistemologies**

Campbell and Wasco (2000) have noted that feminist epistemologies and postmodernism both recognize “woman’s lived experiences as legitimate sources of knowledge” (p. 773). Sigsworth (1995) when discussing nursing has suggested that feminist theory and research processes can contribute to nursing knowledge and that it is women’s experiences that entitle women to be knowers. Sigsworth citing Stanley & Wise (1983) 1990) stated:

> Epistemological issues underpin the feminist research process and include the fact that women’s experience can be a legitimate source of knowledge and that women can be knowers. This implies that subjective knowledge is valid and informants are experts on their own lives (p. 897).
In addition, regarding epistemology, drawing on Bunting & Campbell (1990 cited in Sigsworth 1995) has stated that “[e]pistemology is the theory of knowledge which addresses such questions as: who can be a knower, what can be known, and what constitutes and validates knowledge” (p. 897).

This research has highlighted women’s experiences, perspectives and theories as legitimate knowledge which has been omitted from scientific discourse. To this end, I agree with Sigsworth’s statement that, “[a]pplication of feminist research to the development of nursing knowledge would focus attention upon aspects of intuitive and subjective knowing, which have been largely neglected” (p. 898).

As women’s own inner knowledge through their embodied experiences is subjective and because it has not been internalized from an objective observer and external provider, their own inner knowledge is indeed more intuitive. Intuitive knowledge is necessary as an inclusion and contribution to objective scientific knowledge as the scientific objective knowledge of menopause which has tended ignore the internal embodied experience of postmenopausal women. To search for intuitive and subjective knowledge was my intention for this research.

Ultimately intuitive and subjective knowing from postmenopausal women themselves will enable a more wholistic epistemology and paradigm. In addition, thinking that incorporates intuitive and subjective knowing is also acceptable and common to postmodern feminist thinking. I now turn to the more technical aspects of the feminist research process. It is to Peggy Chinn (2003) that I now turn as she notes the common elements that inform feminist research and writing and I believe they are very relevant to this research project.

**Elements That Inform Feminist Research & Writing**

The following elements are proposed by Chinn, as she spells out the finer points of writing for feminist research and writing. These are especially relevant for the texts I am researching, and in addition, I can also apply these to my own writing. According to Chinn it is important to note three common elements that inform feminist research and writing. They are: valuing
women’s experiences, recognizing systematic conditions that oppress women, and transforming the world for women.

1. Valuing Women’s Experience

Writing that fundamentally values women and women’s experiences is vastly different from the research and writing that dominated professional literature for most of the 20th century. Shifts in both substance and style came from the growing strength of feminist scholars and activists who recognized and challenged the neglect and devaluing of women in literature and offered a wide array of remedies to address the problem (Chinn, 2003, p. 63).

And further:

The earliest recorded feminist writings focused primarily on uncovering evidence demonstrating the pervasive and persistent practices that fundamentally discounted, ignored, or harmed women (Spender 1982), and this focus has continued as new insights have emerged. Along with knowledge of the ways in which women and women’s experience have been silenced or distorted, feminist scholars increasingly address ways to shift fundamental philosophies and theories, and in turn, methods, to more accurately represent women and women’s experiences (p. 63).

The use of a feminist methodology focuses on this. Because shifts are also very much a focus of this research, the shifts I propose for menopause are from quantitative to qualitative, from analysis to creating conceptual meaning, from interpretation to juxtaposition. The final shift from interpretation to juxtaposing ensures that there are no exclusions occurring, either consciously or unconsciously. In addition, the multi methods serve to enable a case for a paradigm shift. Further the crucial benefit here is that movement has been created between polarities. Finally the juxtaposition creates the potential for either separating or joining of the polarities. By leaning away from the biomedical model (whose characteristics are to divide and separate) whilst still including it, and also moving towards inclusions, an interlocking of models is then possible thereby creating a paradigm shift. Andrist & MacPherson (2001) have confirmed the importance of this, together with the value of critical analysis and interlocking social relations that impact a woman’s particular experience as follows:
Feminist scholarship includes a critical analysis of women’s position in society and of interlocking social relations that impact a woman’s particular experience. Patricia Collins (1990) noted that, instead of using additive models of oppressions, interlocking models create new paradigms. Rather than an either/or model (race/class), one can conceptualize either/and models of oppression that beg to include other categories of oppression (p. 340-35).

Regarding the value of multi methods for feminist research. Drawing on multiple feminist theorists they state that “[f]eminist research has evolved from a position in which there was debate about a unique ‘method’ (Harding 1987) to the understanding that there are multiple methods and perspective that comprise feminist inquiry …” (Andrist & MacPherson, 2001, p. 35).

Also to value women’s experiences, it is beneficial for feminists to research topics that are of necessity to women. Most importantly then, the prime focus of feminist scholars and activists is to insist on a shift to research that values women and also values women’s experiences. In this case I believe it is through postmenopausal women and their experiences, their narratives and texts, that we can be more aware of the value of menopausal experiences. This in turn contributes towards a paradigm shift.

For me the main task in this research project is to uphold the value of postmenopausal women in literature, those who have published texts regarding their significant experiences, perspectives, and theories of their embodied subjective menopausal experiences as their experiences negotiate a terrain where the positive values become evident. Therefore, I have chosen the most appropriate multi methods as noted in the paragraphs above, to achieve this.

2. Recognising Systematic Conditions That Oppress Women

While it is not always necessary for a researcher or writer to lay claim to one particular theory of explanation of women’s oppression, feminist approaches to scholarship bring personal perspectives to the surface, making explicit the ideological lens that is brought to bear upon the work. The perspectives of the researcher fundamentally influence the choice of research purpose, questions, methods, procedures and the selection of relationships with participants. The perspectives also
influence the choice of language used in the methodology and in the reporting of the research (Chinn, 2003, p. 65).

My own personal embodied experiences of menopause have propelled me to search for, through this research, the forces that silence postmenopausal women’s theories and menopausal life-cycle experiences. The forces that silence make it impossible for these personal life-cycle transitional experiences to be considered as viable human experiences, important enough to be included in policy design and development and distributed to every midlife woman. Therefore I have my own perspectives on the phenomenon and this has influenced my choice of research purpose, questions, methods, procedures and my selection of postmenopausal women author’s texts only. This has enabled a broader and wider vision. This has also served to highlight the many ways in which “women’s reality has been misrepresented by male scholars who have interpreted women’s experience without concern for what women themselves actually think, feel or experience” (Chinn 2003, p. 66). This is evident from Wilson (1966) and Utian’s (1978) influential books which have been conceived, birthed and written by male scholars and practitioners who have not personally experienced the phenomenon within themselves and have defined the phenomenon from a Western scientific, pathological reductionist, objectivist biomedical perspective only.

In addition, the object of this research is the purposeful focus on texts where language is the tool of communication, as well as an implement of policy making, policy design and development. The language and terminology evidenced in both Wilson and Utain’s medical texts is therefore of significance at more than one level. Texts and language have been identified from poststructural and postmodern perspectives as sites of control. Therefore, examining this language from a place of feminism has confirmed the need for women to relate to a different language, one which reflects the reality of the experience at deeper levels. This new language is urgently required as it will enable the positive aspects and the more meaningful levels and substance of the phenomenon beyond the physical to emerge, thereby allowing the potential for creating both personal and social transformation for women. Accordingly,

Feminism has secured a place in the domain of public discourse, and feminist insistence on the importance of language as a political reality has had a measurable,
Menopause: The Need for a Paradigm Shift from Disease to Women’s Health

Margaret T.C. Harris

In addition Bammer suggests “[i]n theoretical terms, feminism presents itself as a radical critique of language, which its sees, on the one hand, as an emblem and tool of power and, on the other hand, as a means of social and self transformation” (p. 255).

A reflection on the radical critique of the biomedical language and discourse, together with the presentation of postmenopausal women’s language, presents a much needed critique of the episteme of our time, and the use of biomedical terminology and language as the universal law for the phenomenon of menopause.

3. Transforming the World for Women

Understanding the experience of menopausal and postmenopausal women and how the biomedical model constructs the experience provides the basis for potential future positive transformation. Feminism seeks understanding, education, reflexive awareness and transformation both personally and on a societal level. Taking account of the tension between the critical feminist oppression narrative, dualistic constructs and postmodernism Peggy Chinn (2003) makes several highly relevant points.

Postmodern feminist scholars have influenced feminist thought particularly in the realm of transforming the world (Tong 1998). Generally, postmodern feminist scholars have rejected the idea of oppression, of dominance and submission that many of the early feminist theories held as central. Instead, postmodern feminist views tend to focus on the advantages of being the ‘other’ in the world, and have examined ways in which the construction of ‘other’ has sustained generalised assumptions about women and women’s experience (p. 66).

Generalised assumptions about women, they claim, are as damaging as the patriarchal forces that have been assumed to be solely responsible for any disadvantage that women have experienced. From a postmodern view, the construction of oppression has been an artefact of a language and a way of thinking that divides the world into ‘this or that’, good or bad’, oppressed of oppressor’. The transformation that is
required involves a refusal to categorise or name the world in terms that have been constructed in a binary and oppositional language/thought system, and instead to address each individual experience and reality in its own right, without imposing categories or values (Chinn 2003, p. 67).

Rather than viewing women as ‘victims’ of circumstances beyond their control and seeking transformations that seek to change limiting circumstances, feminist scholars are increasingly turning to work that views women as ‘survivors’, with unique talents and strengths that have developed to a remarkable extent and that can serve well the transformational projects of making a better world for women (Chinn, p. 67).

It is these three above points that are very important to my research. Firstly, it is women’s experiences that indicate difference to the scientific biomedical model of menopause that is my search. That is those that represent ‘other’ in addition to the pathological representation, and which highlight the positive aspects of the phenomenon. Secondly, postmodern perspectives do not require definition of truths. Categories are not considered important. What is important is that there are many and diverse experiences of the phenomenon. All of which carry equal value. Thirdly, I am searching for the talents and strengths that are the result of the phenomenon of menopause, and therefore the gains and resulting strengths in addition to the weaknesses or losses of the menopausal and postmenopausal woman. Further, regarding the above three points, the following are also relevant.

Regarding the first point: Whilst I am employing a postmodern/feminist methodology, I consider ‘postmodern’ to be the adjective. Therefore, for me the noun ‘feminist’ carries slightly more weight. Feminism, whilst carrying more weight, when working with postmodernism, allows for the early feminist scholars ideas of oppression, of dominance and submission that they held as central, as also relevant.

Regarding the second point: The importance of language, and in turn, meanings is central to this thesis. The language of the biomedical discourse is totally negative and pathological in its diagnose of menopause and therefore menopausal women. A discourse analysis through a feminist perspective highlights the oppressive tool of language. This is especially highlighted when this negative language is juxtaposed with the women’s language and meaning that has
emerged from these postmenopausal women’s texts. This juxtaposition is instrumental in raising consciousness levels, and gives a clear example, as mentioned previously in the introduction to this thesis, of the importance of language as a revolutionary impact on the general consciousness about the use of language. In addition it presents a clear case for the feminist politics of not only resisting the discourse of the current language, but also “appropriating the right of others to speak for themselves, in their own voices” (Helen Cixous cited in Bammer 1992, p. 255). This enables a shift from “the authoritative stance of a universalizing monologue” to “the interactive space” that Bammer refers to (see my Introduction chapter p. 17) where all are equal and nearby each other, (therefore not marginalized), and where dialogue can then occur.

Regarding the third point: Feminist scholar, Heather Dillaway’s (2007) research highlights the need to analyse social contexts for menopause as she identifies “women’s mother-daughter ties” (p. 95) and how they define menopause as one such context. She has noted that “The hegemony of biological interpretations and elevation of the biological mother-child relationship is evident in interviewees’ conversations” (p. 93).

What has also emerged from my research is the gains and strengths, the unique gifts and talents of both menopausal and postmenopausal women. These women and their strengths in turn, need to be employed to serve well the transformational projects of making a better world for women and in turn, making a better world for all future generations. This would ensure that a different discourse would be passed through mother-daughter ties. In addition, I also present visions, directions, and submissions to support the importance of the menopausal and postmenopausal women’s gains, strengths, gifts and talents. “The written account of research is more than a simple report. It is an active process that shapes social and political relations and shapes the relationship of the research to the culture, the people, and the society” (DeVault, 1999, Ehrlich 1995, Young 1997, cited in Chinn 2003, p. 67).

**Feminist Perspectives in Research**

Andrist and MacPherson (2001) state that feminist perspectives are embedded in a variety of theoretical approaches to research, and although “each theoretical approach might differ in its world view” (p. 34) there are four characteristics common to all.
1. Feminist research is grounded in women’s lived experience
2. The researcher is in-relation to those being studies
3. The researcher’s ability to be reflexive is a source of insight
4. Research findings should be useful to women, thereby contributing to social transformation (Andrist 1993 cited in Andrist & MacPherson p. 34)

Regarding these four characteristics, I have already referred to the importance of women’s lived experience. Women’s lived experience for me is the experience of those women who have lived through the phenomenon. Regarding myself (the researcher) and the texts of the postmenopausal women authors, is my relationship as a white postmenopausal woman myself, who has transversed the process and therefore has inner knowledge of the phenomenon. The third characteristic is elaborated on below as a feminist ethical perspective, and the fourth, I firmly believe the research finding will be useful to all midlife and older women in assisting their transformation both personally and socially.

**Methods - Feminist Ethical Perspective**

As I contemplated, from a feminist/postmodern perspective, an appropriate research method of analysis for my textual data, regarding this phenomenon of menopause as specifically a woman’s experience, I found I was confronted with many questions to myself. These were my inner female thoughts. I have presented them in small text (below), as they were the little things that kept coming into my mind. I considered them small at the time, as they were new and young questions to myself. They would appear and then disappear only to return again. Something like being in early stages of pregnancy. One knows one is pregnant with something new, but it does not necessarily feel like one is pregnant as the thoughts about this idea move from being there, to not being there. Then at some point one knows, these questions have some legitimacy.

*How do I, through a method of analysis do justice to each woman’s story without modifying, distorting, interpreting or reducing each woman’s words and her experience?*

*How can each woman’s story stand as significant in itself without my judgments and interpretations?*
How can I adequately respect and validate the woman’s story beyond just using it as data for my analysis without any manipulation?

How does each woman’s story not become my object?

How would the research best assist other women?

How can I be sure that what I come up with at the end of the research will be very useful for women?

Will it be what women really need or will it be what I think is needed by women?

How useful will the data be for women?

What will it really do for women?

Do they want to know my conclusion and interpretation only, or do they want to hear and learn from various women’s narrative as well?

Through my research, how can each woman’s experience, her subjectivity be duly validated and valued?

How can it be valued to the same degree that objectivity and the medical gaze of the ‘other’ is valued in scientific research, and which is the main function of the biomedical model?

In making use of each individual diverse woman’s story as data, can I do justice to each woman’s story, or do I do justice to the method only.

I believe, these are moral questions for myself as a feminist qualitative researcher.

Underlying my questions was the feeling of fear I have that the real individual woman will be lost, as I believe she has been, when diagnosed as diseased by the scientific biomedical model. Importantly there was a strong sense to keep the woman herself very ‘present’ and
‘up front’ in an effort to ensure that she does not become invisible as a whole person. Therefore I have made the decision to include women, both menopausal and postmenopausal, together with menopause, very often when there is a reference to menopause. This will ensure that the woman stays present to the reader and is not get lost in the term menopause. For example, because the biomedical model’s diagnosis is on menopause, and my critique is on their diagnosis of menopause, therefore I will include both menopausal and postmenopausal women each time. It is because the biomedical model focuses on menopause only, not the whole woman that has allowed HRT/HT and its benefits or risks to become the main focus of heavily funded research whilst the totality of woman herself is missing and not considered.

Of equal importance to me was also the question:

How can my work be emancipatory for women rather than being useful data for my project only (using other people’s writings) being for my own purposes (my research)?

Hence my tentativeness in presenting my own interpretation, or label, or my own concepts through analyzing the research data. How then can I identify another way to approach this predicament rather than using a reductive analytical method that requires my own summary and interpretation of the woman’s stories?

Perhaps an emancipatory impulse would be to question the rule, and to seek freedom from the rule if it was not conducive to promoting and validating not only individual women’s experiences but also individual women’s authentic voices, ideas and theories. I wanted to be sure to allow each woman to stand in and behind their own diverse reality and I did not want to interpret it in any way. Postmenopausal women standing in their own realities and formally sharing this with many other women, allows freedom, and I believe is directed towards emancipatory ends for postmenopausal women.

In order to explore all my above questions in more detail, initially my own reflection on the practices of the scientific methods was required.
Philosophy of Science

According to Garry & Pearsall (1989) “philosophers of science are interested in questions that are presupposed by the practices of science” (p. 173). They noted what counts as proper scientific method:

- the connection between theory and observation
- models
- causality
- rationality
- objectivity
- values in science.

However, Garry and Pearsall state further that “Feminist philosophers and historians of science” have raised new issues for consideration and they ask whether science can serve what Sandra Harding calls “emancipatory ends‘ for gender, race, and class” (as cited in Gary & Pearsall, 1989, p. 173). Emancipatory ends for women can also be described as releasing women’s from restrictions that are oppressive for them.

Two oppressive restrictions indicated by Lerner (1986) which refer to the body, I believe, are particularly relevant to the issue of menopause for women. These are those that are imposed by sex, and also those imposed on women’s self-determination (p. 236). As Lerner explained:

> Freedom from oppressive restrictions imposed by sex means freedom from biological and societal restrictions. Self determination means being free to decide one’s own destiny; being free to define one’s social role; having the freedom to make decisions concerning one’s own body (p. 237).

Restriction is indicated by the biomedical diagnosis of disease. Therefore the menopausal woman as diseased indicates and implies the ‘woman’ as restricted. The word ‘disease’ then becomes the source of restrictive connotations. More importantly it remains the dominant discourse and dominant construct regarding the menopausal woman, thereby preventing the discourse that would be emancipating for the normal life cycle process of the menopausal woman.
This can have critical health implications for the menopausal woman as it indicates to the woman, community, society and the world that the woman is restricted for the second half of her life. The implications of this dominant paradigm holds sway resulting in the construct of ‘woman as restricted’. This then is instrumental in developing a society in which makes it more difficult for women to define new social roles for herself. As a restricted ageing human being, the menopausal and postmenopausal woman in not constructed positively in our culture. She is considered unable to make any worthwhile contribution. Instead she is diagnosed as ailing.

Even more critical and specific for the menopausal woman is the issue of how to emerge from under the “paternalistic dominance” (Lerner, 1986, p. 233) of the western scientific biomedical diagnosis, so she has the freedom to make decisions concerning her own body, in the form of what she decides are her needs, and, in addition to her needs as an important contributor, through her embodied experience as a woman, to society. This would mean shifting “the analysis from a form of technical knowledge to understandings that issue from women’s perspectives, whether experiential, theoretical, cultural, or political” (Komesaroff et al., 1997, p. 4). Therefore, in line with this thinking. I decided against the rule of interpretation and decided to leave the data to stand in the women’s own words exactly as they are presented in their texts. And furthermore, holding these women’s words up as the basis for a different discourse than that of biomedical science.

I now follow on with the checks and balances, which will be the guide to uphold the epistemological framework I am choosing, namely multimethodology and multimethods.
POSTMODERNISM

Postmodernism allows for difference and diversity of thinking. Rather than working within parameters of one discipline, postmodernism allows for thinking through multiple disciplines, or thinking in other ways. Postmodernism is described by McIntyre (1998) as “both/and thinking”, rather than either/or thinking’ is characteristic of what is now called post-modern thinking” (p. 26). McIntyre also goes on to say “[p]ost-modernist thinking is reflexive, contextual and open to the idea that there is no one solution for all situations. It is less bound to structuralist thinking limited to disciplines and single sectors “(p. 28). Postmodernism therefore allows for a multidisciplinary or interdisciplinary approach.

Postmodern/Poststructural Philosophies

Firstly, to the philosophies of Lyotard, Foucault, and Derrida as they have particular significance to the discourse analysis on biomedical texts. Then in the beginning of chapter four, the philosophies of French female philosophers, de Beauvoir, Irigaray, Cixous, Kristeva will signify the importance and value of women writing themselves, through their own internal experiences, into their own texts and into herstory.

Lyotard

Firstly, this research project builds on the work of philosopher Jean Francois Lyotard, born 1924. In his text The Postmodern Condition he states, “I define postmodern as incredulity toward metanarratives” (2004 p. xxiv). Lyotard is well known for his rejection of metanarratives, sometimes called grand narratives, whilst he also acknowledges local narratives, or micronarratives as just as important. As Laugharne and Laugharne state:

There is a disillusionment with the unifying ‘big stories’ offered by science, religion or politics to explain the way reality is. Instead people look towards the narratives of individuals or local communities, which are seen as less tyrannical – less demanding of mass allegiance. Instead of ignoring those who do not conform to a grand theory of everything, postmodern theory celebrates individual difference and non-conformity (2002, p.207).

Further, Laugharne and Laugharne “discuss the potential impact of postmodern philosophical and cultural change”, and state “that science is a discourse rather than a mechanistic process –
social, not neutral and objective. Science cannot lead to definitive statements about objective reality. Every experiment relies on a network of theories, opinions ideas and traditions of a community” (2002, p. 207-208).

Lytard’s work is extensive, but it is his words on knowledge that are particularly relevant, as it is necessary for knowledge to reach beyond western scientific truths (metanarratives) in search of local narratives, to enable the encompassing of wider and deeper knowledge regarding natural life processes and the human condition. This wider and deeper knowledge is also important in the search for an evolutionary impulse within the woman’s natural life cycle process, an impulse that has not been recognised formally beyond what is already known as disease. This project then is an in depth search for knowledge of the evolutionary meaning of the woman’s natural life-cycle process and phenomenon, rather than just simply a metanarrative of diagnosis of loss and lack of hormones (disease) which has been identified by western scientific biomedical practices. And in our culture, knowledge that is not accepted within a scientific paradigm is incommensurable, meaning it is impossible to measure, not in accordance with, and therefore inadequate.

Regarding tolerating the incommensurable and our sensitivity to differences, Lytard states: “[p]ostmodern knowledge is not simply a tool of the authorities; it refines our sensitivity to differences and reinforces our ability to tolerate the incommensurable. Its principle is not the expert’s homology, but the inventor’s paralogy…” (Lytard, 1994, p.28). Homology from the “Greek word origin, homologia agreement, from homologos agreeing” (www. Biology etc…), and paralogy in Lytard’s words “is a conversation that tries to break out of the old systems of thought” (Shawver, 2001, p. 245). And further by Fritzman (1990), “it is urged that Lytotardian paralogy – the constant search for new ideas and concepts that introduces dissensus into consensus …” (p. 371), ... or “new ideas and concepts which upset previously existing solidarities” (p. 373).

Lytoard believes that postmodern education and science are legitimated by paralogy, by the constant introduction of dissensus into consensus. That is, Lytard urges that postmodern education and science flourish, instead of stagnating, through the search for new ideas and concepts which disrupt and destabilize previously existing consensuses. The goal of
postmodern education and science is the discovery and invention of these new ideas and concepts (Fritzman, 1990, p. 372). From Lyotard himself:

> It is the changing of the meaning of the word knowledge, while expressing how such a change can take place. It is producing not the known, but the unknown. And it suggests a model of legitimation that has nothing to do with maximised performance but has as its basis difference understood as paralogy (2004, p.60).

Regarding knowledge, Lyotard (2004) further explains, “Knowledge is not the same as science, especially in its contemporary form” (p.18). He also identifies two important aspects of knowledge:

Knowledge, (*savoir*) in general cannot be reduced to science, nor even to learning (*connaissance*). Learning is the set of statements which, to the exclusion of all other statements, denote or describe objects and may be declared true or false (Lyotard, 2004, p.18).

Knowledge, then, is a question of competence that goes beyond the simple determination and application of the criterion of truth, extending to the determination and application of criteria of efficiency (technical qualification), of justice and/or happiness (ethical wisdom), of the beauty of a sound or color (auditory and visual sensibility), etc. Understood in this way, knowledge is what makes someone capable of forming ‘good’ denotative utterances, but also ‘good’ prescriptive and ‘good’ evaluative utterances… (Lyotard, 2004, p.18).

It is to the good and positive definitions and ethical wisdom of this natural life cycle process rather than the negative pathological definition that this research project seeks to locate, and it is postmenopausal women’s embodied narratives that have identified for us, good and positive, internally birthed life giving and life supporting impulses, in addition to external interventions.

Also Lyotard also makes the following point regarding knowledge:
It is not a competence relative to a particular class of statements (for example, cognitive ones) to the exclusion of all others. On the contrary, it makes ‘good’ performances in relation to a variety of objects of discourse possible: objects to be known, decided on, evaluated, transformed … From this derives one of the principal features of knowledge: it coincides with an extensive array of competence-building measures and is the only form embodied in a subject constituted by the various areas of competence composing it (Lyotard, 2004, pp. 18-19).

As has been identified in Chapter four of this thesis, the words of these postmenopausal women are not all cognitive statements, they move between both empiric and abstract concepts. Also the postmenopausal women’s narratives of the process of menopause can be seen as birthed and composed from a female embodied competence, from within the women’s bodies, minds, souls and spirits which indicate a wholistic health process which is more complex than a reductionist process. Lyotard has identified that a reductive system reduces complexity to maintain power. He states:

On the one hand, the system can only function by reducing complexity, and on the other, it must induce the adaptation of individual aspirations to its own ends. The reduction in complexity is required to maintain the system’s power capability (Lyotard, 1994, p.33).

Therefore, it is important that women can have access to more knowledge and complexity than the reductionist biomedical dominant discourse offers. An expanded knowledge creates the potential for greater power to enable increased control of their own processes. Thus women are enabled to make informed decisions about what they require beyond the control of what the dominant discourse only offers through its reductionist processes.

Finally, Lyotard’s above statements support my recommendation that the following postmenopausal women’s local narratives have value and power in their contribution to the complex knowledge of health care for menopause which goes beyond just the limited knowledge of the scientific, pathological diagnosis of loss and lack, and therefore disease. Philosopher, Michel Foucault’s work also addresses the power within health care practices and in particular why local narratives are important. It is to Foucault that I now turn.
Foucault

French philosopher, Michel Foucault, born 1926. As “[a] key postmodern theorist” according to Cheek, Shoebridge, Willis and Zadoroznyj (1996, p.173), his work has particular relevance to an analysis of health-care. Foucault’s concern is with the relationship between knowledge and power and how they shape our social reality. His works include analyses of sections of the health-care system, such as psychiatry in *Madness and Civilisation* (1971); medicine, *The Birth of the Clinic* (1973); and psychology, *Mental Illness and Psychology* (1976).

Foucault has identified how power and power relations operate through the silencing of other knowledges; knowledges that have been present but rejected and disqualified as inadequate to the task, those that have not been included in current knowledge or those that different to current knowledge. According to Foucault, these other knowledges, these different knowledges, are also important. Foucault emphasises plurality, difference and diversity rather than the structuralist modern notion of homogeneity within discursive entities (Best and Kellner, 1991).

In addition Foucault identified how disciplines of power constituted the subject and produced “docile bodies” (Grimshaw, 1993, p. 53). McHoul & Grace argue that:

> Foucault’s interest in social techniques is both critical and historical (for example, how do medical discourses during and before the twentieth century produce a particular kind of social subject; how does this limit ‘who we can be’; and what strategies are available for broadening or even defeating this limit? (1995, p. 30).

Foucault also talks about how the knowledge of discourses are always formed within a history, and how “they reside on a base of human practice and human history; and that since these things have been made, they can be unmade, as long as we know how it was that they were made” (Foucault 1990, p. 37). In addition, “Foucault thinks of discourse (or discourses) in terms of bodies of knowledge” and “The formal approach to discourse analysis considers discourse in terms of text” (McHoul & Grace, 1995, p. 27). Hence a discourse analysis on two texts on menopause published by high profile medical authors follows in Chapter Three of the thesis.
Foucault in his historical approach and analysis of medicine and public health uses the term ‘Genealogy’ “to describe his method of tracing the emergence of discourses, body of knowledge and power relations over time, to write a 'history of the present'” (Lupton, 1995, p.17).

Also:

According to Foucault … the genealogist ‘needs history to dispel the chimeras of the origin’, to demonstrate the fragmentary and heterogeneous nature of knowledges. Genealogy is also a means by which to trace the inscription upon the human body of events, to describe ‘the articulation n of the body and history’ … (Foucault, 1984, p.80 cited in Lupton, 1995, p. 17).

Further Foucault explains that the problems are not with the individuals or their thinking. “The problem is not changing people’s consciousnesses or what’s in their heads – but the political, economic, institutional regime of the production of truth” (Foucault, 1980 cited in Cheek et.al., 1996, p. 176). This can be seen as temporarily taking the focus off the individual to enable the focus to be on objectification, defining from outer sources (external to the subject), and to see how the definitions have occurred and been defined by the external authority and to ascertain as to the reality of this external definition or diagnosis. However, Foucault’s words of dispensing with the subject does not, I believe, mean that the subject is no more. It does means that the subject is dispensed with for the purpose of performing a genealogy, to ensure that the focus will not be on the subject, but will remain on the political, economic, institutional aspects of the research. In addition, Foucault recalls the individual subject as valuable, with their own knowledge thereby acknowledging diversity in knowledges rather than metanarratives. As Lupton states:

Genealogy is also a means by which to trace the inscription upon the human body of events, to describe ‘the articulation of the body and history’ (1984b, p.83). In doing so, Foucault was concerned to emphasize the discontinuity and non-linear nature of social change, to focus on local knowledges, or ‘discreet and apparently insignificant truths’ (1984b: p. 77). These include human emotions and abstract concepts such as morals, ideals, liberty, sentiments, love, conscience, instincts and how they emerge
and re-emerge in different roles or are absent at certain moments (Lupton, 1995, p. 17).

And Foucault himself refers to local knowledges, or ‘discreet and apparently insignificant truths’ which are disqualified, as subjugated knowledges.

By subjugated knowledges I mean two things: on the one hand, I am referring to the historical contents that have been buried and disguised in a functionalist coherence or formal systematisation … Subjugated knowledges are thus those blocs of historical knowledge which were present but disguised … and which criticism – which obviously draws upon scholarship – has been able to reveal. On the other hand, I believe that by subjugated knowledges one should understand something else … a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated; naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity … It is through the reappearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work (Foucault, 1980, pp. 81-82).

This is very significant, as the human emotions and the abstract concepts that have been identified by the postmenopausal women in their texts have been absent in the definition of menopause as disease, but at the same time many of them are very relevant to the woman’s experience as they have been revealed in the postmenopausal women’s narratives. These would be the disqualified, inadequate, insufficient, naïve knowledges located low down on the hierarchy, beneath the required level of cognition or science that Foucault refers to. These knowledges are in conflict with the dominant discourse as they are, according to the dominating scientific knowledge, inadequate and insufficient and in other words incommensurable. They appear in Chapter Four of this thesis. On this point Foucault states:

It is not therefore via an empiricism that the genealogical project unfolds, nor even via a positivism in the ordinary sense of that term. What it really does is to entertain the claims to attention of local, discontinuous, disqualified, illegitimate knowledges against the claims of a unitary body of theory which would filter, hierarchies and order them in the name of some true knowledge and some arbitrary idea of what constitutes a science and its objects (Foucault, 1994, p. 42).
Foucault has stated that it is through the reappearance of these so called illegitimate knowledges, these local knowledges, and these disqualified knowledges which are in conflict with the dominant scientific discourse that criticism performs its work. In addition, the value of critique also lies in its ability to make visible the need for different modes of action. In an interview with Foucault regarding conflicts, Foucault contends:

> It is a question of making conflicts more visible, of making them more essential than mere confrontations of interests, or mere institutional immobility. Out of these conflicts, these confrontations, a new power relation must emerge, whose first, temporary expression will be a reform. If at the base there has not been the work of thought upon itself and if, in fact, modes of thought, that is to say modes of action, have not been altered, whatever the project for reform, we know that it will be swamped, digested by modes of behaviour and institutions that will always be the same (Foucault, 1988, p. 156).

The purpose of this thesis was to critique two medical texts, together with reflection on postmenopausal women’s texts to define where change would be necessary in an attempt to alter the pathological negative biomedical scientific diagnose of the phenomenon of menopause. Through this process together with my method of juxtaposition, conflicts emerged and were highlighted which indicated a reform or a shift in paradigm as necessary and would involve a shift in the power relations. Regarding a critique, according to Foucault:

> A critique is not a matter of saying that things are not right as they are. It is a matter of pointing out on what kinds of assumption, what kinds of familiar, unchallenged, unconsidered modes of thought the practices that we accept rest (Foucault, 1988, p. 154).

Whilst Foucault has brought the relationship between power and knowledge to our attention it is Jacques Derrida who has developed a strategy of critique to enable the exploration of texts to expose the modes of thoughts on which dominant discourses function. Further Derrida’s strategy enables us to seek out and identify power relations and subjugated knowledges, those knowledges which have been disqualified as inadequate; or insufficiently elaborated; or those located low down on the hierarchy.
Derrida

It is to Jacques Derrida, born 1930, one of the most well-known philosophers of the twentieth century that I now turn, as his strategy enables through the critiques of texts, the sourcing of more knowledge which allows us to move and think beyond meta-narratives. This can serve as an evolutionary turn. Following on from or, “[d]istancing himself from the various philosophical movements and traditions that preceded him on the French intellectual scene (phenomenology, existentialism, and structuralism), Derrida, in the mid 1960s developed a strategy called ‘deconstruction’” (Reynolds, 2010, para.1).

Derrida in defining deconstruction as a strategy for use in texts, highlights how and where dominant paradigms operate through language and writing to subordinate, subjugate, marginalize and delete other aspects of a phenomenon, therefore of other aspects of knowledge. Deconstruction works through reading the text and defining the dualisms or binary opposites that maybe present. According to Norcross:

Deconstruction can perhaps best be described as a theory of reading which aims to undermine the logic of opposition within texts. For Derrida, this requires a scrutiny of the essential distinctions and conceptual orderings which have been constructed by the dominant tradition of Western philosophy (1996. p.136).

Derrida’s term deconstruction is most relevant to this research project, especially within the discourse analysis on the medical texts because the binary opposites of terms emerged from within these texts. Not only binary opposites, but one term has been elevated to a higher value at the expense of the other term and this in turn has been favoured as more acceptable than the secondary opposite term or value. As noted in the Internet Encyclopaedia of Philosophy:

Although not purely negative, deconstruction is primarily concerned with something tantamount to a critique of the Western philosophical tradition. Deconstruction is generally presented via an analysis of specific texts. It seeks to expose, and then to subvert the various binary oppositions that undergird our dominant ways of thinking … (Reynolds, 2010, para 1).
Although this research project did not originally set out to locate binary opposites from within the medical texts, binary opposites emerged and were identified through the process of the discourse analysis of (or in) the biomedical texts. The ‘losses’ of the menopausal phenomenon had been privileged at the expense of the ‘gains’, in other words, the decrease in hormones were the focus whilst the increases in hormones were marginalized, rejected and ignored in the medical diagnosis. Whilst the gains were acknowledged as a reality by the medical authors, the gains were then ignored, marginalised and finally dismissed altogether to enable the judgement of the diagnosis of loss and disease, therefore rejecting the meaning of these gains for the woman herself.

And according to Reynolds who cited Derrida’s writings on Paul de Man (1989), “[a]ll of the elements of a deconstructive intervention reside in the ‘neglected cornerstones’ of an already existing system”. In the case of menopause, the ‘gains’ in hormones were the ‘neglected corner’ of the biomedical texts. Clearly this is an example of how:

the definitional dynamic extends to the primary term as well in that it can only sustain its definition by reference to the secondary term. Thus the definition and status of the primary term is in fact maintained by the negation and opposition of the secondary partner (Cheek, et.al.,1996, p. 189).

Cheek et. al. also state:

Derrida holds that any positive representation of a concept or idea in language rests on the negative representation or negation of its ‘opposite’ or antithesis. As Derrida puts it, one term is always ‘dominant or prior’ and the other ‘subordinate and secondary’. Examples of dominant and subordinate terms are masculine/feminine, science/art, and reason /emotion. These terms are binary oppositions where the dominant term (e.g. masculine, science, reason) is given primacy over the secondary ‘weaker’ or derivative term in the pair that is defined in terms of ‘not the dominant’ (e.g. feminine art, emotion). However, the definitional dynamic extends to the primary term as well in that it can only sustain its definition by reference to the secondary term. Thus the definition and status of the primary term is in fact maintained by the negation and opposition of the secondary partner (1996, p. 189).
And “Derrida’s critique aims to expose the paradoxes, ambiguities and contradictions which destabilize the initial opposition” (Norcross, 1996, p. 137). In the case of menopause, the loss of hormones has been privileged over the secondary (subordinate) term which are the gains (increases) in hormones in the brain, these being Gonadotropine Releasing Hormone (GnRH), Follicle Stimulating Hormone (FSH) and Luteinizing Hormone (LH) all of which have been negated and allocated secondary (subordinate) status whereas the losses have been the focus and therefore the privileged primary term. This negation of increased hormones, together with their influence on the brain and the new meanings that these increased hormones create for the woman herself, have been totally ignored and deleted within the scientific biomedical diagnosis. And critical for all women and most importantly:

Derrida insists that the subordinate term has an equal claim to be treated as a system of possibility for the entire system. It is essential to recognise that binaries are not ‘natural’ or given but are themselves artefacts of, and contributors to, dominant discourses (Cheek, 1996, p. 189).

In the case of menopause then, for the woman herself, the secondary, subordinate term of ‘gains’ has both an equality and equity claim of importance to the phenomenon. It is Derrida’s following assertion that has further specific relevance to my intention in this research, which is to explore postmenopausal women’s texts for their perspectives and experiences of menopause. Derrida asserts “[g]o where you cannot go, to the impossible, it is indeed the only way of coming or going” (Reynolds, 2010, para.12).

Derrida’s above words are instructive and congruent with my own intentions to go to postmenopausal women’s texts as they present the impossible as an alternative source of knowledge according to the scientific biomedical reductionist process of dualisms. The postmenopausal women’s experiences and theories (revealed in Chapter Four), in relationship to the scientific diagnosis, would not be acceptable according to Western scientific practices, as they would be incommensurable.

I believe Derrida’s comment ‘it is the only way of coming or going’ can reveal the content between the binaries of loss and gains that provides us with the richness and depth of meaning of the menopausal phenomenon. In addition, to accept the content between binaries requires
movement, that is the ability to move from one’s known dominant term to one opposite term, and also including them both together with and all others that sit in between the space and movement back and forth. Regarding menopause the terms that are presented by postmenopausal women vary considerably and not every woman will experience the transition in exactly the same way. In addition, not all terms including the diagnosis of disease are acceptable to all women; therefore there is a range that justifies a space for ‘differánce’ and acceptance of the movement between one or the other polarity. I believe this is similar to Derrida’s term ‘differánce’. Derrida defines differánce as:

The systematic play of differences, of the traces of differences, of the spacing by means of which elements are related to each other. This spacing is the simultaneously active and passive … production of the intervals without which the ‘full’ terms would not signify, would not function (Derrida, 1872/1981, p. 13 as cited in Diprose, 2009, p. 11).

Therefore, I adopt Derrida’s term differánce as a term that can define the space that exists between the two terms, the space between the preferred and non-preferred term, between the active and passive terms, where all are acceptable and where there is no hierarchy present. This is echoed in my chosen method of ‘Creating Conceptual Meaning’ defined by Chinn & Kramer (1999), out of which has emerged many unearthed terms which have been suppressed, oppressed through scientific biomedical marginalisation and deletion of the gains in support of a reductionist method. Through the method of creating conceptual meaning and my method of juxtaposition, this space between the active and passive terms as been invested with various empiric and abstract terms, which sit between both the losses and gains of menopause. In addition, “[d]econstruction not only scrutinizes the primary texts of Western culture, it also reflects on the readings and interpretations which have predicted the status of these dominant works” (Norcross, 1996, p. 137). In particular “Derrida’s critique of conceptual oppositions is often facilitated by his focus on what has been relegated to the margins of a text’s argument” (Norcross, 1996, p. 137).
Chapter Two – Methodology and Methods

Criticism of Derrida’s Deconstruction

Finally, a word regarding criticism of deconstruction. According to Cheek:

> Deconstruction has been criticised for being essentially destructive: by displacing and negating perceptions of reality nothing is left in its place. However this is to misinterpret the project of deconstruction. Deconstruction seeks to expose taken-for-granted assumptions underpinning our very concept of reality itself in order that from such informed understanding action can then take place. It does not, and should not seek to replace one set of binaries with another. There can be no closure to deconstruction as it constantly probes the way in which views are constructed. Deconstruction challenges, rather than overturns and abandons, all existing beliefs and opinions. With respect to the health arena, deconstruction enables the unravelling and exposure of the otherwise invisible assumptions that have shaped contemporary health-care practice (Cheek, 1996, p. 191).

In responding to this criticism I would agree that binaries should not be replaced with the subordinate or secondary terms. To avoid this occurring and also to avoid ‘nothing left in its place’ is to pick up Derrida’s message ‘to go there where you cannot go’, to seek out the variables that have a place between the binary positions, to fill the ‘nothing left in its place’. This is a process which would consider and include all the binaries, together with those in between as well. It could also allow movement between one binary and the other. This is an inclusive stance and is in total contrast to the theory of a hierarchical value.

The potential of Derrida’s work resides “in its persistent questioning of the ideologies, dogmatisms, and hierarchies of existing political thought” (Norcross, 1996, p. 138-9). To this end, this research aims, through Discourse Analysis to question the diagnosis of menopause as a disease through ‘loss’ as the hierarchical term, and the domination of this political thought. An additional aim is to explore the subordinate term through the women’s narratives in Chapter Four.

More fundamentally Derrida’s aim is not at the “dissolution of analytic distinctions altogether” but to “displace and reinscribe concepts into larger and more encompassing
contexts” (Norcross, 1996, p. 136). In doing so he also attempts to “prise open the metaphysical closures of Western philosophy” (Norcross, 1996, p. 136). In this thesis closure in seen in the western philosophy of Descartes’ and his theory of Cartesian dualism and the dominant Western scientific pathological diagnosis that needs to be prised open. The process of discourse analysis is a method that revealed this closure.

As stated by Norcross:

To affirm a politics of deconstruction would perhaps be premature, but its potential may reside in its persistent questioning of the ideologies, dogmatisms and hierarchies of existing political thought. This impulse may not spark a revolution, but it might ensure a democratic vigilance towards post revolutionary complacencies (1996, p. 138-9).

Derrida’s undermining of the logic of oppositions, opens the door for the first step towards the creation of different knowledges that can only serve to give women more choices of knowledge than the knowledge they have already received as result of historical and present theories regarding the menopause phenomenon. This serves to allow evolutionary impulses to occur. It makes sense to me therefore to access the knowledge of postmenopausal women’s own internal bodily experiences, including their experiences of the natural increases in hormones, rather than just their symptoms. This is addressed in Chapter Four.

**Affirmative Postmodernism**

In this project I take an affirmative postmodern stance, one that delineates from the sceptical postmodernists. The sceptical postmodernists offer a “pessimistic, negative, gloomy assessment, argue that the post-modern age is one of fragmentation, disintegration, malaise, meaningfulness, a vagueness or even absence of moral parameters and societal chaos…“ (Rosenau, 1992, p. 15). Rosenau describes these further as distrusting and says “They emphasize the negative and lack confidence or hope in anything.” They are inclined to anticipate the worst possible outcome” (p. 15). Further regarding the affirmatives:

The affirmative post-modernists, also referred to as simply the affirmatives, agree with the sceptical post-modernist critique of modernity; they have a more hopeful,
optimistic view of the post-modern age … The generally optimistic affirmatives are oriented toward process. They are either open to positive political action (struggle and resistance) or content with the recognition of visionary, celebratory personal nondogmatic projects (p. 16).

Most importantly affirmatives have ethical concerns. I too have ethical concerns and this becomes evident as the thesis moves along. And as Rosenau states “Most affirmatives seek a philosophical and ontological intellectual practice that is nondogmatic, tentative, and non ideological. These post-modernists do not, however, shy away from affirming an ethic, making normative choices, and striving to build issue-specific political coalitions” (Rosenau, 1992, p. 16).

**Postmodernism and Poststructuralism**

Postmodernism and postructuralism are closely aligned with each other. I refer briefly to the relationship between postmodernism and postructuralism. The main distinction between the two is: “[p]ostmodernism is a theory of society and culture (following Foucault and Lyotard) and Postructuralism is a theory of knowledge and language (following Derrida)” (Cheek, Shoebridge, Willis, & Zadoroznyj, 1996, p. 189).

In this thesis I have chosen postmodernism as methodology as I consider postmodernism as an umbrella term, as it allows with its overarching expanse for cultural, political and social dimensions, and can also include the poststructural lens utilized for the discourse analysis of the medical texts. Exploration of menopause cross culturally has revealed that this Western scientific biomedical diagnosis of ageing women as pathological and deficient is not common to all other cultures. In various other cultures ageing menopausal and postmenopausal women are valued very highly as important contributors to the culture, rather than being seen as sick or deficient. It is our Western culture that has promoted this dominant biomedical paradigm which is supported by drug companies. This can be seen as a culturally bound diagnosis.

I have employed a poststructuralist approach to explore further, and in more detail, the conceptions and birthing of the diagnosis of menopause as disease as this knowledge is
presented in medical journals and texts. The exploration of texts within the poststructuralist perspective, utilized the ‘interdisciplinary approach to enquiry as noted by Cheek et al. (1996). This is termed discourse analysis and is the method I utilized. “Discourse analysis explores the discourses used to construct the everyday world of healthcare practices” (Cheek et al., 1996, p. 184).

Also according to Cheek (1996), “[u]nderpinning discourse analysis is the notion of discourse as determining and limiting the range of possibilities by which reality is constructed. Such discourses find expression in language as a meaning constituting system” (p. 184). Cheek et al. further suggest:

Consequently, discourse analysis involves more than content analysis, a study of semiotics, or ethnomethodology as it seeks to move the analyses into the cultural, political and social dimensions that have shaped both the form and the content of language in the first place (p. 184).

It is for this reason that I also employed a postmodern methodology as it was important to explore also the cultural, political and social dimensions of the phenomenon. Cheek goes on to explain this as both “the meanings as they are represented in texts, and the texts themselves, are framed by powerful hegemonic discourses.” Cheek also explains that the “text is not a dependent variable, or an illustration of another point, but an example of the data itself” (Lupton 1992, cited in Cheek et al. 1996, p. 185). I now move on and refer to postmodernism in more detail.

POSTMODERNISM EXPLORED
To clarify, describe and understand postmodernism, I think further detailed exploration is required. This is also an attempt to define a suitable method that will be congruent with a postmodern-feminist approach. I now refer to Pauline Rosenau (1992) as her book Post-modernism and the Social Sciences defined and described postmodernism extensively. Rosenau described that which is particularly relevant for my work, postmodernism’s all-encompassing acceptance of many views, and the equal place it prescribes to each. The questioning stance of the postmodernists she also described in the following extensive explanations. Extensive explanations, I believe are important when discussing, reflecting, and
contemplating a phenomenon through a post-modern lens. In contrast to a modernist approach, the postmodern is not easily defined in brief, succinct statements. The very nature of its inclination towards a wider vision, its inclusiveness, by its acceptance of many truths, in effect rejects the tendency to knowing one truth, and therefore the difficulty to give an explanation in a short statement. It denies brief explanations. This is in contrast to the modern, to the true, hard and fast rules and facts, where supposedly correct statements regarding the truth can be pronounced as dogma in clear, concise, and brief statements. Postmodern just by its nature, appreciates a bigger picture and the expansion of the phenomena. It seeks out a more diverse vision and continues to search. I therefore consider Rosenau’s (1992) own words, themselves very descriptive, very much in the vein of the postmodernist, and very relevant to postmodern visions.

True to post-modernism, Rosenau (1992) herself does not state truths, but gives us descriptive pictures. Hence her lengthy descriptions are appropriate and worthy of presentation for a deeper understanding of the character and philosophical thinking of postmodernism. Her writing itself, I believe reflects the post-modern. It is rich in its explanations. She herself, is a good example of one with a larger vision.

Postmodernists question any possibility of rigid disciplinary boundaries between the natural sciences, humanities, social sciences, art and literature, between culture and life, fiction and theory, image and reality in nearly every field of human endeavour …. They consider conventional tight definitions and categorizations of academic disciplines in the university context simply to be remnants of modernity. No surprise, then, that post-modern trends, breaking through these boundaries, are apparent in architecture, art, dance, film, journalism, linguistics, literary criticism, literature, music, philosophy, photography, religion, culture, theatre, and video, as well as in the social sciences and, increasingly, the natural sciences (pp. 6-7).

Less rigid boundaries are indicated as more appropriate. Rosenau (1992) referred Michel Foucault as “an example of the cross-disciplinary character of post-modernism”. He, himself, “was at once a philosopher, historian, social theorist, and political scientist” (p. 7).
Furthermore, referring to various postmodern writers, Rosenau (1992) explained:

Postmodernists question the superiority of the present over the past, the modern over the pre-modern...They reject any preference or the complex, urban life-style of the intellectual over the rural routine of the peasantry in the countryside. Therefore, they attribute renewed relevance to the traditional, the sacred, the particular, and the irrational...All that modernity has set aside, including emotions, feelings intuition, reflection, speculation, personal experience, custom, violence, metaphysics, tradition, cosmology, magic, myth, religious sentiment, and mystical experience ... takes on renewed importance (p. 6).

This indicates post-modernism as exploratory in a very wide sense. Its value is expansion and inclusiveness, rather than exclusiveness. Inclusiveness can be seen as a priority, as postmodernists reject preferences for superiority and allow for the importance of, the reverence of, and the inclusion of 'others'. This is indicated by their less rigid boundaries.

And for Postmodernism itself, Rosenau (1992) cites a number of scholars and explores a range of constructs.

Postmodernism challenges global, all-encompassing world views, be they political religious, or social. It reduces Marxism, Christianity, Fascism, Stalinism, capitalism, liberal democracy, secular humanism, feminism, Islam, and modern science to the same order and dismisses them all as logocentric, transcendental totalizing meta-narratives that anticipate all questions and provide predetermined answers. All such systems of thought rest on assumptions no more or no less certain than those of witchcraft, astrology, or primitive cults .... The post-modern goal is not to formulate an alternative set of assumptions but to register the impossibility of establishing any such underpinning for knowledge (Ashley & Walker 1990a) ... to ‘delegitimate all mastercodes’ (Hassan 1987, p. 169). The most extreme post-modernists urge us to be comfortable in the absence of certainty, learn to live without explanation, accept the new philosophical relativism (Bauman 1987).
Importantly, she warns not to formulate alternative sets of assumptions as underpinning for knowledge. More specifically do not assume or make any other interpretations as underpinnings for knowledge.

According to Rosenau (1992), “[t]he postmodern challenges to modern rational organization radiates across fields” (p. 7). She quoted the following as illustrating “post-modernism’s radically interdisciplinary character”:

Post-modern art, therefore, emphasizes the aesthetic over the functional. In architecture this means abandoning a modernist, efficient, pragmatic layout of mass and space and, instead, ‘giving people buildings that look the way they feel,’ that is, that reflect alienation, anxiety, chaos (Seabrook 1991). Appearance and image have priority over the technical, practical, and efficient (Hutcheon 1986). In literature challenging rationality leads postmodern novelists to suspend strict linearity of plot: any organized story elements or design must be provided, invented by each reader. In psychology it questions the conscious, logical, coherent subject (Henriques et al., 1984). In the fields of administration and public planning, suspicion of rational organization encourages a retreat from central planning, a withdrawal of confidence from specialists and experts. In political science it questions the authority of hierarchical, bureaucratic decision-making structures that function in carefully defined, non-overlapping spheres. In anthropology it inspires the protection of local, primitive cultures and opposition to ‘well-intentioned’ First World planned intervention that seeks to modify (reorganize) these cultures. In philosophy this translates into a renewed respect for the subjective and increased suspicion of reason and objectivity (p. 7).

I refer to the statement that appearance and image have priority. Whilst this maybe ideal in some situations, it would not be ideal in health care situations where action is necessary also. In these situations, the technical, practical and efficient would also be required. These aspects also need to be addressed and considered in addition to, and in conjunction with, postmodernism’s emphasis on the aesthetic. For further consideration by me is the question, ‘what would be the impact of the postmodern challenge on the issue of menopause and the menopausal woman?’
Most importantly the following words are very significant. Whilst post-modernism may be unsettling to some, maybe because of its almost flippant character, it does have a serious component. According to Rosenau, there is a genuine concern present. She states:

Postmodernists in all disciplines reject conventional, academic styles of discourse; they prefer audacious and provocative forms of deliver, vital and intriguing elements of genre or style and presentation. The distinctness and specificity of post-modernism itself is certainly, in part, a function of these characteristics. Such forms of presentation shock, startle, and unsettle the complacent social science reader. They are explicitly designed to instigate the new and unaccustomed actively of a post-modern reading. Post-modern delivery is more literary in character while modern discourse aims to be exact, precise, pragmatic, and rigorous in style. But the post-modern emphasis on style and presentation does not signify an absence of concern with content (pp. 7-8).

Postmodernism then, could be seen as being genuinely concerned with issues, and especially content. A concern that prompts a search for many perspectives of an issue or phenomenon. One truth is too limiting as the total all-knowing form of knowledge of a phenomenon. It seeks to present and explore issues from many perspectives to enable a more holistic understanding of one phenomenon. I believe it is a wise stance. Feminism also upholds the value of difference and diversity of women’s experiences. Before further exploring, a brief reference to modernity could be appropriate to enable a backdrop for the purpose of highlighting the emergence of post-modernism.

Post-modernism can be seen as a reaction to modernity. Briefly, Rosenau (1992) provides a sense of the purpose of modernity. The following allows an image of the modern age:

Modernity entered history as a progressive force promising to liberate humankind from ignorance and irrationality, but one can readily wonder whether that promise has been sustained. As we in the West approach the end of the twentieth century, the ‘modern’ record – world wars, the rise of Nazism, concentrations camps (in both East and West), genocide, worldwide depression, Hiroshima, Vietnam, Cambodia, the Persian Gulf, and a widening gap between rich and poor (Kamper and Wulf 1989) –
makes any belief in the idea of progress or faith in the future seem questionable. Post-
modernists criticize all that modernity has engendered: the accumulated experience of
Western civilization, industrialization, urbanization, advanced technology, the nation
state, life in the ‘fast lane’. They challenge modern priorities: career, office,
individual responsibility, bureaucracy, liberal democracy, tolerance, humanism,
egalitarianism, detached experiment, evaluative criteria, neutral procedures,
impersonal rules, and rationality (Jacquard 1978; Vattimo 1988). The post-modernists
conclude there is reason to distrust modernity’s moral claims, traditional institutions,
and ‘deep interpretations’ (Ashley 1987). They argue that modernity is no longer a
force for liberation; it is rather a source of subjugation, oppression, and repression
(Touraine 1990) (p. 5).

More specifically:

Almost all post-modernists reject truth even as a goal or idea because it is the very
epitome of modernity (citing Foucault 1984; Ashley 1989a). Truth is an
enlightenment value and subject to dismissal on these grounds alone. Truth makes
reference to order, rules, and values; depends on logic, rationality, and reason, all of
which the post-modernists question. Attempts to produce knowledge in the modern
world depend on some kind of truth claim, on the assumption that truth is essential
(Rosenau, 1992, p. 77).

Postmodernists then, claim that there is no one truth that can be claimed at the truth.
Searching for the truth is not a goal for postmodernists. Rather what is important for
postmodernists is to search for and acknowledge what is omitted, rejected, cancelled out, de-
centred or ignored in the goals of modernity.

**Postmodern – Concern with Content**

I refer to postmodernism once again to enable further explanation. Rosenau (1992) stated
succinctly but also in more detail. This is true to her style, as her descriptions do not leave us
unclear or unsure. She continued to search for more words, rather than less words, as
Post-modern social science focuses on alternative discourses and meaning rather than other on goals, choices, behaviour, attitudes … and personality. Post-modern social scientists support a re-focusing on what has been taken for granted, what has been neglected, regions of resistance, the forgotten, the irrational, the insignificant, the repressed, the borderline, the classical, the sacred, the traditional, the eccentric, the sublimated, the subjugated, the rejected, the nonessential, the marginal, the peripheral, the excluded, the tenuous, the silenced, the accidental, the dispersed, the disqualified, the deferred, the disjointed – all that which ‘the modern age has never cared to understand in any particular detail with any sort or specificity’ (Nelson 1987, p. 217).

Post-modernists, defining everything as a text, seek to ‘locate’ meaning rather than to ‘discover’ it. They avoid judgment, and the most sophisticated among them never ‘advocate’ or ‘reject’, but speak rather of being ‘concerned with’ a topic or ‘interested in’ something. They offer ‘readings’ not ‘observations’, ‘interpretations’ not ‘findings; they ‘muse’ about one thing or another. They never test because testing requires ‘evidence’, a meaningless concept within a post-modern frame of reference (p. 8).

One particular sentence here, I consider very relevant as a guide to my thinking regarding an appropriate method for my research. Whilst maintaining an interest and concern, postmodernist avoid judgement, never advocating nor rejecting. But their rejection of testing could prove a problem for biomedical science. Rosenau (1992) continued, and although referring once again to social science, her indications could be relevant to biomedical science. The last paragraph highlighted the task of postmodernism and gives direction for a suitable method.

Postmodernists rearrange the whole social science enterprise. Those of a modern conviction seek to isolate elements, specify relationships, and formulate a synthesis; post-modernists do the opposite. They offer indeterminacy rather than determinism, diversity rather than unity, difference rather than synthesis, complexity rather than simplification. They look to the unique rather than to the general, to intertextual
relations rather than causality, and to the unrepeatable rather than the re-occurring, the habitual, or the routine. Within a post-modern perspective social science becomes a more subjective and humble enterprise as truth gives way to tentativeness. Confidence in emotion replaces efforts at impartial observation. Relativism is preferred to objectivity, fragmentation to totalization. Attempts to apply the model of natural science inquiry in the social sciences are rejected because post-modernists consider such methods to be part of the larger techno-scientific corrupting cultural imperative, originating in the West but spreading out to encompass the planet (Lyotard 1984). Post-modernists search out the intellectual weaknesses, excesses, and abuses of modernity. They speak to ‘puzzles’ and strive to ‘illuminate’ general issues, not an easy task if at the same time an effort must be made to avoid offering an alternative point of view (p. 8-9).

MY CONCERN

To ‘illuminate’ the issue and phenomena of menopause is very much my concern. At this point, I do not wish to give a final ‘finding’ as a result of my research. To do this, I would need to offer my own alternative point of view. Rather than offer an alternative point of view, I intend to highlight, by bringing forth more perspectives, in an effort to ‘illuminate’ alternatives to the one ‘universal truth’ of the Western scientific biomedical model of menopause. My task is to explore across disciplines as well as from women themselves, thereby allowing a more encompassing presentation of the phenomenon.

I now see that my procedures will require me to adopt a model, which allows for the ‘inclusion of many’, rather than ‘an analysis of the many’. Analysis of the many would result in a reduction of the material to allow my own label or interpretation of the data, thereby resulting in my interpretation of the ‘truth’ from the data. This would be a limited interpretation (my own) and a simple portrayal of menopause as analysis, which is defined as “resolution into simple elements” (Webster Dictionary, 1965). Alternatively, inclusion of all the data as it is presented would allow for a wider vision that is more ‘total’ or ‘wholistic’ in its effect, rather than an interpretation that is limited by my own single perspective of menopause. Multiple representations that are allowed to stand as they are presented, would, I
believe, be relevant to the methodological perspectives of both postmodernism and feminism as both acknowledge the value of diversity and difference. Accordingly, reducing or minimizing the diversity of perspectives would not support my choice of methodology, as it would not allow multiple representations to stand as they are presented. To simplify or reduce in any way, a complex phenomenon, I believe is not congruent with my approach.

Further, according to Rosenau (1992), postmodernism:

- rejects epistemological assumptions,
- refutes methodological conventions,
- resists knowledge claims,
- obscures all versions of truth, and
- dismisses policy recommendations (p. 3).

The last point is very relevant to my project and is a need of further explanation. Dismissing and rejecting ‘menopause as disease’ together with the prescribed intervention of HRT/HT implies dismissing the policy recommendations, exemplified in the Medicare rebate, as well as the lack of Medicare rebate for any other interventions put forth by the dominant Western scientific biomedical paradigm. How does post-modernism justify this? If it ‘dismisses’ how can it be totally encompassing? This is a dilemma, which I believe needs to be addressed at the level of ‘methods’. The policy recommendation of menopause as disease, and HRT/HT as appropriate intervention, is based on or is the result of scientific empirical methods. It is a construction of the Western scientific biomedical model, where disease is the focus and the operable word. Ultimately the task of the biomedical model is to search for disease. It considers the woman’s body at middle age to be out of step with her so called ‘biological role’ and therefore a diseased body. In the process, the total woman becomes invisible, as the disease is made visible. Or in other words, the disease is visioned as central and the prescription to target the disease is the policy recommendation of HRT/HT. In the process the woman is lost and the disease becomes the centre of attention and the focus. Accordingly, post-modernists could be correct in dismissing this policy recommendation, as this is based on one truth only, that of menopause as disease which remains the dominant paradigm for the menopausal woman in our society. In addition, feminists would claim to
keep the woman central, or in other words, the woman’s story and her individual needs is just as important and central as the vision of disease which the biomedical model upholds.

A method that reflects a model that is inclusive of all processes and realities can be acceptable to all. A policy recommendation that is based on many individual experiences could be in line with both and therefore more acceptable and more appropriate to both postmodernism and feminism. A reductionist method does not allow for multiple realities to stand and be present. It deletes and does away with the broader net. I aim to keep the broader net. The policy recommendation of menopause as disease, with HRT/HT as magic bullet, is based on or is the result of scientific empirical methods of knowing, where one truth only rules.

**Affirmative postmodernism and the return of the new subject**

It is acknowledged that the notion of authenticity in postmoderism is problematic (Diamond, 2006). Further it is recognised that there is a proliferation of postmodern theories (Rosenau, 1992). In the present research ‘authenticity’ and the ‘authentic voice’ is located within the more affirmative postmodern perspective. This perspective proposes that, rather than the death of the subject, there is a return of the new subject with limited authority to tell stories of embodied knowing and personal meaning (Diamond, 2006; Rosenau, 1992). Embodied knowledge is further explored by Game (1991, p.192) who argues “the body provides the basis for a different conception of knowledge: we know with our bodies. In this regards, the authentic of experience might be reclaimed; if there is any truth, it is the truth of the body”.

As the focus of the research is an experience of bodily changes and transitions, Watson’s (1999) notion of the postmodern ’body-as-subject’ situates the authentic voice within bodily knowing. Wright and Brajtman (2011, p.25) suggest that “[w]e experience the world through our bodies, and our sense of our own body is inexorably linked to our sense of self”. Embodied knowing can therefore be conceptualised as knowing through our bodies as we live our experience of the world (Sodhi and Cohen, 2012, Grosz, 1994). The ‘body-as-subject’ is therefore not restricted to physical sensations but is negotiated discursively through “socio-material practice” … and “networks of relations that produce ‘knowing locations’ (Mulcahy, 2000) “… (Woodcock, 2010, p.360). In relation to this present research and women’s stories of menopause Lang (2011, p. 95) expands on these ideas suggesting that “[w]hen knowledges
are understood as embodied and situated socially, culturally, racially, sexually, linguistically, and politically; [then] knowledge claims spring from contexts that include the affective and subjective along with personal testimony…”

Therefore, if embodied knowing is the context (Lather, 1991) or location that frames the storyteller’s reality, then it is argued that reality is within us (Natoli, 1997). Given this, reality is specific to time and place (Game, 1991). Authentic knowledge claims are situated within local narratives and are therefore slices of reality or partial truths (Diamond, 2006, Game, 1991). Drawing on Haraway’s (1991) notion of “situated knowledges” Emad (2006, p. 199), further suggests that “embodiment must be the core of knowing, and knowing then must always be partial and local”.

The author of the menopausal story is an interpreter of this bodily knowing within the community of other menopausal and postmenopausal women, and to other readers. This then becomes a shared reality (Atkinson, 1990) which is echoed in Emad’s (2006) storytelling research with women with endometriosis. Emad (2006) speaks of the embodied community brought forth in the enactment of the story of the pain of endometriosis. This discursively created communal embodiment allows for stories of fragmented and multiple realities (2006). Therefore, rather than a strong ant-realist stand the postmodern position in this thesis proposes that existence is not uniform or identical (Natoli, 1997) and that reality has to do with representation of each woman’s bodily experience. What we realise or observe as represented takes place within the context of the reality of our circumstances, and it is what we attend to within the discursive space; this then frames our reality.

In summary, in this research ‘authenticity’ and the ‘authentic voice’ arise from the bodily personal knowing of a postmenopausal woman which becomes a story of a contextualised (Lather 2001; Lather 2002) and shared reality that is partial and specific to a particular time (Lather 2002, Rosenau, 1992) and space (Game, 1991). In addition it is a particular personal experience within a social context.

METHODS AS DRIVEN BY MY METHODOLOGY
Rosenau (1992) stated that post-modernists are “not inclined to use the word method, though they sometimes discuss strategies or struggles around truth and knowledge in terms that
approximate methodology” (p. 116). As I am approaching my research through a post-modern/feminist lens, this would seem to be significant for my work, as it should influence my choice of methods. Because of this I wish to refer to Rosenau’s (1992) further elaboration concerning methods. The following points, I consider to have particular relevance.

1. Post-modernism is oriented toward methods that apply to a broad range of phenomena, focus on the margins, highlight uniqueness, concentrate on the enigmatic, and appreciate the unrepeatable (p. 117).

2. Post-modern social science presumes methods that multiply paradox, inventing ever more elaborate repertoires of questions, each of which encourages an infinity of answers, rather than methods that settle on solutions. All its methods relinquish any attempt to create new knowledge in the modern sense of the word (p. 117).

3. As substitutes for the scientific method the affirmative post-moderns look to feelings (citing Hirschman 1997), personal experience, empathy, emotion, intuition, subjective judgment, imagination, as well as diverse forms of creativity and play. (Todorov 1984 cited in Rosenau, 1992, p. 117)

This then, can be seen in contrast to the modern reductionist methods that aim to produce explanatory generalizations in the form of labels. This brings me to a critical point. If all postmodern methods relinquish any attempt to create new knowledge; what method would be appropriate for discussing ‘strategies or struggles’? I believe a postmodern method could be
one that originates in a display of, or array of, meta-knowledge. Or more precisely one that enables a wider vision of many knowledges. This it seems to me would allow one to consider alternative strategies to deal with the phenomenon, or on the other hand to survey the struggles that maybe occurring within different ways of thinking. This would, by displaying ‘many’ or ‘meta’ knowledges, be more congruent with both postmodern and feminist perspectives and would proclaim and uphold diversity as a value. Therefore to enable maintaining or containing multiple knowledges, I believe a different philosophy and framework is initially required. This would enable knowledge from other disciplines beyond the scientific discipline to have a place also.

**Feminism and Women’s Health**

As menopause is distinctively a women’s health issue, I think it important to focus specifically on what would be required to assist women with their specific issues. Through my own experience as a woman, I know that the medication, Hormone Replacement Therapy (HRT/HT) is often limited in its effect to aid women’s health problems and well-being. It is not the one and only requirement that women may need to be healthy. For a truly feminist approach a brief consideration of ‘women’s health’ is appropriate here.

Dan, Jonikas & Ford (1994), in their book *Reframing Women’s Health* noted that a critique of the medical model has two components which are related but distinct aspects of 20th century medicine:

(a) Criticism of the hierarchical organization of health institutions  
(b) Criticism of biomedical science as it is applied to women’s health (p. 387).

(a) Criticism of the hierarchical organisation of health institutions is indicated by Dan, Jonika & Zylphia (1994) as follows:

Another important lesson from post-modernist theory is the relationship of power to definitions of reality. Hierarchical systems, like doctor-patient or doctor-nurse relationships, define reality from the standpoint of the dominant group. This means that ‘health’ for the subordinate is defined as what looks good to the dominant (p. 387).
And menopause has been defined by men. Dan et al (citing Bartlett, 1991) state that “[i]n feminist legal thought, this has been referred to as ‘positionality’” (p. 387). It is also reflected in feminist standpoint theory.

What concerns me is that health is defined as what looks good to the dominant group. Even of more concern is what looks good to the dominant group in the case of menopause, namely the diagnosis of disease for a life cycle process. What comes into question then is the one and only prescription of HRT/HT, as it has been conceived from a dominant standing over or overlooking others, position. For women, this places them in a disempowering position, as the power is being held by the dominant group rather than in women themselves. This prevents women having a voice in their health needs at this time in the ageing process, and more importantly, they are disempowered in relation to what prescriptions would be of more benefit to themselves and their well-being.

(b) In referring to the critique of biomedical research, Dan et al. (1994) indicated that it is “a positivist model of science which is reductionist, with an over-emphasis on universal truth, and an objective stance that mystifies the values and interests behind the scientist mask” (p. 387).

Again, the one universal truth of menopause as disease, emerging from the objective stance and scientific medical gaze only, and the prescription of HRT/HT, are hailed as the only way, the proven way and the dominant paradigm. Much research money is invested in proving the benefits of this prescription, employing infallible scientific methods, where objectification and reductionism have central place.

In addition, as a contrast to the medical model, Dan et al. expressed the following:

Post-modernist theory, particularly as expressed by feminist writers (citing Haraway 1989, 1991, and Harding 1991), is especially helpful in understanding the multiplicity of what we call reality, how it is knit together from fragmentary experience, and that who does the knitting determines the design. We want to create a many colored quilt (citing Anderson 1993), a collage, a tapestry or a dinner party to which we all contribute (citing Chicago 1979) (1994, p. 387).
This very descriptive piece of writing is also an example of how we could represent women’s experiences, and it also indicates how we could be totally inclusive, enabling each women’s story or writing to stand as it is, and to be representative, together with, and alongside others. This will allow many writings in the foreground, a very full collage, a compelling tapestry, an intricate representation of many women, thereby making a statement about the value and importance of validating the gift, richness and contribution of the multiplicity of women’s voices, stories, thoughts and ideas. In this structure there is no standing over. It allows for ‘equality and enquiry’.

To counteract then, and to balance out the modern limited view, and to enable a view of greater understanding rather than a ‘standing over’, a wider vision which considers views from women themselves is required. To enable this, a structural framework that enables containing and maintaining a breadth of views, is also required.

**Discourse Analysis as Method**

Firstly, what is discourse? Some aspects of discourse have been discussed in the section on postmodernism. According to Cheek, Shoebridge, Willis and Zadoroznyj (1996) “[d]iscourse is ‘a system of statements which cohere around common meanings and values…that are a product of powers and practices, rather than an individual’s set of ideas’” (p. 174). Extending the discussion citing Davies (1992) and his summary of the work of Foucault (1971), Carr (1996, p. 197) states “what we are and how we relate to each other is ‘spoken into existence’. Language is constitutive of human relationships and human reality and is therefore produced socio-culturally …”

The power of culture is well stated by Roberts and Taylor (2006, p. 471) who suggest that:

Knowledge that counts as ‘truth’ is that which has won recognition in a culture as being successful and thus has gained and exercised power. For example, biomedical technology has been so highly successful in treating disease that the powerful discourse of medicos has influenced other members of the health team to the extent that biomedical discourse is the benchmark by which effective patient management is judged. The power-knowledge of biomedical discourse is immersed in the culture of
health care settings, especially those organised around hierarchies and bureaucracies that exercise the power of ‘ownership’ of human health care by experts (p. 471).

As indicated in the quote above discourses are socio-politically embedded and are therefore specific to the cultural and historical period of the time. Institutions within society, such as medicine, sustain the dominant ideologies, for example normative constructs of menopause (J. Wilson, 2001). Redwood (1999) argues that discourses provide institutional support, they produce and reproduce power and they have ideological outcomes.

What is discourse analysis? Horsfall (2000) suggests that discourse analysis is a more recent approach to knowledge production and refers to this form of analysis as an umbrella term that covers a diverse range of methodologies and research approaches. According to Powers & Knapp (1995), discourse analysis is:

An examination of language use - the assumptions that structure ways of talking and thinking about the topic of interest and the social functions that the discourse serves…There is a focus on ideology and an intent to reveal how ideas and beliefs that underlie discourse are socially determined…And it is not presumed that the beliefs are necessarily true or false (p. 46).

What is important is: “[t]he focus is on the relationship between knowledge and social structure”. And more significantly: “[t]here is a particular interest in the ability of social discourse to close down conversation; that is, within a discourse there are things that cannot be said (Powers & Knapp, 1995, p. 46). In other words it is the silences, the hidden and the taken-for-granted that discourse analysis seeks to reveal.

According to Roberts and Taylor (2006), “[e]ssentially, a discourse analysis asks questions about the knowledge and power inherent in all kinds of spoken and written life texts” (p. 472). Philosophically, in defining discourse, Roberts and Taylor, citing Lupton (1992), state that “discourse can be defined as a ‘group of ideas or patterned way of thinking which can be identified in textual and verbal communications, and can also be located in wider social structure’” (p. 436). Therefore discourse analysis is a suitable method to reveal the way in which ideologies inform and shape practice, in this case medical practice (Horsfall, 2000). In this research discourse analysis is framed within a postmodern feminist perspective.
Ultimately, throughout the analysis, I will read and reread the medical texts in order to search for patterns of thinking, and as there is “no set recipe” (Cheek 2000, p. 51 as cited in Roberts and Taylor, 2001, p. 437) for doing discourse analysis, I will also be looking for the images of the menopausal woman, that emerge from the texts, as a result of this patterned thinking. However, equally important will be, through discourse analysis, will be the highlighting of what is omitted, ignored, disregarded, or made invisible (the things that cannot be said), including also omissions of a more “intuitive nature” (Roberts and Taylor, p. 438) within each perspective or model, that is being promoted or proposed.

Therefore, discourse analysis will be employed to address the scientific/biomedical model, the diagnosis of ‘disease’ and the menopausal woman as diseased. In this project two seminal historical medical texts on menopause, that influenced the medical and cultural understanding of menopause for many generations, were selected for the discourse analysis. The selected texts were Doctor Robert A. Wilson’s *Feminine Forever* (1966) and Doctor Wulf H. Utian’s ‘The Menopause Manual: A woman’s guide to the menopause’ (1978).

These two chosen medical texts do not represent medicine in its entirety as a multidisciplinary and multifaceted epistemology. Rather these two texts represent the historical influences on more modern perspectives of the episteme of menopause only, and how the biomedical diagnosis defined menopause in particular, as a disease. The reductionist and biomedical aspects came into focus as they emerged specifically from the discourse analysis on Wilson and Utian’s texts.

In addition, the women’s stories and feminist scholarship bring into focus and highlighted the influence of the reductionist and biomedical model process only, in this case, of the pathological diagnosis in their lives in the last 20th century (1960s-2001).

Therefore, in this research project I have focused on one particular aspect of medicine only, that is medicine in relationship to the diagnosis of menopause. In this particular case, the reductionist and biomedical aspects were very influential in the experience of menopause right up to the early 2000s, as pathological processes and concepts have been the defining processes in this particular diagnosis. I acknowledge that this may not be so in other cases, which are not included in this research project.
Representations in texts and literature from various disciplines, including biomedical texts, will enable me, as I dialogue between disciplines and their accompanying perspectives, to highlight patterns of thinking, especially scientific/biomedical thinking. In particular I will search for representations of the menopausal woman by highlighting the attitudes and images that are presented within the Western scientific/biomedical model. Discourse analysis will also be the first method I will employ to ascertain how language maybe an emblem and tool of control and power, and more importantly to explore what affect this language may have in repressing and oppressing other theories, realities and truths in its definition of menopause. Redwood (1999) drawing on Parker (1992) proposes that there are seven criteria for a discourse analysis. The criteria includes, seeing all data as text; identifying textual subjects, objects meanings and self-reflective tropes; recognising competing and interacting discourses and the socio-cultural and historical context of the discourse.

However, I have chosen a more straightforward approach and will explore, through the repeated rereading of the chosen biomedical texts, to answer the following questions.

Questions:  
What type of text is this?  
Who is the author?  
What concepts underlie the construct?

Women’s Texts – Search for a Second Method

I now refer to my exploration of the most suitable second method to explore women’s narratives. Initially I considered Concept Analysis (Walker & Avant 1998) to be a suitable choice. However, as I explored this method in detail I realized it was not congruent to a postmodern/feminist methodology. This prompted me to search further.

Additionally, I explored Evolutionary Concept Analysis (Beth Rodgers (2000), Concept Synthesis (Walker & Avant, 1988) and Theory Synthesis (Walker & Avant 1988). As a result I realized all these methods were based on traditional scientific thinking and therefore were not congruent with a feminist approach.
FEMINIST CRITIQUE OF THE TRADITIONAL METHOD

The scientific method, or the ‘traditional approach’, I believe is not relevant for the study of the phenomenon of menopause, as its reductionist process, which reduces each woman’s experience to what is common. Wuest (1994), in her article, ‘A Feminist Approach to Concept Analysis’, also referred to the “traditional approach”, specifically in relationship to concept analysis. She stated that:

Traditional approaches to concept analysis in nursing have stemmed from a reductionist view of reality that values objectivity. The limitations of this approach become evident when the world is viewed through a feminist lens (p. 577).

Wuest then defined some different approaches regarding concept analysis put forth by various writers. She referred firstly to Walker & Avant (1988) and stated that their approach is the most common in nursing. She also described Beth Rodger’s (1989) proposed evolutionary approach to concept analysis and referred to it as replacing the “positivist, static definition and its frigid conditions and distinct boundaries” (Wuest, p. 580). Wuest stated that Rodgers (1989) approach “fosters examination of common usage and recognizes that concepts are subject to change” and that Rodgers also “urged inspection of surrogate terms to identify all uses of the concept” and also “to sample a range of domains or disciplines across a broad time frame to identify historical evolution” (p. 580). Although, according to Wuest this signifies a “move away from the mechanistic approach” resulting in a more fluid interpretation, “it too lacks the means to identify bias” (p. 580). Wuest concluded that Chinn and Kramer (1991) “focused on the need to create conceptual meaning from the interaction of the empirical experiences of the symbolic label or word, the thing itself, and the feelings, attitudes, and values surrounding both the word and the perception of the thing” (p. 580).

Most importantly Wuest stated that Chinn and Kramer’s “acknowledgment both of the power of language and of the potential of diverse ways of knowing (my emphasis) move this process closer to feminist analysis” (p. 580).

Diversity of ways of knowing is also congruent not only with a postmodern approach but is significant to both postmodernism and feminism. Furthermore, the acknowledgment of the
power of language as critical to a feminist approach is very valuable. More importantly, knowing where and how, and by whom, the language has been birthed is significant in defining women’s experiences and phenomenon. Questioning the bias is important from a feminist perspective. The question Wuest poses is:

Does the existing label represent exclusionary bias, particularly in terms of gender, race, class or sexual orientation, and thus support a white male, middle-class hierarchy? Answering this question requires thoughtful reflection on traditional definitions, common usage, and consideration of surrogate terms, as Rodgers (1989) suggested (p. 583).

In relationship to menopause the existing label of ‘disease’ required questioning.

Having identified Walker & Avant’s (1988) empirical model of concept analysis, as well as concept synthesis and theory synthesis, as all unsuitable for my work as well as Rodger’s (1994) method, I then searched further. My intention was integration and inclusion of all perspectives, not just those that are in common, or those that are equal. My purpose is the accommodation of all that are uncommon, different, diverse, new, and of equal importance or deviant. This will allow for all women’s perspectives to stand, and is consistent with feminism and postmodernism. Ultimately the concept will not be formed by an analysis from myself as the researcher, but the visibility of each women’s own concepts of their experiences of menopause would be significant. To enable this total visibility, I believed a different approach was required.

The Importance of Understanding

Referring again to Wuest (1994), she aptly summarises similarly my own concerns regarding traditional methods of concept analysis.

Despite the variation of approaches evident in the work of Rodgers (1989) and Chinn and Kramer (1991), the empirical analysis described by Walker and Avant (1988) remains the most common approach in nursing. It results in a precise operational definition that has construct validity and is a common reference point for nursing practice. From a positivist perspective, this method strengthens theory construction.
From a feminist perspective, the merits are not so obvious. This empiricist approach to analysis can fail to consider either the subjective diversity of concept meaning or the social and historical construction of the concept … Perhaps the major issue here is whether a positivist, objective method is compatible with feminist theory (p. 580).

It is here that I ask the questions: does the positivist, objective, pathological interpretation of menopause as disease and the post menopausal woman as patient, assist or encourage women towards empowerment and emancipatory ends or states? If not, why not? If not, is this diagnosis a just diagnosis for women? How ethical is it? Does it allow for subjective diversity? How does it validate diversity by allowing each woman’s experience to be totally central and visible? The answers to these questions emerge further in this thesis from a detailed exploration of the philosophical underpinning of biomedical model contrasted with the postmenopausal women’s narrative. This process of juxtaposing the different philosophies has resulted in a much broader and deeper understanding of the phenomenon of menopause.

As I attempted to answer these questions, I found what came up for me as a feminist researcher, researching a woman’s phenomenon, is the question of the woman herself; rather than the question of the concept, the subjectivity of the woman. Where is the value of understanding? What is the understanding of the woman herself and what is the understanding of the society/culture of the woman, and what is the understanding of the medical profession of the total woman herself, not just the object of her physical body, body parts and physiological processes. Understanding has also been identified by Sandra Harding (1989). She states that “[r]esearch for women must recover the understanding of women, men, and social relations available from the perspective of women’s activities” (p. 195). I think that understanding the relationships between women, men and society are important. I believe they are critical to women’s emancipation, as well as to the phenomenon of menopause, as women are embedded in a patriarchal society where men’s expectations of women have been conditioned by this patriarchal society. However unfortunately, I am unable, in this particular research project, to search out these three variables. My focus is to recover and understand various women’s perspectives as well as other cultural presentations on the phenomenon together with the “paternalistic dominance” (Lerner, 1986, p. 233) of the patriarchal society as presented through the scientific/biomedical interpretation of menopause and the postmenopausal woman. It is in an effort to highlight that these three, women, men
and social relations are all definitely related, and how greater understanding is required to enable profitable work to be done in the areas of these three interconnections. This particular research project allows values and amplifies and highlights women’s menopausal experiences, thereby providing an alternative understanding of the cultural model that both women and men have been and are led to believe regarding the phenomenon. To leave a space for the value of each story (the value of each woman), there is a need to incorporate the differences as valuable as well as the similarities. This also allows for a whole rather than reduced construct. In other words, how do I ensure that I do not lose the total, whole, woman themselves? Does a concept analysis shift the focus from the woman to the concept only? How does one continue to maintain and be open to understanding?

It is here that I refer to Code (1989). Code believed that first-person accounts of experiences, person’s stories or narratives provide another kind of knowledge, one which is not usually considered “as appropriate for epistemological consideration” (p. 168). She defined this as a “gap in male-stream epistemology”, and she too is concerned about what “has become of the people whose knowledge” the male-stream way of knowing claim to know (p. 168). My own personal concern is that the real people become invisible and are replaced by a concept or a method. Code proposed the following as she expressed her concern:

I have suggested that reflection upon epistemological and moral matters that is responsibly attuned to such narratives might be able to retain a kind of contact with human lives that is often lost in formalistic and abstract theoretical structures. Moreover, the subtlety and variety of narrative of this kind is such as to highlight the crudity of stereotypes, and their ineffectuality as putative cognitive devices (p. 169).

Individual stories enable a larger picture of individual women’s realities, thereby highlighting the inadequacy of a stereotyped interpretation that supposedly applies to all women. Or in other words an interpretation that stereotypes all women. However, Code also cautions us regarding the truth aspect of stories, as she draws our attention to the value of stories. She states:

Stories, even first person stories, are not necessarily truer either than stereotypes or than standard philosophical analyses. Nor is there any kind of reliable criterion for
determining their truth. Rather the main point is that stories convey something about cognitive and moral experience, in their manifold manifestations, that slips through the formalist nets of moral principles and duties, or standards of evidence and justification. The modest proposal urged here is that perhaps, by taking stories into account, theorists will be better able to repair some of the rifts in continuity that are so glaringly evident between moral theory and moral experiences, and theory of knowledge and cognitive experiences (p. 169).

I propose also that each person’s story will not present the total truth either, but they will draw our attention to the fact that there are differences in each person’s story, which could in turn, alert us to the fact that ultimately we should continue to allow appropriate space for many stories rather than reduce the information to a few stereotyped concepts that are similar. In other words to ‘stereotype’ is not to know totally. The male-stream biomedical interpretation of menopause as disease and thereby the menopausal woman as diseased presents us with a stereotype of the ageing woman (my emphasis). It purports to represent the total or whole truth. This is contradictory to postmodernism.

As Code (1989) continued to tell us about experience, knowledge and responsibility, she refers to understanding as the point of reference, and as a means of moving away from the male-stream stereotypes. As she said:

> The point is not to generate a neat, comprehensive theoretical structure, but to learn how to let experience shape and reshape theory. In a word, the aim is to understand rather than to find methods of justification, verification, and control (p. 169).

However, she is also aware, “that the price to be paid in terms of loss of certainty, clarity and precision is, admittedly, high” (p. 169). More specifically she articulated this high price as a “vertiginous” position, and “understanding as fleeting” (p. 169). But, she also said, “the certainty, clarity and precision claimed for dominant theoretical structures is as illusory as the truth claimed for stereotypes” (p. 169). Finally, her reassurance is that:
the vertigo will not be the source of dismay that it may at first seem if thoughtful, responsible practice can generate theoretical accounts of knowledge that stand a good chance of retaining contact with women’s experiences without, carelessly and dismissively, simply slotting them into stereotyped categories (p. 169).

For me, then, the protection of women’s stories as they are presented, is critical to epistemological concerns, women’s ways of knowing as distinct from ‘male-stream’ modes of knowing, and finally to assist a more wholistic, inclusive system of knowledge, rather than one that is dependent on reductionist, objective methods. My next questions to myself is ‘Who experiences the vertigo (giddiness, dizziness) and why? Perhaps it is those working from a reductionist, objective model, as this model does not allow for multiple subjectivities.

Also then, how can my method guarantee and incorporate and do justice to many perspectives and multiple women’s experiences without reducing them to a single stereotype? In an attempt to answer my question, I refer once again to Code (1989):

An intellectually virtuous person would value knowing and understanding how things ‘really’ are, to the extent that this is possible, renouncing both the temptation to live with partial explanations when fuller ones are attainable, and the temptation to live in fantasy or illusion (p. 161).

This too is very much in line with the postmodern focus on ‘concern’ and ‘content’. However, I believe of even more significance, is that when Code’s statement is used as a backdrop, ‘menopause as disease and the postmenopausal woman as diseased’, can be highlighted as fantasy or illusion, as it is possible that this diagnosis is a “partial explanation only” (p. 161). It is lacking in breadth and depth. Of even greater significance, I believe is Code’s next statement as she identified the mentality necessary to enable a greater understanding of how things are, to the best possible extent, and to be able to integrate new and other ways of knowing.

The value of understanding how things are, to the best possible extent, is greater than, and supersedes, any value that might be taken to attach to consistent adherence to established theory or received opinion about how things might be. To achieve the
‘right’ perceptions implied by such an approach requires honesty and humility, the
courage not to pretend to know what one does not know, the wisdom not to ignore its
relevance, and the humility not to yield to temptations to suppress facts damaging to a
cherished theoretical stance (p. 161).

I think, to take a humble stance, is what is required. I agree with both Harding and Code that
‘understanding’ is a valuable orientation to pursue. How does one understand? I believe, one
does just that, ‘one stands under’, so to speak. This moves the medical practitioner, the
researcher, or the authoritative figure to a different place, a less dominant position, one that
allows the other to be the authority on their own experience. And for those who think they
really know, to then try to understand or ‘stand under’ could be a cause for vertigo, as many
variations or even seemingly too many variations, may have to be understood, and a position
change required. A model to address this issue is pertinent to this research.

It is also interesting to note that Belenky, Clinchy, Goldberger & Tarule (1997) in their book
‘Women’s Ways of Knowing also refer to “understanding” (p. 117) as naturally more present
in females as a way of knowing. This they referred to as “connected knowing” (p. 117) citing
Bakan (1996) as the source of this term. Belenky et al. (1997) also described connected
knowing as more present in females than in males.

Women seem to take naturally to a nonjudgmental stance. In teaching undergraduates
we have found it necessary to ask many of the males to refrain from making
judgments until they understood the topic. On the other hand, we have often had to
prod the females into critical examination: Even when they disagreed vehemently
with an opinion, they hesitated to judge it wrong until they had tried hard to
understand the reasoning behind it (p. 116).

And equally significant,” [c]onnected knowers do not measure other people’s words by some
impersonal standard. Their purpose is not to judge but to understand” (p. 116).

This is my intention also, not to measure, not to judge, also not to interpret and not to
modify (my emphasis) the text in any way, for the purpose of bringing to closure the stories
(data), which would result in defining menopause in “explanatory generalizations” (Dray
To put it more simply, my intention in this research is not to judge, interpret or modify, but to try to ‘understand’ more fully. Through a continued search for a suitable means for enabling this intention a suitable structure will emerge. My new questions to myself were:

1. What method can I use that will allow women to remain very present, rather than invisible, one that employs, incorporates and integrates ‘understanding’ as a value and one that also maintains and holds up the concepts as described by women in their own stories, rather than myself, as the researcher creating my own concept from the data, as I have identified previously?

2. What model will move from an authoritative stance, shifting me as the researcher, from the authoritative voice to allow the women’s words themselves, and perspectives from other disciplines, in the final instance, to be valued and validated equally with, and to stand alongside the biomedical model. One that will allow for, and is also congruent with a postmodern orientation?

Thirdly and most importantly,

3. How do I as researcher, as having the authority of a researcher, maintain a humble stance. In my own words to ‘stand under’, thereby enabling me to honor more fully the value of ‘understanding’ and the importance it has for woman’s ways of knowing, especially when a woman’s issue such as menopause is being explored?

For me, Belenky et al’s words are most significant here:

Connected knowers begin with an attitude of trust; they assume the other person has something good to say … because all opinions come from experience and you cannot call anyone’s experience wrong, you cannot call the opinion wrong (1997, p. 116).

It is on this premise that I aim to continue to put forth and hold up, not only women’s experiences, but also in some cases, women’s thinking as well. Both experience and thinking
have relevance to women’s stories and more importantly may assist a greater understanding of
the phenomenon of menopause.

I now refer back to Code’s (1989) words once again, regarding “the value of understanding
how things are to the best possible extent”, because this value is “greater than, and
supersedes, any value that might be taken to attach to consistent adherence to established
theory or received opinion about how things might be” (p. 161). In order to clarify I have
made note of the points she proposed in relation to understanding, below:

- honesty and humility,
- the courage not to pretend to know what one does not know,
- the wisdom not to ignore its relevance,
- the humility not to yield to temptations to suppress facts damaging to a cherished
  theoretical stance (p. 161).

Code leads us beyond limited thinking. Because of this, I refer once again to Code’s words
regarding understanding. It is the value of understanding how things are to the best possible
extent, that I sought to hold foremost in my mind as I considered the most suitable method.
To enable me to do this I needed to be able to include each woman’s writings in her own
words, to let her words speak for themselves, without my modification, to ensure a more
wholistic and comprehensive understanding (my emphasis) of menopause.

These remained present within my thinking as I contemplated further a perspective that would
allow the inclusion of many aspects that I consider important for the development of this
research project. A method that reflects a model that is inclusive of all processes can be
acceptable to all. A policy recommendation that is based on many individual experiences
could be in line with both postmodernism and feminism, therefore being more acceptable and
more appropriate. A reductionist method does not allow for multiple realities to stand and be
present. It deletes and does away with the broader net. I aim to keep the broader net. The
policy recommendation of menopause as disease, with HRT/HT as magic bullet is based on,
or is the result of scientific empirical methods of knowing, where one truth only rules and
where other truths are ignored, avoided and shunned.
Specifically for my work the question is, what method will enable women’s individual issues regarding menopause to come to the fore and become more visible, as I need to keep the woman central, rather than the disease? I now refer to the methods I have chosen to enable me to address firstly, the dominant paradigm of the scientific biomedical model, and secondly women’s own stories. With these in mind I now refer to the method of Creating Conceptual Meaning. I found this the most valuable and suitable for my purpose as I believed it reflected the above position proposed by Code (1989).

**CREATING CONCEPTUAL MEANING**

**Introduction**

Creating conceptual meaning is the second method I utilized. This method is referred to by Chinn & Kramer in *Theory and Nursing: Integrated Knowledge Development* (1999). They described ‘creating conceptual meaning’ as “methods for explaining and structuring empiric phenomena” (p. 49). Accordingly, two processes are involved in explaining and structuring empiric phenomena. They are: “[c]reating conceptual meaning [and] …[s]tructuring and contextualizing theory” (p. 49).

The first process that of creating conceptual meaning is a suitable method for my research, for two reasons. Firstly, it is the first step in structuring and developing a possible model of menopause. Secondly, the following explanations describe creating conceptual meaning and its relationship to both theory building, and experience. This will be important for further development of my research.

**Definition of Creating Conceptual Meaning**

Chinn and Kramer provide the following explanation of creating conceptual meaning which they see to be “a theory-building approach that depends on mental processes” and this means that “mental constructions or ideas are used to represent experience” (p. 52).

**The Process of Creating Conceptual Meaning**

The process of creating conceptual meaning involves assuming:

1. “Common yet unique human experiences and shared meaning among people” and
2. “That a person’s own subjective construction of reality is more accessible than anything else” (p. 52).

This is especially relevant for menopause and the menopausal woman as she is the one who actually ‘has the experience’ and ‘lives the reality’. Also the first point allows for the postmodernist value of difference and diversity, whilst still holding a common unity. These ideas are relevant as menopause is a common ageing process for all women, but at the same time is, or can be experienced differently. The second point acknowledges and validates the value and meaning of women’s subjective experience. Therefore, the acknowledgment of the person’s own subjective construction of reality is necessary to be included as a priority as it is the reality for the woman, and then, according to Chinn and Kramer (1999), “what is mentally constructed is expressed in words” (p. 52).

**Benefits of Conceptual Meaning**

Creating conceptual meaning is also worthwhile for two reasons as it “brings dimensions of meaning to a conscious, communicable awareness…[and it]…makes it possible to identify the limits of conveying empirical meaning” (p. 52). Chinn & Kramer provide an example:

> If someone is called clever, that person begins to form an awareness of self that may be new… If the word represents a desired value, the description given contributes positively to self-awareness. At the same time, the word clever may not adequately express the rich inner experiences and instead trivialize what is experienced within (p. 52).

Clarifying the meaning of menopause is important if the disease prescription trivializes, ignores, omits or renders invisible, women’s richer inner experiences of their reality. A space and place to enable and validate differences in awareness is fundamental to this research project and highlights the scientific biomedical diagnosis of menopause as limited and limiting.

Very importantly, Chinn and Kramer (1999) believe “that conceptual meaning is something that is created. It does not exist as an ‘out there’ reality to be objectively discovered. Rather, it is **deliberately formed from experience**” (my emphasis) (p. 53). Equally important is
Chinn and Kramer’s statement that “forming word definitions is not the same as creating meaning. Conceptual meaning conveys thoughts, feelings, and ideas (my emphasis) that reflect the human experience of the concept (p. 54).

This is especially relevant for my research as it will acknowledge and value further dimensions of, thoughts, feelings and ideas of women themselves and others, who have a different perspective regarding the phenomenon, rather than just observations produced by scientific/biomedical procedures.

**Concept Definition**

For my purpose of creating conceptual meaning I used Chinn & Kramer’s definition of ‘concept’ as it has particular relevance for ‘experience’. They define a concept as “a complex mental formulation of experience” (my emphasis) (p. 54). They go on to state:

Experience is considered empiric when it can be symbolically shared and verified by others with sensory evidence. Three sources of experience interact to form the meaning of the idea:

1. The word or other symbolic label
2. The thing itself - (object, property, or event)
3. Feelings, values, and attitudes associated with the word and with the perception of the thing (p. 54).

**Empiric and Abstract Concepts**

Drawing on Jacox (1974) and Kaplan (1964), Chinn and Kramer (1999, p. 54), propose that in a sense, concepts can be both empiric and abstract.

All concepts can be located on a continuum from the empiric (more directly experienced) to the abstract (more mentally constructed). They are empiric because they are formed from encounters with perceptible reality (my emphasis) (1999, p. 54).

Menopause diagnosed as a disease is an empiric concept. Abstract concepts “are abstract because they are cognitive representations of what is perceptually experienced” (my
emphasis) (1999, p. 54). This is especially so regarding menopause and women’s experiences of menopause. Acknowledgement of both empiric and abstract concepts are therefore necessary and essential to a construct of menopause.

Chinn and Kramer explain in more detail, the difference between both the empiric and the abstract concepts.

Concepts differ in their relationship to perceptible reality. Some concepts are formed from very direct experiences with reality, whereas others are formed from indirect experiences. Relatively empiric concepts are ideas that are formed from direct observations of objects, properties, or events. As concepts become more abstract, they can be experienced only indirectly. The most abstract concepts encompass a complex network of subconcepts that can only be inferred (1999, p. 54).

The following diagram from Chinn and Kramer illustrate these ideas.
Therefore, “the most concrete empiric concepts have direct forms of measurement” (Chinn & Kramer, 1999, p. 54). Concepts formed empirically about objects, property or events (empiric indicators) can be directly experienced through the senses. For example, biological sex can be observed directly by noting the primary and secondary sexual characteristics, so too can height and weight be measured by standardized instruments (Chinn & Kramer 1999). In the case of menopause, reproductive organs can be directly observed for changes that occur at the time of menopause. However:

As concepts become more abstract, their reality basis and their empiric indicators become less concrete and less directly measurable. Assessment of an abstract concept depends increasingly on indirect means. Although an indirect assessment or
observations is different from direct measurement, it is considered a reasonable indicator of the concept (Chinn & Kramer, 1999, p. 55).

The example by Chinn & Kramer for indirect assessment or observation is that of haemoglobin levels, which is representative of a concept, but cannot be directly observed, only measured. In the case of menopause the changes in hormonal levels can be measured also but cannot be observed directly.

Chinn and Kramer make a significant and important comment regarding concepts that are midrange on the empiric-abstract continuum and describe the following as an example:

Cardiovascular fitness is an example of a concept that is midrange on the empiric-abstract continuum. Concepts increase in complexity in this range, and several empiric indicators must be assessed. Because no object such as cardiovascular fitness exists, a definition is required if we are to know what it is. Even though definitions for less empirically based concepts are thoughtfully formulated, they are arbitrary because many different definitions could be chosen. As concepts become increasingly abstract, definitions become more dependent on the theoretic meaning of the concept and the purpose for defining it (1999, pp. 55-56).

**Constructs**

Moving further up the continuum, the concepts become more highly abstract. According to Chinn and Kramer “highly abstract concepts are sometimes called constructs” (1999, p. 56). They go on to explain:

Constructs are the most complex type of concept on the empiric-abstract continuum. These concepts include ideas with a reality base so abstract that it is constructed from multiple sources of direct and indirect evidence (1999, p. 56).

Further to this Chinn and Kramer (1999) describe highly abstract concepts as “constructed from other concepts” (p. 56). They state that “all concepts shown on the continuum (as well
as others) can be included in the concept of wellness” (Chinn & Kramer, 1999, p. 55). Ultimately, then a construct can be totally inclusive.

**METHOD FOR CREATING CONCEPTUAL MEANING**

The following is important to note:

Creating conceptual meaning produces a tentative definition of the concept and a set of tentative criteria for determining if the concept exists in a particular situation. We use the word tentative because both the definition and the criteria can be revised. The term tentative does not mean that anything goes or that any definition that suits the author will do. This process is a deliberative, disciplined activity.

The person who is creating meaning draws on many information sources, examines many possible dimensions of meaning, and presents ideas so that they can be tested and challenged in the light of the purposes for which the concept is being clarified (Chinn & Kramer, 1999, p. 57).

The following utilised the process as posited by Chinn and Kramer (1999) which identifies the processes utilised in the second method.

1. **Concept Selection**

According to Chinn and Kramer “[s]electing a concept is a process that involves a great deal of ambiguity. Concept selection is guided by purpose and always expresses the values of the person who is choosing” (p. 59).

Chinn & Kramer also state “if you are a postdoctorate student, you maybe led to create conceptual meaning by a dilemma you encounter in moving through the research process” (p. 59). A dilemma which I too experienced. I refer to this, in detail at the end of this chapter. This dilemma occurred for me because of my beliefs regarding values and attitudes about the nature and the phenomenon of menopause. In this research project my concept selection will be any and many concepts that are contrary to that of ‘disease’.
Menopause is the phenomenon in question. I believe the biomedical concept of ‘menopause as disease’ is limiting in its definition and also very limiting to the menopausal woman. I do not value a pathological diagnosis of a woman’s natural life-cycle ageing process. Men’s ageing process is not defined as disease, although they too suffer from physical symptoms as they age. The negative attitude towards the ageing menopausal woman, as prescribed by the biomedical model, which remains the dominant paradigm in our society/culture, has little value in relation to my own experience. I therefore wish to search for and locate other concepts that are descriptive of a woman’s own experience of menopause, and reflect the thinking and experience within other disciplines. Ultimately what is presented will present will be alternative constructs to the concept of ‘disease’. Therefore selecting ‘different’ and ‘diverse’ concepts will be the aim of my reading of the women’s texts presented in Chapter Four.

2. Clarifying my Purpose

Chinn & Kramer (1999) stated that “[t]o provide a sense of direction you must know why you are creating conceptual meaning” (p. 61).

Clarification for my project

a) This method will also allow for multiple meanings that will emerge from multiple textual sources, that is, from multidisciplinary literature. My purpose is to examine ways in which menopause and the menopausal woman are depicted in existing writings from sources beyond the scientific/biomedical.

b) This method will form the basis from which I will be able to move in the future, towards the second process of explaining and structuring empiric phenomena, that being “structuring and contextualizing theory” (Chinn & Kramer p. 49).

c) This method will support my search for a new and more suitable constructs.

3. Sources of Evidence

“Once a concept has been selected, the process of creating conceptual meaning proceeds by using multiple sources from which you generate and refine criteria that include indicators for the concept” (Chinn & Kramer, p. 62).
Sources of Evidence for my project

The criteria for sources of evidence will be any concept in the woman’s narrative that is not only different but that is contrary to the scientific/biomedical diagnosis of menopause and the menopausal woman as diseased. The Western scientific/biomedical model still stands as the dominant paradigm in our culture and prescribes the universal ‘truth’ regarding menopause to all. Concepts that have been specifically expressed by the women themselves, which will represent a range of multiple truths will be presented. I shall repeat the concepts exactly as they are expressed in each individual woman’s own words. This will allow many women’s own words to stand for themselves (my emphasis) without modification in any way because they are considered as ‘data’. Together with my reading of significant concepts that women describe, I will present my meaning of their concepts in the form of ‘images’.

4. Popular and Classical Literature

“A variety of literature resources can provide information about conceptual meaning” (Chinn & Kramer, 1999, p. 65).

My literature Sources

The literature sources will consist of both academic texts as well as general literature. Much general literature on menopause is written by women, whereas the scientific biomedical academic literature on menopause is usually written and prescribed by men, or based on men’s prescriptions. Professional literature from other disciplines that write on menopause and the menopausal woman will be additional sources as others have also written on this phenomenon. Chinn and Kramer (1999) refer to philosophers, as well as nurses, as having written about the concept of ‘presence’ as a way of being with another. Both are valuable sources for exploring meanings. Chinn and Kramer also stated “[w]hen the literature of other disciplines is considered, meanings may not clearly apply to nursing, but meaning found across disciplines contributes to concept clarification “(p. 66).

In Chapter Four I have explored four postmenopausal women’s narratives. Each women being a professional practitioner from varying disciplines was chosen on the basis that they held professional positions in a related area health including a gynecologist, social worker, psychotherapist and a counselor. They all chose to write about their personal experience of
menopause and provided a rich in depth story of their life journey beyond a narrow focus on biological changes.

5. Contrary Cases

In relation to this research project, I believe the consideration of Contrary Cases would be most appropriate. “Contrary cases are those that are certainly not an instance of the concept … they represent something that most observers would recognize easily as what you are not talking about (Chinn & Kramer, 1995, p. 84). For example, “for the concept of restlessness, calmness could be presented as a contrary case” (Chinn & Kramer, p. 84).

In my project the concept of ‘Menopause as Disease’ is what I have not searched for. The alternative concepts that emerged from my search were not instances of this concept. These contrary concepts are valuable stories to enable a more comprehensive and wholistic construct of menopause and the menopausal woman. Creating conceptual meaning enabled me to bring together ‘the thing itself’ plus ‘the associated feelings, values and attitudes’ as expressed by each woman through her writing. Contrary cases have been located within women’s writing.

6. Criteria for Concepts

According to Chinn and Kramer (1999):

The conceptualization is reliable if the concept can be consistently recognized on the basis of the criteria that you have created. The meaning you create is also adequate if it reflects a reasonable and communicable understanding that is useful for your purposes … A conceptualization is valid if it is based on multiple examples that are fully representative of the range of meanings for the concept, if you used multiple interpretive stages during the clarification process, and if the essential structure (or pattern) of the concept can be understood from the criteria (p. 72).

The criteria that guided my search for contrary cases is:

1. The concept is not developed from the biomedical model of disease.
2. The concept is an alternative or different expression to that of disease.
3. The concept emerges from multidisciplinary writings or women’s own writings.
4. The concept should challenge the dominant paradigm.
5. The concept presents a challenging perspective to our current Western society/cultural thinking of menopause and the menopausal woman.

Finally, creating conceptual meaning became my choice of method as a result of the dilemma, which I encountered as I searched for a method that was inclusive of expressions and concepts that emerged from each woman. Not just those concepts that were ‘in common’, and those that could be difficult to prove by scientific methods, but concepts that are contrary to scientific diagnosis.

The following statement from Chinn and Kramer (1999) also indicated the need for the value of creating conceptual meaning. “Many nursing concepts are highly abstract … it is not factually based concepts that nursing theory reflects” (p. 57). Chinn and Kramer (1995) also accommodate the possibility of more than one truth when they say “[a] single phenomenon can also be represented by several different words” (p. 79).

Creating Conceptual Meaning – A Brief Summary

In Chinn and Kramer’s (1995) chapter on Creating Conceptual Meaning, which they stated “provides a foundation for developing theory”, “contrary cases” is of particular relevance for this project. Explorations of the biomedical/scientific diagnosis of menopause as disease, together with women’s own perspective of their experiences, many concepts that are contrary to that of biomedical disease are evident in the texts. I needed to account for varied contrary constructs that emerged and were different and more complex than the medical diagnosis of disease. Therefore an emphasis on different meanings was important. The following two points of Creating Conceptual Meaning are, I believe, particularly significant and relevant to my project of the menopausal woman:

2. They also state that conceptual meaning is created by considering all three sources of experiences related to the concept:

   the word
   the thing itself
   the associated feelings (p. 78).

These will remain present within my thinking as I contemplate further the search that will allow me to include the many contrary concepts that I consider are important for the development of this research project. I find this a most valuable and suitable method for my purpose as I believe it reflects the above position as proposed by Code. I have explained my methodology previously but now present it once again as a brief summary noting the most significant aspect for me. In other words what my bias is in my selection of texts.

A feminist/postmodern perspective presents an alternative to the option of reducing the text to data from the literature. A feminist perspective is also inclusive of diversity, therefore the purpose would be to include, embrace and validate the concepts from each woman’s story. Therefore, the purpose is to acknowledge, include, and validate each woman’s concepts as having some significance and value to the redefined concept of menopause. Also from a postmodern perspective, expansion, inclusion and consideration of many, including the unusual, the different, the strange, the margins and the unproven is required.

**RIGOUR IN RELATIONSHIP TO MY PROJECT**

Ultimately postmodernism allows for multiple theoretical perspectives and truths. Postmodernism counteracts modernism where consideration of rigour is instrumental in suppressing and repressing multiple truths and perspectives.

Under this reign of modernist rigour, women’s individual perspectives, which emerge from within, as a result of their own experiences, may not be considered a legitimate source of knowledge. Basically, they are not amenable under this regime of rigour, and therefore are not considered a representation of truth. Because my project will allow for and include the reality from the inside, the woman’s internal experience, that is the woman herself, I believe a new reframing of rigour is required. Postmodernism, by viewing from another perspective,
allows for a reframing of rigour. This would appear to be appropriate as Davis (1998) stated that “[w]orking in the postmodern paradigm demands that the notion of rigour itself be critiqued” (p. 407).

Drawing on early work by Stanley & Wise (Stanley & Wise, 1983), Hall & Stevens (1991) refer to rigour from a feminist perspective and stated that “[r]igour in feminist inquiry includes the degree to which research reflects the complexity of reality “ (p. 23).

Menopause is a complex phenomenon. Because a woman’s menopausal experiences cannot be predicted and prescribed, as some of these experiences are not *simple* happenings, and cannot be controlled, a simple diagnosis and prescription very often does not solve the problem. Appropriately, then the phenomenon of menopause could more aptly be called complex.

Menopausal embodiment is thus a rather complex terrain. It may invite interpretation, present hardship, suggest clarification, and offer treatment, but it is also the potential ground for the subject of the experience herself to enter the field as one who is very much part of it rather than merely its object” (Rothfield, 1997, p. 48). Komesaroff, Rothfield & Daly (1997) also indicated that menopause is no simple phenomenon, they suggest that:

…”there is no such thing as the menopause. There are menopausal experiences. The menopause can be a time of biological disruption, of physical change, of social transformation, of philosophical reflection. The various components do not fit together in a single, well definable whole, nor should they. This does not mean that women do not experience discomfort, perplexity, turmoil, or pain. It does mean that menopause is more complex and interesting than its public façade has hitherto suggested (p. 13).

Because of this, I believe that feminist research is also an appropriate study for my topic as this will allow for many women’s differences. Therefore, rigour in relationship to my project will be the degree to which the research reflects the complexity of the menopausal phenomenon. The test of rigour will be how valid my choice of research approach is to the
menopausal phenomenon? The significant word here, and one deserving a focus, is the word ‘valid’. Davis (1998), in her thesis, devoted half of chapter six, *Shaping the Research*, to the significance of rigour and validity. Ultimately she stated that “valid research is ethical research” (p. 425).

Ethical concerns are also my concern. It is against this backdrop, that my project explored multidisciplinary perspectives and individual postmenopausal women’s experiences of the phenomenon of menopause. I believe a postmodern/feminist approach enables the complexity of menopause to be highlighted and addressed, as more than one truth can be acknowledged regarding the phenomenon. Postmodernist/feminism allows for and argues for more than one truth. Therefore, this methodology and the methods I have chosen are both the appropriate and ethical approach to take for the exploration of multiple knowledge’s of menopause, menopausal and postmenopausal ageing woman.

The following Chapter 3 explores, through the first chosen method of discourse analysis, the biomedical discourse of two classic seminal historical texts published on menopause. Chapter 4 explores the postmenopausal women’s narratives through the method of creating conceptual meaning from the women’s own words. Repeating the women’s exact words formed reflection and contrary concepts. Images were formed as extensions to the woman’s words, but were represented as less central. This method I have termed ‘Without Interpretation’, in other words the ‘data’ stands alone and gives witness to each woman’s experience of the menopausal journey.
CHAPTER THREE – DISCOURSE ANALYSIS:
THE BIOMEDICAL GAZE
Introduction

This chapter is an exploration of the biomedical discourse on menopause; the reductionist medical paradigm is the dominant paradigm and episteme of our time.

Firstly, the subject/object divide, specifically objectification and the medical gaze, is addressed with a short discourse analysis as an example. A further in depth discourse analysis on two pivotal seminal medical texts published by prominent medical professionals, both of whom were very instrumental in promoting hormone replacement therapy for menopausal and postmenopausal women follows. Finally a summary and the bio-politics of the medical model of menopause are presented.

Postmodernism encourages and values diversity, and challenge the “Absolute standards, totalizing categories and meta-narratives” as “oppressive or exhausted” (Mitchell, 1996 p. 202). Mitchell, citing Seidman (1994), states that the focus of postmodernism is to ‘foster conceptual innovation, proliferating paradigms, research programmes and conceptual strategies’ thereby subverting ‘unifying conceptual schemes’ (p. 202). Mitchell goes on to say that “new conceptual schemes are required” and citing Best & Kellner (1991) adds that “radical postmodern discourses call for new categories, modes of thought, writing, values and politics to overcome the deficiencies of modern discourses and practices” (p. 203).

Postmodernism is about valuing local narratives in preference to grand narratives and Mitchell (1996) has identified the telling of local stories rather than articulating general theories as gaining ‘legitimacy’ through their usefulness (p. 202). As to the usefulness of these postmodern theories, Mitchell alerts us to the implications. He cites Nicholson (1992) stating that “as a consequence of this pragmatism, it is argued that science loses its privileged epistemological primacy and can be viewed as on a par with other discourses (e.g. history, poetry, etc.), legitimate only in proportion to its utility” (p. 203).

Discourse Analysis of the Biomedical Model

It is against this backdrop that the phenomenon of menopause is in need of further consideration. The biomedical model, and the medical profession have defined and diagnosed menopause as a disease, (Wilson, 1966) a hormone deficiency disease, and more recently ‘endocrinopathy’ (Utian, 1987, p. 1281), thereby diagnosing the menopausal woman as
deficient and requiring medicalization. This is the dominant paradigm, proposed as the universal ‘truth’, based within the dominance of science as the power to define truth. The medical and professional intervention prescribed for this diagnosis of disease is Hormone Replacement Therapy (HRT/HT). Whilst the biomedical discourse continues to dominate, and whilst labelling the menopausal woman in our culture and society as diseased and deficient, it fails to acknowledge the complexities of the female body as changing into something powerful and good, nor does it acknowledge the complexity of the phenomenon. This negative inscription of woman as deficient is promoted to women themselves and reinforced within society. Mitchell (1996) argues that the “medical and professional discourses have come under increasing criticism for being uncaring, stigmatizing and disempowering” (p. 202). But in spite Mitchell’s echoing of a number of voices on the limitations of the biomedical diagnosis in relationship to the menopausal woman, it is the biomedical, scientific discourse that continues to dominate and define ageing women as deficient.

Mitchell argues that discourses are not mere words and offers Parton’s (1994) description of discourses as “structures of knowledge, claims and practices through which we understand, explain and decide things” (p. 202). It would seem that further exploration of the biomedical scientific discourse may be helpful to discern what philosophical theory, dominant values and unquestioned certainty underpins this type of thinking and knowledge that proclaims the one universal truth and grand narrative of ‘diseased’ women to our society.

Therefore, it is to the exploration of the values of scientific thinking, and the underlying philosophy of knowledge (epistemology) of the dominant scientific paradigm, with its universal claim of the menopausal woman as diseased, and its scientific practice and promotion of medicalization as intervention, which follows. The discourse analysis, which follows, enabled further exploration of the biomedical scientific diagnosis of menopause and the menopausal woman.

**Considering the Dominant Paradigm**

The basic premise of the scientific research process is that of the conceptual tool of rigor. According to Ratcliffe and Gonzalez-del-Valle (1998), (citing Webster’s Dictionary 1965),
rigor is described as “an exactness without allowance for deviation; inflexibility; strict precision and scrupulously accurate” (p. 361). A fundamental assumption underlies this recipe for rigor. By following this ‘recipe’ for rigor in research, “both the researcher, and the data collection and analytical processes, will be protected from bias, and as a consequence, will generate valid and reliable information” (Ratcliffe & Gonzalez-del-Valle, 1988, p. 361). As a consequence of this assumption, what is presented to the consumer is considered to be the truth, truth being the result of rigorous and analytical thinking. These assumptions are part of the Newtonian Paradigm of science. According to Ratcliffe & Gonzalez-del-Valle (1988, p. 362) the ‘Newtonian Paradigm’ is:

Based on the doctrines of reductionism and universality, emphasizes the analytic mode of thinking … Reductionism is the doctrine that the properties of all objects and events, and our experience and knowledge of them, are made up of ultimate, indivisible elements … Analytic thinking complements reductionism; it is the mental process whereby that which is to be understood through explanation is broken down into parts.

In our society, this western scientific/technological approach towards menopause dominates, and a bioscientific, reductionist, objective, pathological view of menopause is promoted even though it is a normal life process. Whilst medical science and medical literature define menopause as a disease, an estrogen deficiency disease entitled endocrinopathy and claims this as the universal truth, recognition of a natural normal change is misconstrued, and ignored and over-ridden when bioscience considers biology as the crucial focus and the menopausal and postmenopausal woman as diseased. The following refers to objective and reductionist practices.

**Objective/Subjective Divide**

Central to this scientific practice is objectivity. Ratcliffe and Gonzalez-del-Valle (1988) referred to Jacques Monad who stated that only one value is compatible with science, and this is the value of objectivity. Monad’s even more definite words are that “all other values are incompatible with, or hostile toward science and should therefore be shunned” (as cited in Ratcliffe and Gonzalez-del-Valle, 1988, p. 362). Consistent with traditional science and the
dominant paradigm then, is not only the importance of objectivity, but the necessity of shunning and denying other values. Accordingly, objectivity is seen to differentiate truth from error.

The fact that other values are ‘shunned’ because of their incompatibility, would seem to indicate non-acceptance and rejection of values that may be able to provide more expanded and expansive thinking and theories in addition to those of the physical body. However, this dominant scientific paradigm has been successful in many areas, and therefore has enabled scientific research to be considered the truth base of knowledge. It also controls the portrayal of truth to our society. With regards to menopause, I propose that this paradigm is too limited and narrow as it portrays one ‘truth’ only. Just as this model sets out to part/divide/isolate and dissect, so too, its conclusions will be partial truths only of the menopausal woman. It lacks and omits a search for any other truths that may be present and also have value. However, it stands firm as the current dominant paradigm.

Because objectification is the value central to scientific research, I think it is also important to reflect upon and consider what is objectified in the case of the menopausal woman. What are the consequences for the women when only her body organs are considered and scrutinize? Fredrickson & Roberts (1997) offer “objectification theory” as a framework for understanding the experiential consequences of being female when the female body is sexually objectified.

Objectification theory posits that girls and women are typically acculturated to internalize an observer’s perspective as a primary view of their physical selves. This perspective on self can lead to habitual body monitoring, which, in turn, can increase women’s opportunities for shame and anxiety, reduce opportunities for peak motivational states, and diminish awareness of internal bodily states (p. 173).

Referring to the work of Bartky (1990) Fredrickson and Roberts argue that:

[S]exual objectification occurs whenever a woman’s body, body parts, or sexual functions are separated out from her person, reduced to the status of mere instruments, or regarded as if they were capable of representing her (p. 175).
It would be reasonable to say then, that sexual objectification is occurring when pathological biomedical research diagnoses the menopausal woman as diseased. In future this model, as demonstrated above, can increase her shame and anxiety and diminish confidence. Further, this model promotes her internal sexual organs as deficient, decrepit and lacking. Moreover, the male scientific gaze, couched within a western scientific paradigm, describes and defines the woman to herself within a disempowering discourse, and then prescribes her ‘the so called cure, HRT/HT’.

Code (1991) proposes that scientific knowledge “seems to caricature a set of practice that only approximates some of these features some of the time” and yet “this ideal of objectivity claims a remarkable degree of respect in epistemological, scientific, social scientific, and other circles” (pp. 35-36). Clarifying her position she adds:

One plausible explanation connects with a fairly common belief about the overwhelming and uncontrollable nature of feeling and emotion. Objectivity appeals so strongly because of its construction as distinct and separate from the vagaries of emotional life. Hence it can offer a refuge of clarity and certainty, free from the apparent irrationality of emotions (p. 36).

Furthermore, objectivity has in practice been particularly attractive to men as distrust of feeling characterizes masculine ways of thinking and the scientific paradigm is traditionally a masculine construct of knowledge (Code, 1991). Code suggests that “the fact that perfect, objective knowledge of other people is not possible” (p. 39). Code takes Satre and Frye to further exemplify her point on objectivity and the gaze.

It is an incontestable fact that vision, for all its detachment, is a remarkably effective instrument of control. Satre talks about situations in which ‘one conscious subject objectifies the other through his or her gaze, thereby casting the other in the mode of being of the en soi, ontologically of a status no different from that of a physical object. The power of vision, of the gaze, is overwhelming and immobilizing in the Sartrean account. It is no less so – and no less paralyzing – in Frye’s stark description of the activities of arrogant (male) perceivers who organize everything seen with reference to
themselves and their own interests…(thereby coercing) the objects of (their) perception into satisfying the conditions (their) perceptions imposes (p.142).

The notions of a modernist objectifying science can be applied to the menopausal life transition. What follows in the discussion below is an exploration of the historically constructed scientific discourse of menopause.

**Objects of Perception**

Along with declining estrogen levels, Krouse in ‘Menopausal Pathology’, Chptr.2, in *Menopause Comprehensive Management* (1994), stated that women’s reproductive body organs undergo atrophy during menopause. Negative images of the ageing menopausal woman are reported by the Victorian gynaecologist Edward Tilt in 1857. He described the climacteric as woman’s fall from youth and beauty (cited in Delany, Lupton & Toth 1988), as a loss of femininity and a gradual masculinisation. Delany, Lupton and Toth (1988) also report the negative gaze and perception of sagging and shrivelling menopausal breasts, organs which are believed to be important to women’s self-esteem that can only be saved by timely administration of estrogen.

More recently menopause, as offered within the biomedical frame, indicates an obvious threat to women’s lives, heralding in other diseases such as heart disease and osteoporosis even though both men and women are likely to develop these diseases. However, it is the menopausal woman who is diagnosed and proclaimed as diseased. This could be seen as ‘in anticipation’ of the actual real diseases.

The results of objectification do not portray the total reality of the woman and the natural process of the phenomenon she is experiencing but reduce the phenomenon to body pathology and further future pathologies. In addition, reductionist thinking or reductionism, is the process of reducing the ‘whole’ into many smaller and smaller divisions or parts, in an effort to develop a more rigorous and precise analysis. This process, whilst targeting particles (parts) discriminates and isolates as it separates and divides. It does not look for or consider the interplay or interconnectedness within systems. The present model of scientific research assesses in a reductionist, objective, and analytical practice, thereby reducing any given
problem to sub-problems. The sub-problems are then assumed to be independent of one another, at the expense of inclusiveness of interdependent circular relationships.

Reductionism is the doctrine that the properties of all objects and events, and our experience and knowledge of them, are made up of ultimate, indivisible elements. Analytic thinking complements reductionism; it is the mental process whereby that which is to be understood through explanation is broken down into parts. Analysis is the process whereby explanations of the behavior and properties of wholes are generalized from the behavior and properties of their parts (Ratcliffe & Gonzalez-del-Valle, 1998, p. 262)

This model with the “fundamental assumptions of the Newtonian Paradigm continue to dominate the theory and practice of science today” (Ratcliffe & Gonzalez-del-Valle, 1998, p. 363). While scientific practice is very appropriate for discerning, naming and targeting ‘foreign bodies’ and abnormal states or processes within a system, menopause, I believe, is none of these.

Summary

The above discourse analysis refers to the limitations of the dominant modernist scientific biomedical paradigm. The advantage of the scientific approach, gaze and technical procedures, is that it can produce biological facts regarding the physical body. However, I believe that biological facts are not the complete story of the menopausal woman. They are partial only, and upon reflection on this biomedical model, I hereby support and conclude with the wise words of Sjöö & Mor (1987), that biology does not determine one’s destiny, but is only the beginning. I now continue with discourse analysis of two biomedical texts.

BIOMEDICAL MODEL - TEXT ONE: FEMININE FOREVER

My Introduction

The title of this text is Feminine Forever (1966). The discourse analysis follows the chapter structure of the book. The author is:
Robert A. Wilson,  
MD, FICS, FACS, FACOG  
Consultant in Obstetrics and Gynaecology,  
Methodist Hospital, Brooklyn, N.Y;  
St. Mary’s Hospital, Brooklyn, N.Y;  
Putnam Community Hospital,  
Carmel, N.Y.

Robert A. Wilson is a man of many credentials. His text was published in 1966, and is significant as it promotes estrogen replacement therapy as the necessary intervention for menopause. Not only does this text promote estrogen as a replacement therapy but it also claims to totally abolish menopause. Wilson claims this as a “new biological destiny for every human female” (p.22). He also claims that he writes this book for the “lay public” (p.22). This is a tightly packed and very informative book. I will be referring mainly to many contradictions which occur throughout the text. I believe these contradictions create confusion and I propose that further reflection and response is necessary as the information in this text can be very misleading to the readers of this book, that is to the public at large, not only to women. The text promotes hormone replacement therapy and specifically promotes estrogen as the means to abolish and eliminate menopause altogether. Wilson claims the elimination of menopause as a “new biological destiny for every human female!” (p.17). He believes that menopause should be eliminated as he has diagnosed it as a disease.

This book is written from one man’s perspective only. However, it has been a great influence, not only on the public, but also the medical profession. The book also educated women to seek estrogen replacement therapy as a solution and as a result this therapy was extensively prescribed over many years.

Wulf H. Utian, another prominent medical professional and proponent of the biomedical model for menopause, in his text The Medical Manual: A Woman’s Guide to the Menopause, refers to this book of Wilson’s thus:

_Feminine Forever_ written by Doctor Robert A. Wilson represents a landmark in the written history of menopause despite the many failings that it had. It placed the
subject directly in the spotlight of public attention and in the hands of the media, thereby succeeding in firing excessive expectations and literally opening the floodgates of patient demand (Utian, 1978, p. 19).

This, he says “presented a grave problem” because not enough research had been done, and therefore “much research still had to be done in this field” (Utian, 1978, p. 19). In other words, this book was instrumental in creating problems. Although there had not been enough research, Wilson published the book and convinced his readers that estrogen therapy was the essential and necessary intervention for all women. And Utian also claims it as a landmark in the written history of menopause.

I believe this is a faulty and flawed text as the predominant focus is the diagnosis of menopause as a deficiency disease and therefore the menopausal woman as diseased. The text is reductionist in that only bodily responses are considered and therefore, it is also limiting in its main premise. To support my argument, I refer firstly to the Foreword in this book, then to the contents of the introduction and the first seven chapters.

**Foreword**

The Foreword is written by Robert B. Greenblatt MD, Professor and Chairman, Department of Endocrinology, Medical College of Georgia, who signals us in an authoritative voice as to the destiny of every woman. His following statements also set the scene for this book.

> “The life history and destiny of each women is dependent to a great degree on the intensity and duration of her ovarian function” (p. 13).

This book has been birthed from male thinking. It is not an accurate representation of a woman’s perspective of her life history and destiny. I believe it is critically limited and flawed, as a woman’s life history and destiny involves much more than her reproductive system. Whilst Dr. Greenblatt is supporting Dr. Wilson’s medical opinion, his statement is lacking any understanding of women’s reality. A woman is much more than a system of ovarian function.
Greenblatt then follows on with a description of woman’s femininity. “Her femininity encompasses three phases: puberty, the reproductive years, and the climacteric or the menopause” (1966, p. 13). These three phases define her in terms of her reproductive system, which are all dependant, according to Greenblatt, on her ovarian functions.

But women’s femininity is not limited to her reproductive system; however her reproductive system is characteristic of a female body. However, women’s destinies can also be dependent on other systems within their bodies, as well as various systems external to their bodies. Greenblatt’s words give a false impression of women to women and also to men, particularly to men who too do not really know what women’s destinies are dependent upon. This particular text *Feminine Forever*, is in effect misleading, not only to the medical profession, but also to women who seek more information on menopause, and also to the public at large; that is anyone else who chooses to read this book.

Greenblatt continues by telling us that a woman enters the climacteric with dread.

> When we consider a women’s biological constitution, and the vicissitudes of her environment, it is clear why she enters the climacteric with uneasy and uncertain tread. She dreads the threat of declining femininity, of waning romance. For her, it may well become a period of emotional irritability and instability. Little wonder, then, that the psychosexual upheaval connected with this time of life is apt to trigger a train of varied symptoms - one physician stamping these as psychoneurotic, another considering them as menopausal (p. 14).

This paragraph initially refers to the biological constitution and her environmental vicissitudes as the reasons for the confusion the woman experiences as she ventures forward into the future. Then he cites waning romance as a result of her declining femininity as her dread. However the paragraph ends up reassuring us that the psychosexual upheaval causes confusion within the medical profession itself, that it is not easily defined, as indicated in his own words. I believe this is so because a male gendered lens cannot define the phenomenon of menopause and as a result the so called psychosexual upheaval causes confusion for the medical profession. I believe the destiny of women based only on ovarian function needs to be corrected as this can cause even more confusion for women themselves. It is a shock and
an insult and a contradiction to be considered as a reproductive machine only, one that is dependent on one’s ovarian system alone. This is a partial truth, a belief that has been birthed from one gaze only and lacks women’s knowledge and understanding of her own embodiment.

However, the point Robert Greenblatt is making is that “the menopause has been regarded as - a physiological state, admittedly damaging to the body economy; an inevitable though unwelcome expectation” (p. 14). Consequently, because of the above the damage to body economy, Dr Greenblatt tells us that Dr. Robert Wilson has seen fit to abolish menopause completely. This is scary as this is one whole phase of a woman’s life-cycle developmental processes that he is abolishing as demonstrated in the following words:

Dr. Wilson, with messianic zeal, has campaigned for its abolition. His voice is being heard and re-echoed. Like a gallant knight he has come to rescue his fair lady not at the time of her bloom and flowering but in her despairing years; at a time of life when the preservation and prolongation of her femaleness are so paramount (p. 14).

He also goes on to say “[n]ow, Doctor Wilson, with boldness and clarity of purposes, sounds the clarion call, awakening a slumbering profession to a woman’s needs, and defies the traditional laissez-faire of physicians towards the hormonal treatment of the postmenopausal woman” (p. 14).

In Greenblatt’s words, as he introduces Wilson’s work to all, after admitting confusion within the medical profession, he claims that Wilson has all the answers. Dr. Greenblatt has actually named Dr. Wilson as the rescuer of women from a natural stage in their lives, naming and honouring him as a ‘gallant knight’. Greenblatt even supports his defiance of the traditional reluctant attitude of physicians to prescribe hormonal treatment to post menopausal women.

Even more pronounced than his call for physicians to defy their traditional attitude towards menopausal treatment, Greenblatt continues further in support of Wilson’s ability to abolish menopause (one total phase of a woman’s life) and his intentions to challenge and brainwash physicians who do not agree with this abolition, to agree. He announces how Wilson:
By throwing down his gauntlet, he challenges the reluctant physician to follow him in providing the hormones that may allow for a smoother transition to the menopausal years ahead. Woman will be emancipated only when the shackles of hormonal deprivation are loosed (p. 15).

These words indicate that the emancipation of women depends on hormone replacement treatment. In contrast from a feminist perspective, women’s emancipation is defined by the woman herself.

Finally Greenblatt, after stating how Wilson claims emancipation for women, he then states that Doctor Wilson by bestowing woman with the right to remain forever feminine he returns to the elegiac pronouncement of days gone by quoting Shakespeare:

“To me, fair friend, you never can be old,
For as you were when first your eye I ey’d
Such seems your beauty still” (p. 15).

The non scientific romantic quote presented above is proposed as the justification for the application of hormone treatment to the body of the menopausal woman. The romanticisation of HRT/HT as rescue is further echoed in Greenblatt words when he refers to Wilson as the knight in shining armour who saves his fair maiden. It could be seen that he is playing God as and in addition to abolish one whole phase of her life, menopause.

**Introduction: A Biological Revolution**

In his own introduction, Wilson (1966) himself introduces us to his “biological revolution” (p. 17), by telling us that “this book is an invitation to all women everywhere in the world” to share the adventure “of a new biological destiny for every human female” (p. 17). This is, in effect, Wilson’s own biological revolution.

Wilson then goes on to explain that a pioneer group of “six to twelve thousand women” are “spearheading a new kind of sexual revolution and they are pointing the way to a new biological destiny for every human female” (p. 17). They will never suffer from menopause.
and because of the employment of menopause prevention techniques they are defying ageing and staying youthful.

“The outward signs of this age-defying youthfulness are a straight-backed posture, supple breast contours, taut smooth skin on face and neck, firm muscles, and that particular vigour and grace typical of a healthy female. At fifty, such women still look attractive in tennis shorts and sleeveless dresses” (p. 18).

The image of woman is very important to Wilson, and a more youthful and attractive image at that. Wilson tells us about attractiveness in women.

“To the emotionally mature woman, this physical attractiveness is rarely an end in itself. Rather, it is a subtle psychological means by which she relates to the world around her. While this quality may not be directly erotic, its charm usually derives from a woman’s sexual self-confidence. And now, thanks to recent medical advances, it is possible for any woman to retain her sexual appeal as well as her sexual vitality throughout later life. By retaining these functions she also safeguards the less direct and more elusive aspects of her total femininity” (p. 18).

In other words, it is her physical attractiveness that ensures her relationship with the world. This is not only an objective limited account of women, but also ignores her real self, which in actual fact, is more than her physical body interacting in the world.

Wilson goes on to say that the new biological revolution is the result of a series of medical discoveries about the chemical causes of the menopause. “Before these discoveries, the menopause had been regarded as a normal condition for women at a certain age” (p. 18). Even today, according to Wilson, many reputable physicians shrug the “change of life” off as “nothing but a state of mind” (p. 18). However, Wilson claims to know more, he states:

“In the course of my work, spanning four decades and involving hundreds of carefully documented clinical cases; it became evident that the menopause – far from being an act of fate or a state of mind – is, in fact, a deficiency disease” (p. 19).
Also:

“By way of rough analogy, you might think of menopause as a condition similar to diabetes. Both are caused by lack of a certain substance in the body chemistry. To cure diabetes, we supply the lacking substance in the form of insulin. A similar logic can be applied to the menopause - the missing hormones can be replaced” (pp. 19-20).

Wilson has defined and diagnosed menopause as a disease. However, although Wilson draws our attention to this similarity above, he has difficulty receiving support from the medical profession for his categorization. Although he gives recognition to his opponents he continues to pronounce and advertise from his own authoritative voice the need for preventative treatment even before the lack of estrogen actually occurs.

“Although this new concept of the menopause has been distressingly slow to find acceptance in the highly tradition-minded medical profession, the following clinical facts are now firmly established. The menopause is curable. Under proper treatment nearly all symptoms cease in the vast majority of cases. The bodily changes typical of middle age can be reversed, and sexual functions can be restored, together with a fully feminine appearance. The only sexual function that cannot be restored is fertility. The menopause is completely preventable. No woman need suffer if she receives preventive treatment before the onset of the menopause” (p. 20).

The second point is not only risky, but it is also dangerous as it attempts to control a normal process before it even occurs and before the reduction in hormones occurs. However, Wilson informs us that he is the ‘originator of this form of treatment, and that he is very grateful for the good fortune that has enabled him to find this ‘key’ needed by every woman to enable her to gain “a new control over her destiny” (p. 20). The key being estrogen replacement.

Wilson also defines this hormonal treatment as sexual restoration as he later refers to the “number of sexually restored postmenopausal women in America” in 1967 as 14,000 (p. 22), stating also that the “obstacles of full femininity, along with the mental impediments” will now be eliminated. The definition of mental “impediment” is questionable. This
terminology gives negative connotation to the changes in women’s brain functioning at this time of life. His statement indicates that the natural brain changes that do occur should not be allowed to do so identifying them as impediments, thereby indicating to women that they will be mentally impaired without hormone replacement therapy.

Chapter One: A Woman’s Right to be Feminine

The title of this chapter is “A Women’s Right to be Feminine. However this Chapter is more about Wilson’s commandment for the woman to remain sexy and feminine for life, by his claiming the abolition and elimination of this one whole phase of woman’s life - menopause. Wilson teaches us that menopause must be recognized as a major medical problem and that this is the responsibility of medical science and also that “the treatment and cure of the menopause becomes a social and moral obligation” (p. 25). What he is claiming here, is that the scientific and medical profession have the responsibility and the power to control women’s bodies. In other words they are the ones that state what it is that women need medically for the rest of their lives. Wilson states, “at this point in history, medical science can no longer evade the responsibility of helping women to remain feminine for life” (p. 25). Furthermore in his very bold fashion he tells us “[w]omen, after all, have the right to remain women. They should not have to live as sexual neuters for half their lives” (p. 25). However, I believe that most women after menopause quite rightly may believe that they are still women, and not neuters. This is his terminology only.

Wilson then goes on to explain to us that a woman has to be sexy. This is necessary for her to be able to function effectively in a sex-dominated world. He goes on to state:

“This need for distinctive femininity as an indispensable social asset is by no means confined to young girls in search of a husband. A matron’s prestige, a business woman’s success, all depend, at least indirectly, on the body chemistry that enables a woman to attain full femininity, both physically and psychologically. And with the extra years of a longer life span, the modern woman understandably longs for ways to retain her invaluable aura of femininity long past the traditional barrier of the menopause” (p. 26)
The above statements are ensuring that the woman adapts to, and remains continually compliant with the values of a sex dominated society. This control of the woman’s body becomes one way in which the patriarchal sex-dominated values continue to hold power. From Wilson’s perspective a woman’s body is the gauge and measurement of the woman’s success in this sex-dominated society, where her other attributes are not considered important and worthy of consideration at all.

Wilson continues in this chapter to focus on the need for physically attractive femininity. He particularly emphasizes appearance such as “dress, grooming, manners, and style of language” as being “part of a woman’s femininity as her physical attributes” (p. 27). Once again the woman is viewed objectively. And, again from Wilson’s objective perspective he states:

“The elimination of the menopause is perhaps the most important technical advance by which women may equip themselves for an enduringly feminine role in modern life. As a physician, it is therefore disconcerting to me that large segments of the medical profession still fail to understand the modern woman’s need to remain fully feminine throughout her lengthened life span” (p. 29).

Wilson has difficulty understanding that the medical profession at large have difficulty accepting his interpretation of what woman’s needs are through her life-span. He continues in this chapter to relate the hesitance of many physicians to cure the menopause. Wilson states why this is:

“It is not difficult to explain why so many doctors have a ‘blind spot’ concerning the menopause in their diagnoses. One reason, as I have pointed out, is the tradition of regarding the menopause as a natural phase of ageing rather than a disease. Another reason that menopausal symptoms are so common that the doctor fails to notice them - even in members of his own family” (pp. 31-32).

Wilson’s statements can be seen as a great source of confusion. Menopause is, in reality, a natural phase of a life-cycle process rather than a disease. This reality would account for the
hesitancy of large segments of the medical profession to profess menopause as disease. What is particularly critical here is that Wilson himself tells us it is a ‘great segment’ of the medical profession who fail to understand his own personal agenda regarding the woman, and not a minority. Surely this would be an indication that Wilson’s theory is very questionable. However Wilson blames the “limitations of medical training as the reason for the blind spot” (p. 33). This he also refers to as “the engulfing sea of ignorance” (p. 34). This would mean that the medical profession have not been trained appropriately and correctly, according to Wilson, to know that menopause is really a disease and not a natural life-cycle process.

After Wilson has put forth examples of this ‘sea of ignorance’ of his profession, he then moves into men’s fantasies of women.

“A man always marries Helen of Troy or Aphrodite - an angelic, ethereal creature whose beauty was sung by poets of the past. And through the daily round of shopping, drying dishes, or looking after babies, he stubbornly clings to the image of his wife as a mysterious, dreamlike incarnation of some superb fancy. Men are incredibly loyal in this way, provided they get a little co-operation from their wives in supporting this gallant fantasy” (p. 34)

This is a very dangerous and disturbing statement. Wilson’s statement indicates that wives should support this fantasy and be co-operative in upholding this so called “gallant fantasy.” This will then ensure men’s loyalty. In other words, a woman is required to live up to an image of herself that is not necessarily herself at all, for men’s sakes. Woman is not a “mysterious, dreamlike incarnation of some superb fancy.” She is a real life person, separate from any person’s fantasy of her, and she is much more than a dream.

Ultimately, Wilson is implying that when a woman does not fill the fantasy, and is not feminine, she does not deserve her due recognition and loyalty by a man. Wilson aims to restore the man’s fantasy of woman by diagnosing her as diseased and thereby eliminating and abolishing one aspect of her natural life cycle. This he believes will ensure her femininity forever, or in other words, will ensure his fantasy of her, as he wishes her to remain physically attractive only, forever more, to fulfil men’s fantasies and that this can be achieved by estrogen therapy. This chapter indicates to women that they should live to meet men’s fantasies rather than be authentic selves.
Chapter Two: Must Women Tolerate Castration?

This book is written from a male’s perspective or in other words from a male’s fantasies and his own perspectives. Wilson defines the menopausal woman as ‘unnatural’ because she does not meet the fantasies. In this chapter he argues for her abnormality, in particular her abnormal menopause. Therefore I particularly wish to focus on statements which I think require correction or at least require reflection. Wilson’s statement that menopause is castration is one such statement.

“Whenever I speak of the menopause as castration, some shocked nice-Nellies of either sex - a good many of them doctors - protest that I am overstating the case. But castration, I believe, is the proper term for a syndrome depriving a person of his (or her) sexual functions. It makes no difference whether castration is brought about by removing the genital organs with a knife-as in the surgical removal of the ovaries - or whether the ovaries shrivel up and die as a result of the menopause. In either case, the effect is the same: the woman becomes the equivalent of a eunuch” (p. 37).

Wilson believes that woman becomes a eunuch. This is untrue as it is Wilson’s terminology for the menopausal woman, and it is from his perspective only. He even interprets many of his colleagues from his own perspectives, that is, other doctors as nice-Nellies. Incredibly worrying, however, is the fact that this text has been published by Wilson to educate the public, that is to educate us all.

Wilson then attempts to give us the evidence that supports his diagnosis of menopause as castration, by telling us that menopausal castration is not only confined to the sexual organs. “Because the chemical balance of the entire organism is disrupted, menopausal castration amounts to a mutilation of the whole body” (p. 39). He bases this on an extensive list of symptoms that occur about the time of menopause. However, many of these symptoms may not be due to menopause alone. He states:

“In all but 15 per cent of menopausal women, the following symptoms develop in varying degrees:

- the tissues dry out
- the muscles weaken
- the skin sags and
- the bones, because of the hormonal deficiency become brittle and porous, easily fractured” (p. 36-37).

It can be said that all of these symptoms, except for the first one, also occur in men as they age. However, Wilson continues:

“Moreover, while women during their fertile years are immune to coronary disease and high blood pressure, the menopausal woman-lacking female hormones - soon loses this advantage and becomes as prone to heart trouble and strokes as a man of a similar age. These are the secondary effects of her castration” (p. 38).

Whilst Wilson indicates that the menopausal woman is more prone to heart trouble and strokes, at the same time, so too, he admits are men. This hardly makes a case for the castration of women. I believe his authoritative, but contradictory statements are instrumental in causing both confusion and fear in many women. His following words would certainly instil much fear into those who read them: He states “no woman can be sure of escaping the horror of this living decay (my emphasis) …[e]very woman faces the threat of extreme suffering and incapacity” (p. 39).

Ultimately, Wilson gauges women’s incapacity and castration and her living decay against the model of a male:

“The normal, natural, harmonious ageing rate with respect to the life-span is found in the example of a healthy man. A man remains male as long as he lives. Age does not rob him of his sexual appetite nor of the means of satisfying it. Throughout life he retains his appreciation of a charming girl or a handsome woman, and with, a certain liveliness of outlook that makes him function fully and responsibly as a human being. True, his supply of sex hormones diminishes over the years, but his sexuality decreases gradually. No abrupt crisis has to be
faced. A man’s life proceeds in smooth continuity. His feeling of self
remains unbroken” (p. 45).

In other words, woman’s ageing process is faulty. She is the dysfunctional sex. She is
betrayed by her own body!

“How different is the fate of woman! Though modern diets,
cosmetics, and fashions make her outwardly look even younger than
her husband, her body ultimately betrays her. It destroys her
womanhood during her prime” (my emphasis) (p. 45).

Menopause, according to Wilson, destroys her during her prime.

But, once again our gallant knight reminds us that ‘medicine offers a practical escape from
this fateful dilemma’ and he reassures us that women no longer need to be handicapped, and
that through the help of estrogen pills, we can be just like men (my emphasis).

“With estrogen therapy, the basic handicap of women with respect to
men – their fast and painful ageing process – is overcome. Now
women need not age faster than men. If a woman’s body is furnished
through pills with the needed estrogen which is no longer supplied by
her own ovaries, her rapid physical decline in post-menopausal years
is halted. Her body retains its relative youthfulness just like a
man’s” (p. 46) (the above emphasis are mine).

Then what follows is an almost God-like statement from Wilson regarding the menopausal
woman.

“It is the untreated woman – the prematurely ageing castrate –
that is unnatural” (my emphasis) (p. 47).

More fear circulated for the menopausal woman, but once again God enlightens us with the
good news that “[e]strogen therapy doesn’t change a woman. On the contrary, it keeps her
from changing” (my emphasis) (p. 47). This statement from Wilson ignores that it is women’s nature to change.

Wilson concludes this chapter focused once again on the evil phenomenon of the castration of women stating that:

“I rest my case on the simple contention that castration is a bad thing and that every woman has the right – indeed, it is her duty – to counteract the chemical castration that befalls her during her middle years. Estrogen therapy is a proven effective means of restoring the normal balance of the bodily and psychic functions throughout her prolonged life” (my emphasis) (p. 48).

By this time, many women would not only be confused by their menopausal castration, they could also be petrified. This last statement from Wilson, by playing God, he is actually laying down the law for woman. By naming her menopause as a bad thing, he claims that every woman has her duty (my emphasis) to correct this bad thing by accepting estrogen therapy throughout her life time. He does this by claiming that she can counteract this so called castration by embracing his diagnosis of deficiency disease, as well as estrogen therapy as the cure.

Chapter Three: A Woman’s Chemistry

In chapter three we learn, amongst other things, that estrogen does not predispose towards cancer. Wilson makes us aware again of women’s reproductive systems and continues to argue for the wonder drug, estrogen.

Once again, another contradiction is evident. After commenting that ‘the working of the body is still hidden from human knowledge’ he then states that ‘through investigations into the chemistry of the female sex organ, we have arrived at a new understanding of femininity’ (1966, p. 50). In another contradiction:

“This approach to femininity in terms of hormones should not be construed as an attempt to reduce womanhood to a chemical formula. A woman’s secret lies in her human individuality – a realm far beyond the reach of science” (p. 50).
Although Wilson admits that reducing woman to a chemical formula is not the ideal understanding of femininity and that her secret lies in her human individuality, he then reverts back to chemical science once again to extol its virtues and that chemistry provides the conditions for essential womanhood to reach its full unfolding. He indicates that “new insights into the chemistry of the female organism help to provide the conditions under which essential womanhood may reach its full unfolding” (p. 50).

Wilson even states that “in a family situation, estrogen makes women adaptable, even-tempered, and generally easy to live with” (p. 56). In other words, she will be very compliant. And more importantly, Wilson reassures us that no woman “is in danger of losing her sexual self-control due to estrogen therapy”, as it “does not stimulate sexual aggressiveness” (p. 57). In other words estrogen has a calming, pacifying and controlling effect.

Then a most startling statement from Wilson. A main point he wishes to stress is that “estrogen, unlike some other hormones, has almost no undesirable side effects” (p. 56). He alerts us to the misconception concerning hormone therapy that “estrogen predisposes towards cancer.” He then reassures us that “the truth is exactly the opposite” (p. 58).

**Chapter Four: A Woman’s Body**

“A woman’s body is the key to her fate.” (p. 60)

The above is the main point of this chapter, Wilson’s main focus is the objective gaze on the woman, in particular the importance of her physical body. Wilson reassures us that physical attractiveness is no substitute for other feminine qualities, such as wifely devotion and a girl’s charm. But he believes that most women know that it is her physical appeal that allows her to function well in our society and to be able to attract a man. In his own words, “[i]n short, a woman’s physical appeal is her starting capital in the venture of life – the ‘ante’ which lets her into the game” (p. 61).

In a more convincing way Wilson tells us just how it is for a woman:

“To a woman, physique is a more decisive factor than to a man. Since husband, marriage, and children are the fundamentals of her life, her physical, social, and
psychological fulfilment all depend on one crucial test: her ability to attract a suitable male and to hold his interests over many years” (p. 60).

This statement has obviously been birthed from a man’s thinking. Most women know that their physical, social and psychological fulfilment does not depend solely on attracting a man and to continue attracting him for the rest of her life. I believe the ‘game’ that Wilson refers to, is really what he himself is describing about women. Surely many and most women do not wish to play a game all their lives. They want to live an authentic life.

Wilson continues with his limited perspective:

“Physical attractiveness should not be confused with beauty in the purely visual sense. Almost any man will agree that even a homely girl can be delightful if endowed with a certain quality of physical femininity. This quality, indefinable in itself, is a composite of bodily grace, shapeliness, and the emotional and mental correlates that so often result from a healthy body. In short, while femininity is not purely physical, it stems from certain physical and bodily prerequisites. As we shall see, these are determined directly by the amount of estrogen in the body” (p. 61).

Wilson is pronouncing that even a homely girl is dependent on physical qualities to ensure her as a delight, thereby omitting and denying any other qualities she may possess as being of much value in a woman. It is birthed once again from male gaze. To say that a woman is determined by one hormone only is totally reductionist in thinking. This is also a contradictory statement as Wilson, in the rest of the chapter, tells us that other hormones are involved in the determination of the woman.

As Wilson continues to focus on the female physical body, he makes the following disturbing statements. “[t]he girl-child cannot be considered physically female. With her sexual organs non-functioning and without estrogen - the key to bodily femininity - she is, medically speaking, a neuter” (p. 61). He further states:

“At the end of adolescence, she is at last complete. Everything about her is designed to attract the male, and she becomes increasingly aware of this power” (p. 62).
“It is fascinating to consider how a chemical substance such as estrogen shapes the spirit and defines the purpose of a human being” (p. 62).

I personally, as a woman, do not believe any of these statements approximate the truth, and I think they require reflection and correction. I do not believe a female child is a neuter, and she is certainly not a complete person at the end of adolescence as it takes a life time to become a more complete person. I am sure that one’s spirit is not defined by estrogen alone. I believe these are dangerous statements, as they are misleading and may be believed not only by women, but also any person who reads these words about women. They define women in a very limiting way. They are inauthentic, confusing and misleading and even dangerous, especially to proclaim that a chemical substance shapes a woman’s spirit and her purpose in life.

Wilson then focuses on the ovaries and in particular on ‘the double life of the ovaries’ and that they function ‘as repositories for eggs, and as endocrine glands producing hormones.’ (1966, p. 62). In the following he explains this further:

“They switch every month from one product to the other: estrogen during the first half of the menstrual cycle, progesterone during the second half. Also, as chemical factories, they wear out too fast. Halfway in a woman’s life, these factories break down - causing the onset of the menopause” (p. 63).

Wilson uses the terminology of ovaries as ‘chemical factories’ and then refers to their ‘breakdown’. He then announces that the chemist becomes the new factory.

Wilson then follows this with a very startling statement that “[t]he body doesn’t care whether the estrogen on which it thrives is ‘home-grown’ in its own ovaries or obtained from the nearest the chemist. Just as long as there’s enough of it” (pp. 63-64).

But his argument then becomes contradictory. Whilst having stated that the ovaries are ‘the key’ to her bodily development, he then tells us that “the entire endocrine system of the body is arranged like a tightly organized corporation in which everybody takes orders from
headquarters” (p. 64). And more importantly he then states that the “[h]eadquarters is literally in the head” (p. 64).

The contradiction here being that after he states that the ovaries are the key, he then follows with the news that the real headquarters are in the head.

Wilson then briefly refers to this mind/body link. He devotes less than three pages of this eighteen page chapter to the connections and the functions of the pituitary and the adjacent hypothalamus, and FSH and LH. Similarly, in addition, Wilson also refers to an emotional component being present. His interpretation of this menopausal connection is as follows:

“The hypothalamus – the control centre of the autonomic nervous system – takes a terrific buffeting when the pituitary gland reacts to the cessation of estrogen production in the ovaries. The hypothalamus, in turn, sends out alarms throughout the autonomic nervous system with unpredictable emotional results” (p. 66).

Wilson continues to list all the other organs that these so called hectic and disorganized messages effect. He believes that these organs, “previously so well controlled by the hypothalamus, now revolt against her menopausal confusion” (p. 66). He states:

“In their own way, the organs protest against the panic in the central command. The net result is that the post-menopausal woman suffers a decline in all her bodily functions – not merely in those connected with reproduction. Such perturbation of the body puts her mind and spirit to a gruelling test, and it is hardly surprising that many women become mentally disturbed in their menopausal years” (p. 66).

Even more disturbing for me however, is Wilson’s next statement, “[l]et me, however, call attention once more to the sequence of these events: it is the physical disturbance that caused the mental upset – not the other way round” (p. 66).

Wilson has just previously advised us that the entire endocrine system takes orders from headquarters that is literally in the head. Now, two pages later, it is the physical that causes the mental. It is interesting to note now that Wilson cites the menopausal woman as confused
and says it is not surprising that women become mentally disturbed at this time, whilst Wilson’s own statements are contradictory and therefore confusing. However, Wilson’s contradictory statements do alert us to the fact that brain changes are implicated and actually do occur within the menopausal woman. What Wilson does not direct our attention to, and educate us on, is the importance of the implications of the increased level of hormones and therefore the changes in consciousness that can occur through the interconnections of body, mind, soul and spirit. What he also marginalized, rejected and ignored is the value and effects of the connections that are occurring between the physical and the mental. Whilst focusing on the physical only, together with the loss of estrogen only, Wilson omitted the most dynamic aspect of the phenomenon, including the other increased hormones. This has resulted in this dynamic connection being hidden behind the pathological diagnosis of the estrogen deficiency disease. It was not addressed appropriately in Wilson’s negative pathological diagnosis, and therefore is a glaring omission. Whilst this is omitted by Wilson, it is still a reality for the women.

Moreover, Wilson continues in this long chapter, to focus on the physical body only. In particular he refers to the improvements in physical attractiveness due to estrogen replacement. He discusses the breast in particular, making another startling statement that “woman’s breasts are a psychological organ” (p. 69). He has also witnessed that in certain primitive tribes, a woman’s exposed breasts are painted with ornamental patterns. Also he states they are important as they are, “part of her psyche”, therefore accounting for why the breast is seen as a psychological organ (p. 70). This is a somewhat circular argument as all physical parts of a woman are also part of her psyche, not only her breasts. Further to this Wilson makes statements about painted breasts in certain primitive tribes and then makes the connection that breasts are psychological organs. He then talks about his professionally training in the art of observation. The following example is an admission of how his own objective gaze defines the woman.

“Roving about at a party, a footloose male might scan his surroundings at floor level, searching for a pair of timely legs. A slow upward sweep of the eyes thereupon assesses the general posture of his object of interest. As a physician professionally trained in the art of observation, it has not escaped me that what turns heads at a gathering is not a woman’s face or even her figure. It is an erect, graceful posture
that invariably commands attention. Men are generally unaware that it was a woman’s stance that attracted them. If asked what drew their attention to that particular woman, they would not be able to define posture as the decisive factor” (p. 70).

Also of great significance here is Wilson’s admission of a woman’s body as his object of interest, strongly indicating not only his objective gaze, but also his superior mentality. His professional training as a physician sets him apart from other men who lack skilled observation.

I continue now with his next paragraph as this is also instrumental in the development of subtle contradictions in his writing. He states “[o]nce his interest is aroused, a man usually takes a rather systematic inventory of a woman’s appearance” (p. 70). This sentence indicates that a woman’s overall appearance is important to a man. But it is her sensual body image that is of prime importance to men. According to Wilson as we see in the following:

“He assesses her face, though beauty in the classic sense does not seem to rank high as a sexual attraction, then he examines the way she dresses, reacting strongly to that indefinable quality of chic, which, by the way, has little to do with being fashionable” (p. 70).

Wilson has admitted here, that in a man’s eyes, a women’s body is more attractive and appealing to him than her face. Men are more interested in her body parts, than the deeper self and the real woman, who is more than body parts only, that maybe expressed in and through her face. This body is a shallow and surface attraction only.

Then Wilson continues, to educate regarding dress taste. Although he is remarking about the way women dress, his words are saying more about his objective physical body observations than anything else.

“There are women who look more chic in dungarees than others do in a Dior model gown. The critical survey then proceeds to her hands, teeth, and throat. By that time the investigating male is doubtlessly edging closer in order to hear her voice.
Eventually, his eyes limit the contour of her breast. But this, in most social situations, has low priority” (p. 71).

Having clarified the breast as low priority in social situations, Wilson, however, continues to focus extensively on breasts, perhaps unconsciously if not consciously, considering them in reality, a high priority in men’s objectification of women’s bodies. If not, his words are confusing, as he once again contradicts himself. He continues to tell us in more detail, not only about excessively large breasts but also small breasts, and then moves onto women’s genitals and how sex hormones and estrogen and progesterone therapy can lead to a fuller development of both the breast and the genitals. Wilson continues to focus many words on breasts before he focuses on the vagina. Or, more specifically the vagina and its relationship with estrogen, one which he tells us is not well advertised or known about. He states:

“Few processes in the entire body are as dramatic as the estrogenic transformation of the vagina. However, since it occurs in what are, quite literally, a woman’s private parts, this amazing physiological event is rarely notice and completely taken for granted” (p. 74).

Wilson continues to tell us that estrogen has an amazing effect on many other parts of the body. The skin, the bones, the hips, the eyes are all included in the improvements by estrogen and he elaborates:

“The reason for the pervasive influence of estrogen is that it affects every single cell of the female body from the little toe to the top of the head. This over-all, controlling power stems from the role of estrogen in the basic energy household of the body” (p. 75).

Then Wilson tells us that because of menopause, “the heart, the stomach and intestines, the smooth muscles of the major arteries, the bronchial tubes, the bladder and kidneys – all become damaged in some degree” (p. 76). However, in this chapter, Wilson does not discuss the ‘relation of estrogen to heart disease, coronary attacks and strokes’ but instead states:
“For the present, I should like to emphasize the general nature of these changes, spreading through the entire body. This explains why the menopause is so difficult to define as a specific disease yet can produce truly catastrophic conditions of the whole organism” (p. 77).

Although Wilson admits it is very difficult to define menopause as a specific disease, he definitely does define it as a disease.

Chapter Five: Menopause – The Loss of Womanhood and the Loss of Good Health

In Chapter five, Wilson refers also to men. However, it is not the roving eyes on women that is the focus here but the effect of women’s menopause on men. In this Chapter, he highlights her negative effect on men, and how to fix her. He makes his point by sharing a story with us. The story is about a man who wanted Dr. Wilson to fix his wife up. He arrived wanting to talk but had not come with an appointment. This point in itself seems important to Wilson, never the less, Wilson spoke to him. The story is as follows:

“A skinny man in his fifties with a sharp and sallow face slid rather furtively through the door. His manner was an unpleasant mixture of embarrassment and aggressiveness. For a while he just fidgeted.

“Doc”, he finally blurted out, “they tell me you can fix up women when they are old and crabby”.

I sidestepped the implied question and let him tell me more of his story:

“She’s driving me nuts. She won’t fix meals. She lets me get no sleep. She picks on me all the time. She makes up lies about me. She hits the bottle all day. And we used to be happily married.”

“She’s been to three doctors already”, he continued.

“They all tell her it’s ‘the change’ and nothing can be done about it. Now she tells me to get out and never come back. But I won’t. It’s my home. And if anyone’s going, she is”.

He reached into his back pocket - in those days shoulder holsters were still unknown - and quietly laid a .32 automatic on the edge of my desk.

“If you don’t cure her, I’ll kill her.”
I looked at him doubtfully. “You think that would be better for you?” I asked cautiously, my mind reeling with all I had heard about armed madmen in doctor’s surgeries. But I was wrong. The man was completely rational.

“I have advanced T.B.,” my visitor explained. “I was X-rayed again last week. My doctor tells me that I have less than a year to live. I want to die in peace—and I can’t if she’s around”.

My client, I later discovered, was a prominent member of the Brooklyn underworld. The proposed method of dealing with his wife apparently seemed to him quite proper and businesslike. Fortunately no calamity occurred, I accepted his wife as a patient and she responded well in intensive twice-a-week estrogen injections. Her disposition improved noticeably after three weeks, and soon she was very busy taking care of her sick husband.

I heard no more from him directly. He died within the year, and I received an invitation to his funeral. His widow felt genuine grief at his death” (p. 81).

This story indicates not only this sick man as thoughtless, but a controller and a threatening prospective murderer with a gun in hand. Irrespective of this man’s threatening nature and the fact that he possessed in his hand, and in his home, a deadly weapon, with which he was able to threaten his wife and even Dr Wilson, it was the women who was injected, and was seen to be in need of controlling, not by her own request, but by two men who saw fit to do so.

Wilson refers to her ‘de-sexed’ state as the reason for her inability to respond positively to the man in her life. But very surprisingly he then gives us indications that a dysfunctional marriage would be the cause, although he does not define it as such or even explore the effects, of a love-less and life-less marriage for the woman.

‘Had she been conscious of these feminine longings for the kind of sensual and emotional fulfillment that her marriage failed to provide, she could rationally cope with her disappointment and perhaps even accept the menopause as the end of these hopes. But since her hope and motivations are mostly unconscious, she is incapable of rationally perceiving her own situation. She only knows dimly that the driving power of existence has somehow failed her.
She thrashes about widely, often venting a special vindictiveness upon her husband and family. Eventually she subsides into an uneasy apathy that is indeed a form of death within life’ (p. 83).

Wilson does however advise us that women’s menopausal negativism also depends on social status, education, native intelligence and vocational achievement, as they all exert a strong influence. He elaborates:

“Women with ample financial means and secure social standing generally manage to conceal whatever private dismay they feel at this stage of life. With travel, cultural activities, and social diversions open to them, they rarely accept the fading of their womanhood with passive resignation” (p. 85).

He then contrasts this with those women on the lower rung of the social scale stating that:

“such a woman, shackled to a dull, commonplace man, lacks that margin of imagination, cultural interest, and developed taste that helps upper-class women to fight back against menopausal despair, no matter how misguided their methods” (p. 88).

More importantly, the dull, commonplace man maybe part of her problems also.

Then initially another reference to social class:

“For the lower middle class woman, the range of available options is sharply curtailed. She has sense enough to know that, in her restrictive environment, a love affair in the casual suburban style is out of the question. She rarely has the inclination - let alone the time - to occupy herself with new interests such as volunteer hospital work, community service, amateur theatre groups, and other activities that might help her to retain a positive frame mind. So she gradually sinks into a state of almost cow-like passivity” (p. 88).
Wilson although admitting to curtailed options for the woman, he ignores the issue further and refers to her ‘cow like’ passivity (my emphasis). He then makes a link with ‘a mental problem’ but then states that it is all originating from a physical cause. A biological reduction, on Wilson’s part. Wilson does not address these social issues any further but states that:

“these psychological symptoms have given rise to the widely-held misconception that the condition of the menopause is ‘all in the head’ and that it is primarily a mental problem. This is a flagrant confusion of cause and effect. There is nothing ‘mental’ about the menopause except some of its consequences” (p. 89).

He repeats once again that “its origins are clearly physical” (my emphasis) (p. 89), and what is more important “it is high time that this fact be recognized both by the medical profession and the public” (p. 90). Although he admits it is not a mental problem, he does not include and acknowledge the significant role that the headquarters play.

Chapter Six: Feminine Once More and Forever

In chapter six Wilson not only announces once again with clarity the need for hormonal therapy to eliminate the menopause. He also confirms for us once again the immense value of the hormonal treatment and presents case studies supporting his bold clarion calls extolling the value of the treatment. In spite of his following statement, he non-the-less continues, as the one and only gallant knight, to convince us that menopause is a disease. Wilson states:

“I had already become convinced, as the result of my research in hormone therapy during the 1930’s, that the entire menopausal syndrome is a preventable disease. And though several eminent endocrinologists were sympathetic to this view, only a handful of clinical cases had been reported at the time to corroborate the theory” (p. 94)

Wilson then provides a little of the history of the discovery of estrogens from their discovery in 1923 by a Dr. Doisy (p. 95). Although the initial research was mainly in “agricultural colleges” to encourage “the sex life of chickens” (p. 95), astute doctors saw the same
potential in the sex life of the human female as in the sex life of chickens. Wilson names Dr. Fuller Albright and Dr. Kost Shelton as being early advocates of the therapy. Then however, he announces with pride, how his young age was probably the variable that enabled him to persist in trials on hormone therapy and its sexual potential for women, similar to that of chickens, whilst other medical professionals, whom he regards as ignorant, disregarded it as inappropriate. In Wilson’s own words:

“It was my own good fortune as a young doctor to share in this vital pioneering work. Possibly it was my youthful insouciance that enabled me to persist in a systematic programme of clinical trials at a time when most medical opinion was hardened against the very concept of hormone therapy by the obdurate sort of intellectual cement that is compounded equally of prejudice and ignorance” (p. 95).

Here, he judges, interprets and accuses the majority of medical opinion as intellectually cemented, prejudiced and ignorant.

However, he goes on to relate that the early treatments, including a relatively “potent synthetic estrogen – stilbesterol” (p. 95) had negative side effects on women including nausea, headaches and skin rashes. Also the German preparation ‘estradiol benzoate which proved so effective and trouble-free’, in spite of it being nicknamed the “Cadillac of hormones” by some clinicians, could not be taken orally by the women and needed to be injected (p. 96). Finally, the conjugated estrogens became available. Clarifying he states that “[c]onjugated refers to the chemical link of compounds occurring naturally in the living body. Prepared from the urine of mares in whose bodies this chemical link is accomplished, conjugated estrogens are now available in convenient tablet form” (p. 96). Seemingly then, women’s bodies can be rejuvenated and enhanced by the urine of mares. In other words horse’s urine is instrumental in ensuring that a woman stays sexually attractive to men and remains forever feminine.

Wilson then makes two reassuring statements to signify the safety and widening acceptance of the hormonal treatment. These being that due to ‘metabolic refinement’ the ‘preparations are entirely free of side effects.’ And even later in his years he states that “[i]n the closing years
of my medical career, I take a pardonable pride perhaps in the fact that the sheer bulk of medical statistics drawn from my work seems to augur a widening acceptance of this vital therapy” (p. 97).

He then continues his reassurance, stating that if you are able to “obtain the co-operation of a physician willing to treat you, there is nothing complicated, nothing difficult, and positively nothing dangerous about the therapy itself” (my emphasis) (p. 97). Then a contradiction as he himself follows up with cautions and explains that the therapy may have to be modified, especially in the cases of “cancer, kidney or liver diseases or thrombophlebitis (blood clots in veins)” (p. 97).

He also relates how a medical history will be taken and the doctor will give a complete physical examination, especially of the reproductive organs. A Pap Test – short for Papanicolaou, the Greek physician who originated it, is also indispensable. He then relates to us how the main defining test for the state of your femininity if another smear from the side of the upper vagina. “When this slide arrives at the laboratory, it is stained with certain dyes. Then, brightly illuminated by the powerful light source of the microscope, it becomes an index of your femininity” (p. 98). Even more enlightening, it appears from this slide show, is its ability of the Femininity Index to declare the status of the woman’s body. Wilson states, “[i]t tells whether her body is still feminine, or whether it is gradually turning neuter” (p. 100).

With reference to himself, Wilson appearing as the gallant knight rescuing his women tells us:

“Many of my patients who came to me regularly twice a year for these tests told me that this routine gave them a wonderful sense of reassurance. They knew that they were the first women in history to benefit from an exact measure of their physical femininity and to have it within their power to maintain – or even to restore – this femininity regardless of age. They came to look upon their visits to the doctor not as an occasion of dread and foreboding. On the contrary they were events to point the way to their self-fulfillment in life – events to be approached not with fear but with eagerness, hope and exhilaration” (p. 101).
Wilson’s last sentence tells us that it was with much eager pleasure that the women visited him, as this enabled them to be self-fulfilled through estrogen treatment that restores their femininity.

However, Wilson attempts to educate us even further in terms of its potential benefits. To do this he postulates ‘six typical cases in the hope that one of them may resemble your personal situation’. In other words, you may fit one of these examples. His cases range from women in their thirties through to a seventy-five year old lady whom he believes all require hormone therapy. He prescribes hormone therapy for women who are flat chested and frigid whom he considers to be unfeminine. In the case of the 72 year old lady, she wanted to become attached to a 59 year old healthy man. Because “[a] thin, partially atrophied vagina seemed to forestall all hope of a physical union” (p. 109), Wilson placed Mrs M. on a massive regimen of estrogen, injections every three to four days, together with estrogen vaginal suppositories and estrogen cream. According to Wilson, after three weeks, an “almost miraculous rejuvenation of her sexual organs… [had occurred…and she hardly seemed the same person I had seen at the first consultation” (p. 109). One wonders how many women have been artificially enhanced and manipulated this way by their gallant knight and hero, Dr. Robert Wilson.

**Chapter Seven: Plain Talk about Sex**

I refer briefly to Chapter 7. Wilson in his boldness tells us it is a pity that an emblem that he himself designed had not become a standard form of medical notation. He thought that because he had designed this emblem specifically whilst practising on Park Avenue as a reputable specialist, in the more subtle gynaecological aspects of women, that it would denote an important clinical fact.

“By the time my reputation as a specialist in the subtler aspects of gynaecology enabled me to practice on Park Avenue, I had acquired the habit of making a special mark on some of the files containing my patient’s medical records. The mark was a little three-pointed star. It’s a pity this emblem hasn’t yet become a standard form of medical notation. To me the little star denoted an important clinical fact: it meant the woman was deeply in love with her husband” (p. 117).
One wonders how true it is that being deeply in love with one’s husband is a clinical fact.

Wilson then admits to having favourite patients. These are women who “really love their husbands” (p. 118). Wilson elaborates saying “[t]hey are my favourite patients. In all menopausal complaints, their prognosis under estrogen treatment is excellent, because, in all matters pertaining to sex, love is the best medicine” (p. 118).

It is interesting to note what he considers the wife’s loving role to be. He very authoritatively gives a warning to all women that they should play their role in a loving way, and in particular do not complain at all. However then, it seems that the loving way becomes sexual compliance.

“Considering the complexity of a man’s sexual task, wives, in all stages of life, should be extremely careful never to damage their husband’s confidence, never to criticizes his sexual errors. Encouragement is needed, and, above all, a sense of humour. These are the roads that lead to sexual compatibility – and such compatibility is the best antidote for divorce. Ask any lawyer (p. 120).

In other words, it seems it is best not to be yourself and to relate honestly, because it is more important to submit to your husband’s ways.

Wilson then seems to be functioning as a sex therapist or marriage counsellor as he discusses the ins and outs of sexual functioning. He advises women to “retain an aura of romance of one’s conjugal exercise”, to prevent “premature ejaculation” and to assist the husband from becoming bored, ensure a “pleasant atmosphere”, “provide relaxation”, “always dress well, be appealing in taste” (p. 124-125). To reinforce this statement, Wilson actually admits “[p]erhaps a doctor, should stick to prescribing medicine instead of prescribing fashion” (p. 125). This in fact is Wilson referring to himself, with the recommendation to stick to prescribing medicine. But then he admits and continues to advise how he cannot ignore the dress design of women and how she should dress, in his own words:

“Perhaps a doctor should stick to prescribing medicine instead of prescribing fashion. Yet I cannot in good conscience ignore the matter of dress. Trivial as it may seem, it
is part of the total aspect of sexuality and marital adjustment. In particular, the recent trend of stretch pants for casual wear seems, to me at least, diabolically designed to stamp out mature sex. If the average woman could contemplate the vista she presents from behind, she would no longer wonder at her husband’s lack of ardor” (p. 125).

In other words if the ‘average’ woman wears stretch pants it is a good reason that her husband will not love her. This is a ridiculous statement from any man, but from such a highly esteemed medical professional it indicates stupidity.

However Wilson, playing God, continues to prescribe to women, the correct way to dress for their husbands which will ensure marital harmony.

“Clothes are part of a woman’s charm, and they should be chosen with precisely that in mind. Too many of today’s fashions strike me as distinctly anti-sexual, because, by being too revealing, they destroy the charm and the sense of mystery that stimulate men. If a woman lacks the sense or taste to dress attractively, I believe her husband should insist on a suitable style of dress for her. This may contribute considerably towards marital harmony” (p. 125).

These last words indicate not only bold statements, honourable knights saving their women, but men controlling women. Wilson actually advises men to tell their women what to wear. This statement is indicative of his passion and need also for women to take hormone replacement therapy to remain compliant and therefore attractive in men’s eyes. Ultimately Wilson’s perspective comes from his objectification of women. Objectification as been identified previously in this chapter as characteristic of Western scientific biomedical thinking. And to the male gaze, I refer also to Satre’s words (quoted previously in this chapter).

Wilson continues to the end of this chapter still functioning not only as a fashioner designer, but also as a sex therapist and marriage counsellor, ultimately briefly prescribing medication for men too, in the form of hormonal therapy. He sounds the clarion call, stating that for men, the “gradually diminishing sex hormones must be supplied through medication” and he states
that “excellent male steroids are now available by injection, implantation of pellets or as tablets for this form of therapy” (p. 128).

In his conclusion to this chapter, Wilson reassures men not to worry about the size of their penis as:

“The vagina, being highly elastic, accommodates itself readily to almost any penis dimensions, and a woman’s sensations during intercourse are evidently far less affected by the size of the penis than is normally assumed” (p. 129).

Confirmation to men here, that they should ‘take comfort’ from the fact that they do not have to worry, the woman will accommodate their penis, no matter what.

All the above pronouncements by Wilson indicate that women should comply with all their husband’s wishes and requirements. To do this they need to be compliant, sexually attractive, available, and forever feminine. According to Wilson hormone replacement therapy will assure this. He also tells us that it prevents frigidity and is instrumental in keeping the husband happy when the woman takes it, although it is not necessary for the husband to supplement his waning hormones.

MY CONCLUSION

For the remainder of this book, Wilson continues to support his case for the use of hormone therapy. In a sense this is much of the same. That is, Wilson’s (1966) focus is very much repetition on the same topics, those of bodies, estrogen and hormone therapy, and continually staying feminine forever. He believes he has “presented conclusive evidence in favour of estrogen therapy” (p. 130). He also argues the fact that estrogen therapy does not cause cancer, but rather “tends to prevent it” (p. 133).

From this text I have presented material which I believe is either confusing, contradictory, limited, reductionist in content, or objectifying in nature. Also I have chosen to present material from the first seven chapters only. In view of my selective choices, it would be important to have knowledge of the whole book, to do justice to the gallant knight, Dr. Wilson and his miracle cure. His book whilst informative, is disturbing, because of its many
contradictions, its blatant objective stance and its narrow and limited focus on the physical body only, if nothing else, as it attempts to put his case forward.

TEXT TWO – THE MENOPAUSE MANUAL

I now refer in further detail to the medical text entitled, ‘The Menopause Manual: A woman’s guide to the menopause’, published in 1978 by M.T.P. Press Limited, International Medical publishers. The discourse analysis follows the chapter structure of the book. The author of this Medical Manual is Wulf H. Utian, another medical professional, who established one of the first Menopause Clinics in the world, if not the first (Utian, 1978, p. 9). However, his foundations for the clinic together with his recommendations for Hormone Replacement Therapy can be seen as faulty and limited.

This text is written by a male gynaecologist and expresses a male’s perspective, from a Western scientific reductionist perspective, which focuses on pathological states. Utian (1978) himself stated that the question was to “provide all the information on an authoritative basis and still keep it easy to read” (p. 13). However, this text does not reflect the reality of the experience of menopause, which is basically foreign to men and is not a pathological process. Because menopause is a woman’s experience only and part of her normal life cycle process, she is not only closer to the experience, but has the embodied knowledge regarding the experience. She is the experience.

What, I think is critical to the understanding of the Birth of Menopause Clinic is the ‘premise’ of its origins. What was the thinking and knowledge that gave birth to the concept and reality of the first Menopause Clinic in Cape Town, Republic of South Africa. In the Preface of this Menopause Manual, Utian himself tells us:

“In 1967... I happened to be in West Berlin and was invited to visit a major international pharmaceutical firm. A new female hormone was mentioned, and thereby started my interest in the subject. Upon my return to Cape Town, I spent many hours in the large medical school library and completely surveyed the menopause literature to 1967. I was stunned by its general inadequacy and was bitten
by a challenge to clarify what menopause really was, and to define the proper place of hormone replacement therapy” (p. 9).

Because the literature on menopause up until 1967 was so lacking, Utian then took the opportunity to define menopause as disease, a hormone deficiency disease which he later termed “endocrinopathy” (Utian, 1987, p. 1281), thereby justifying the use of this new female hormone. Clearly, it can be seen that the new female hormone was the main prior impetus for Utian’s recommendations, rather than the woman herself. To this day hormonal replacement therapy still holds the prominent place as the medically accepted, recommended and prescribed intervention for menopause (PBS funded) and since this time attracts a multitude of research to its cause. It can also be seen that hormone replacement therapy was initially promoted and prescribed for a set of symptoms before it had been researched appropriately. The risks and benefits of hormone replacement therapy still continue to attract much media attention and research. I now refer to the Preface and Introduction of Utian’s book.

Preface and Chapter One: Introduction

Accordingly then, it was the impetus from the “major international pharmaceutical firm” (p. 9) that initiated the search for a reason (a disease) to enable Utian to apply the new drug and also to define the recipient of this new female hormone drug. It could be seen that he, Utian, has defined the menopausal woman as the object of disease to which this new female hormonal drug should be applied. However, Utian (1978) himself does not use the word object, but instead uses the word “appliance” (p. 15) to refer to and describe the menopausal woman. With these objectives as the impetus, that is, a new drug plus an appliance, Utian planned a ‘Clinic’ as the desirable avenue to educate, enlighten, give forth knowledge, and to recommend and prescribe this new hormonal drug as the appropriate intervention for the menopausal women (the appliance).

I believe the foundations for the clinic were ill-founded, designed and built on a premise of faulty and flawed reasoning. The following two points are I believe foundations for a flawed and faulty premise. Firstly, when Utian applied for and sought support for his objective to open the Clinic for women and in turn to prescribe this new female hormonal drug to all menopausal women he was successful.
However, in his own words, he describes this idea as presenting “a crackpot idea.” He stated:

“With these objectives in mind, I approached the Chairman of the Department of Gynecology at the University of Cape Town, Professor Dennis Davey, and spelled out my plans for a menopause clinic. Ten years previously, I might have been thrown out of the office for presenting a crackpot idea. But Doctor Davey was a scientist at heart and received the idea with enthusiasm, and in the 10 years following his decision maintained the same positive support for me as well as the Clinic. My own career in menopause research therefore parallels that of the Clinic” (p. 9).

This crackpot idea was supported for at least 10 years. It is difficult to know here if he himself thought the idea “crackpot” or if it was the perception of his colleagues. Never the less, a crackpot idea was his own words. Secondly, the clinic itself and its recommended intervention of hormones were created before sufficient research had been carried out. Utian pursued research on menopause, but this research was carried out concurrently to the establishment of the clinic, rather than prior to the birth of the Clinic. His own words above indicate this. However, he continued to extol the valuable existence of the clinic. The rooms look good, so to speak, but the foundations were weak.

According to Utian, this Menopausal Clinic is of “extreme value” and “deserves a place in all large hospitals and medical centres” for the following reasons:

1. “The centre functions as a ‘well-woman’ clinic, designed to attract women from 45 onward (or earlier with premature menopause). An opportunity is provided for participants to receive medical checkups, be screened for breast cancer, high blood pressure, diabetes, etc” (p. 10).

This means it functions to monitor women’s bodies only.

2. “All patients with menopausal problems are seen by one group of doctors and involved personnel who are highly experienced in this area” (p. 10).

One patient is seen by a group (many) doctors, thus increase the medical gaze.
3. “Follow up therapy is far more efficiently controlled and the patient herself is better able to get to know and become involved with one doctor or group of doctors” (p. 10).

The woman continues to function as ‘patient’ requiring not only one doctor but many doctors’ surveillance. This is increasing surveillance.

4. “The centre can develop a research function. This does not imply that the patient is used as an experimental model, but a continuous search after new knowledge is of vital concern to each woman who uses the facilities of the clinic” (1978, p. 10).

This needs clarification. Utian stated that the patient is not used as an experimental model but he had stated earlier that research was carried out parallel to the clinic. He ultimately stated that a research function can operate from the clinic but he does not define and tell us who the experimental subjects would be. The implication is the woman attending the clinic, who, whilst not experimented on, is never-the-less are objectified.

5. “The clinic becomes a welcoming, friendly place to the patients enrolled, much like a club. The clinic staff support each other and in doing so, create a highly attractive environment for the patient who may feel alone and in need of a chat” (p. 10).

Staff support for each other is seen as the criteria that alleviates the patient’s loneliness. I am not convinced that the clinical staff’s support of each other prevents the patient from being lonely, but it may prevent the staff from being lonely from each other. I see this as a projection on Utian’s part.

Utian (1978) then goes on to state that when he himself would arrive at the clinic for the women’s consultations late, the women would reply with the comment that “were only too pleased to wait for him” (p. 10) as they had could talk to each other. Utian then decided he would start women’s groups at the clinic, where the women could discuss their problems with each other and more importantly, where they were able to call on and access easily “either an interested physician or a menopause clinic” (p. 10) to answer their questions and give them...
the appropriate advice. These were his reasons for instigating these special groups for women. This would, in turn reinforce for the women, how they needed the clinic. Whilst Utian thought women’s groups a good idea, it could be seen that the concept underlying the groups was that there was a physician or the menopause clinic on hand to be their main place of referral.

More significantly and of critical importance is the recommendation and therefore birth of the menopausal clinic was not backed by sufficient research. Also it was a ‘crackpot idea’ as acknowledge by Utian himself, which was now accepted without evidence of its efficiency. It was therefore conceived from a faulty base, a crackpot idea and insufficient research. Furthermore, it was funded consciously, in spite of its faulty premise.

Utian’s Menopause Manual (1978) is to inform women of Utian’s views about menopause. The aim of the book is that the information presented will enable an informed decision to be made, by women (and men too), regarding the value of the clinic and in turn, hormone replacement treatment. In Utian’s own words “hopefully you will read the facts and heed the advice” (p. 13).

I now refer to the contents of this manual in more detail in an effort to explore the thinking that was the impetus for the prescription of hormonal treatment for menopausal women. I will be addressing more specifically up to chapters six and seven of this book, as they present the contradictions, confusion and disarray that is evident in Utian’s thinking, as well as confusion and disarray in the medical profession as well.

The writing and terminology in Chapter One, the Introduction, is very confusing. According to Utian the book is written for both the concerned women and also for men who are seeking insight into the problems of menopausal women. Utian stated that the manual was:

“Written expressly for the concerned woman, it should be read by men too. They need some insight into the problems of menopause, as well as some understanding of the women with whom they associate” (p. 15).

Whilst referring to concerns and problems, Utian however tells us that this book is meant to be read “like a novel” (p. 13) to be referred to when needed. He then referred to it as a “story
book”, one that he describes as having a difference that “is true to life and the main character is you” (p. 13).

The indications here are of a story book, a novel in which the woman is the main character. However, we then get the sense of Utian’s real story in the final paragraph of the chapter. He stated, “[this book is no more than a guide or practical handbook, much the equivalent of a television or new car instruction manual. The difference is that the appliance described is you yourself” (p. 15).

This reveals an objectification of women. However, Utian does not overtly refer to woman as object, but blatantly as ‘the appliance’. The woman here is regarded equally with a television or a new car. This terminology is undesirable and insulting for women, with the potential to create distortion regarding one’s identity. It is worthy of reflection and correction.

However, Utian believed that confusion for women comes from the “distorted image she may have of life and where it is taking her” (p. 14). This he blames on her attempt to seek information from “her friends or family, to women’s magazines or the lay medical press” (p. 14). He also blames “ignorance” and the following as the cause of the distorted image she has of life.

“Whose fault is this distorted idea of menopause? Probably ignorance aided and abetted by societal attitudes, fallacies and misconceptions. The situation, moreover, has often been traded upon by groups as disparate as manufacturers of teen-age fashions, the pharmaceutical industry, sports goods producers and operators of health farms” (p. 14).

However, Utian, himself is distorting her by ‘naming’ her as an “appliance”.

Utian’s purpose is “to provide all the information on an authoritative basis”, as “the need was for a straightforward explanatory book” (p. 13). But he does explain that this is difficult so he recommends it as a novel and a story book. So the book itself becomes confusing as he
continued to provide information that is both fact and fiction. Confusions mount as various contradictions appear throughout the book.

This point is further supported by the statement that “this is not a hormonal do-it-yourself kit” (p. 13). He states that “[i]n other words, where hormones and medical care are necessary, don’t try any shortcuts” (p. 13). In other words, rather than believe this book, “see your doctor” (p. 13). This provides further support that it should only be referred to as a novel or a story book, not a factual account. Again another contradiction.

This book is not quite fact and not quite fiction and in the end one wonders which is which. However, what we do know is that woman is mainly objectified by Utian, but at the same time he is the authoritative base, or in other words, he holds the authority, and therefore he knows. We presume his knowledge to be correct because it is his high professional standing that lends credence to the book and was published by International Medical Publishers, therefore indicating this to be a highly credible text.

**Chapter Two: Historical Perspective**

Utian in his second chapter presents an historic perspective. He indicated how, in past times, menopause has been described in negative terms. As recently as 1967:

“some physicians felt that the termination of the reproductive phase in a woman’s life was an event destined to throw her into considerable turmoil or would make her a negative, harmless creature. It was called a ‘tragedy’ and, in more than one reference, considered to actually be a ‘catastrophe’ which, somehow, the female must muddle through and still make an attempt to be attractive, mentally alert and lead a productive life” (p. 17-18).

Also in his historical perspective he referred to the “miracle” health cures of ovarian and glandular therapies that were seen to be appropriate for women. He comments that “[i]n 1888 one physician reported he was ‘rejuvenating’ himself by injections of testicular juice, and claimed he could do the same for his wife” (p. 17).

And then the emergence of the wonder drug ‘estrogen’! According to Utian himself:
“With the advent of estrogen, papers began to be published in medical journals extolling in virtues. Books were written on the subject. One of them, Feminine Forever written in 1965 by Doctor Robert A. Wilson, represents a landmark in the written history of menopause despite the many failings that it had. It placed the subject directly in the spotlight of public attention and in the hands of the media, thereby succeeding in firing excessive expectations and literally opening the floodgates of patient demand” (p. 19).

He, Utian boasts that Wilson’s (1966) book was instrumental in creating the demand for estrogen, whilst at the same time admitting it had many failings and therefore was flawed. This text being one of the books that emerged extolling the virtues of estrogen, but it has also been identified as having many failings. Utian too some extent supports the above analysis of Wilson’s work.

Although Utian stated that this “presented a grave problem” (my emphasis) (p. 19) he still promoted, advertised and prescribed hormonal therapy as the appropriate intervention just as Wilson had prescribed. However, also according to Utian increasing research has been electrifying as “[t]he postmenopause is becoming more and more an area for study by the physician, the clinical chemist, the pharmaceutical industry and pathologists” (p. 20).

This indicates that the postmenopausal woman was studied by not only physicians, but also other experts such as pathologists, chemical experts and the pharmaceutical industry, where the construction of menopausal and postmenopausal women would once more be diagnosed as pathological.

Wilson’s book had, through the media, opened the floodgates for patient demand for estrogen and thereby putting estrogen treatment in the spotlight, whilst at the same time over shadowing the woman herself. According to Utian (1978), it is because of the “enormous publicity devoted to the debate about estrogen treatment. It has stirred up a lot of action” (p. 20). Once again estrogen treatment became the main focus.
Finally, in this chapter, he stated, “a woman may, with dignity, decide she needs medical help to get her through this period in her life and no longer need to feel embarrassment when she requests this help” (p. 20).

Along with this reassurance Utian (1978) stated that “there is much yet to be done” (p. 20), indicating and hinting that all is not yet quite right with the treatment but his main assurance is that “a new enlightened era has dawned” (p. 20).

Chapter Three: Changing Populations and Vital Statistics

Utian (1978) in chapter three follows on with statistics regarding the ageing woman, telling us that “the average woman today can expect to live at least one third of her life in the postmenopausal phase” (p. 23) and that the quality of this time of life is important.

Chapter Four: The Social, Cultural and Emotional Aspects

He then referred in the fourth chapter to the other aspects needing consideration, these being the social, cultural and emotional aspects. He defined the climacteric syndrome as “complex” and even admits it is not merely a matter of hormones (Utian, 1978, p. 25). Also the development of symptoms at menopause is described as:

1. “The concurrent ageing process and coincidental diseases
2. Decrease of hormones from the ovary
3. Social and cultural factors- the impact of the environment
4. Psychological factors-the nature of the personality” (p. 25).

Whilst admitting the complexity of the phenomenon beyond the matter of hormones, he identified social and cultural factors together with psychological factors as all being implicated. However, Utian devoted two pages only of this book to these other aspects, other than the decrease in hormones, these being the social, cultural and psychological components.

Whilst this is so, he did point out that some societies reward women for having reached menopause whilst others actually punish them. He referred to societies that reward women and he stated that in India, the Rahjput women experience very few symptoms because they acquire higher status. They therefore “look forward to menopause” (Utian, 1978, p. 26). It is for them a very positive experience which brings to them rewards at this time in their lives.
Utian then described how in western societies there is a strong emphasis on youth. Being young and beautiful is important and image is the priority. This is in contrast to other societies who value women for their age, for being older, rather than trying to stay young and living up to a more, so called, appropriate youthful image as Western society expects.

Utian (1978) then referred to other stresses and strains that develop around the age of menopause, parents dying, children leaving home, husband becoming ill and women becoming a mother in law or a grandmother or both. (p. 26). According to Utian these social components are “liable to produce psychological stresses dependent on the basic character of the woman affected” (p. 27).

Importantly he then states that:

> “Several studies have shown that the important alternate roles at the time of menopause, for example a profession, or being the sole wage earner, lessen the symptom profile of the effect in this respect. The lessons to be learned from the above observations are important. It is misleading to consider the climacteric phase as being purely a biological phenomenon, that is as being simply due to a lack of hormones. Social and cultural behaviour patterns directly contribute to the image of menopause. Large Scale educational programs are necessary to explain positive attitudes, and hence improve this incorrect image” (p. 27).

Whilst Utian touched on a critically important point for the health and well being of the menopausal women, that being ‘a profession’ or a wage earner, he devoted the main part of the rest of his book (approximately the next eight chapters) to her biological functioning, and the promotion and administration of estrogen as the cure all for the menopausal woman. His book is limited mainly to education on a biological level only, as this chapter four consists only of three pages, after indicating that social and cultural variables are involved. While it could be that Utian believed that he could only discuss the areas he was qualified to comment on he does recommend “large scale” education programs to encourage positive attitudes. This is once again another contradiction as it is saying larger educational programs are required to counteract the negative representation and diagnosis that he himself is promoting!
Chapter Five: Female Structure and Function

The technical section of Utian’s book is of particular interest as it describes the anatomy and physiology of the woman. But the most interesting, startling and enlightening statement is the following by Utian (1990) himself. He states, “[e]arly gynecologists often regarded their specialty as starting at the belly button and ending at the top of the thighs. That was a way of avoiding what they really knew very little about” (p. 29-30).

Utian, is here stating that historically gynecologists’ had very little knowledge of women beyond the pelvic area and anything else was completely beyond their area of expertise. But then follows a comment out of this main field of interest that the body cycle is under the control of the brain. He suggest that “[i]nevitably it became clear that the female monthly cycle was under the control of certain centres in the brain. You too should know about these higher brain centres, and that is where we will start” (p. 30).

Utian after acknowledging the lack of expertise in this area tells us we should know more about these higher brain centres. But then after the acknowledgment of a body/brain connection, he described this connection in relationship to the menstrual cycle only, rather than to the menopausal woman herself. Therefore, he too ignores the body/brain connection of the phenomenon of menopause.

The remainder of this chapter, Utian assigned to his own field of interest, that of the physical body, and in particular to the ovary, other sex organs, other organs found in the pelvis, and the breasts, and how these reproductive organs function particularly during the menstrual cycle. He did however refer to the other hormones involved in the menopause. Utian contends that “[h]eadquarters works overtime producing large amounts of GRH and FSH and LH but the poor old ovary is exhausted and cannot respond. At this point the patient is postmenopausal” (p. 41).

Utian did not address in any detail at all, the implications of the large amounts of GRH, FSH and LH which are also produced in the brain areas. However, he focused only on the loss of estrogen, and stated that: “[t]he real difference after menopause therefore lies in the amount of hormone around. The most obvious feature is how much less estrogen is present in the postmenopausal woman compared to a fertile woman” (p. 42).
Once again the emphasis on declining and depleting estrogen levels, whilst ignoring the large amounts of other hormones produced in the brain areas together with the difference in brain functioning of the menopausal woman. Therefore, Utian, referred to estrogen as the only hormone that makes the real difference, indicating that it is this hormone, estrogen that is in question. He completely ignored the large quantities of GRH, FSH & LH that he had briefly identified as also being present.

What Utian did not address is what is happening whilst GRH, FSH, and LH are being increased in areas of the brain. Utian’s focus is once again mainly aimed between the belly button and the top of the woman’s thighs, the benefits and advantages of two main hormones only, these being estrogen and progesterone. He actually referred to these two hormones “as builders and decorators that have been around for years” (p. 47). By doing this, Utian was functioning just as early gynecologists had done as a way to cover up their lack of knowledge about the other areas and processes that are also involved.

So this chapter, whilst indicating a process is occurring beyond the pelvic area, does not address in detail, the effects of this body/mind connection and the other hormones that are involved, but returns once more to the physical body parts, and estrogen and progesterone only.

Chapter Six: True effects of Menopause and Role of Replacement Hormones

In chapter six, Utian tells us about the “true effects of menopause and role of replacement hormones” (p. 47). According to him there are two main characters involved in the phenomenon of menopause, these being two hormones only, estrogen and progesterone. And in his own words, he tells us “we now continue the saga of our two main characters, estrogen and progesterone” (p. 47).

Applying the terminology ‘saga’, Utian thereby gives these two hormones the significance of heroic achievement and adventure, and therefore allocating them to hero status. In contrast, a feminist lens would certainly not see estrogen and progesterone as the main characters. The woman herself would be seen as the main character, the one experiencing the phenomenon of menopause. Estrogen and progesterone are external to the main character and are supplied from elsewhere, in an effort to reconstitute a former youthful condition. In Utian’s language
only these two main characters are heroes which he applies to the appliance (the woman). This positions the woman beneath his two main characters, estrogen and progesterone. This is not in reality, empowering for the woman. Utian set his scene for us:

“Estrogen and progesterone have been in business as building contractors and interior decorators for over 35 years, from the woman’s age of about 15 to 50. Unfortunately their financial support runs out and they disappear from the scene. The property they have previously cared for starts to decay. Our purpose will now be to examine the precise deterioration that occurs” (p. 47).

Utian’s language is indicative of the main focus of the western scientific biomedical discourse on menopause, where an objective, reductionist and pathological approach is applied resulting in the menopausal woman becoming an object, in this case “the property” (p. 47). Evident also is the reductionist process, the search for a pathological state. Utian’s purpose is to examine the precise deterioration only that occurs. However, there is more to Utian’s saga.

“Estrogen and progesterone are hardy characters and lurk somewhere in the background. Their place of hiding is the drug store and the doctor’s office. So we will examine too what possible good effects result from replacing these hormones as medical treatment” (p. 47).

This is a very strong recommendation for presenting at the doctor’s office and the drug store in an effort to access the heroes. Unfortunately though, also according to Utian, the heroes have a dark side, and “the story is complicated because estrogen has a sneaky side to it. When given as medical treatment it may produce unwanted effects” (p. 47).

One could now conclude well and truly that the two main characters of estrogen and progesterone are suspect! And contradictions again are emerging.

So there is good news and bad news regarding hormone therapy. At this point the main characters demand a lot of attention. The pros and cons, together with a balanced opinion become an issue. However, in the meantime and in reality, the two main characters, estrogen and progesterone do become the two very main characters, as they continually propel a raging
search for the many pros and cons of estrogen replacement treatment. This search continues until this very day. In Utian’s words it is “[n]ot surprising however is that the good and the bad news about estrogen has created the raging controversy as to whether it should be used or not. The pros and the cons and a balanced opinion will be presented in chapter 12” (p. 47).

From this statement it is evident that all the good news about hormonal therapy is not so good. Also, due to the raging controversy it has created, hormonal replacement treatment has taken centre stage in the phenomenon of menopause rather than the woman herself. Much research continues to investigate these two main character’s risks or benefits, when applied to the appliance (the woman). In other words, as they pursue their so called heroic achievements and adventure.

I now refer to what I see as a discrepancy in Utian’s thinking. This becomes evident in the following. Utian refers to the “true symptoms related to menopause” (p. 47). Firstly, however he stated that:

“Most modern medical textbooks still present long lists of symptoms due to menopause. It is often suggested that estrogen will alleviate them all. Little effort is made to look to the non-hormonal symptoms, that is, those that you will now recognize as the psycho-socio-cultural symptoms” (p. 47).

He then advises us that the list of “true estrogen deficiency symptoms” (p. 47), due to the lack of estrogen is very short and that this should be of no surprise at all to us. He named the early list of symptoms as “loss of periods, hot flushes (flashes) and night sweats (perspiration)” (p. 47). He then names other later symptoms that can develop months to years after menopause, these being “thinner vaginal lining, (intercourse can be difficult), and bones becoming thinner” (p. 47).

Utian then lists what he calls the non-hormonal or psycho-socio-cultural symptoms, which he says are caused by “societal attitudes, the woman’s environment, and the strength or structure of ‘her character’ ” (p. 48). He listed them as:

“ - the inability to sleep (insomnia)
Then Utian makes a most startling statement, that “[t]his is an important group of symptoms of real concern to the woman, but they are not related directly to the loss of hormones” (p. 48-49).

I believe this statement is in need of reflection and correction. The non-hormonal symptoms Utian has listed above are possibly, and could be seen, as a result of the interactions that occur between the hypothalamus, pituitary and the ovary, already explained previously by Utian himself in Chapter five, which indicates a relationship between brain functions and the decrease in hormones. If this is so, I believe there would be a direct relationship to the loss of hormones. A fact, Utian does not address in any detail at all apart from a few words after addressing many physical aspects of the “[e]ffects on skin and hair, Breast changes, Sex organs after menopause, Female hormone and the Skeleton, Hormones and heart disease” (p. 49). He then refers to Estrogen and Mood stating:

“What is proven is that estrogen treatment after menopause makes many women feel better. There is a distinct elevation in mood. At one stage I did not believe this and prided myself that it was what physicians call T/L/C (Tender Loving Care). Now I accept it as the mental tonic effect of estrogen” (p. 52).

However, Utian did not provide evidence to prove this effect of estrogen. The above statement also contradicts his previous statement, that the only true estrogen deficiency symptoms are loss of periods, hot flushes (flashes) and night sweats. And in addition a contradiction is evident in his comment that the non-hormonal symptoms “are not related directly to the loss of hormones” (p. 49).
Utian whilst making the comment that “symptoms due to lack of estrogen must be treated if possible with estrogen” (p. 49), he then suggested that “[t]he other symptoms need something else”. He then advised readers to start menopause groups or better still take the advice offered in Chapter 13 of this book. I will refer to this chapter further on as I presume this advice is meant to alleviate the mood swings. He also advised against non-hormonal medication and also against psychotherapy, which he stated should not be necessary at all.

Chapter Seven: Risks of Hormone Therapy

Utian’s title for chapter seven is ‘Risks of Hormone Therapy’. I could have named this chapter, Contradictions, Confusion and Disarray. Whilst contradictions appear, confusion also occurs. This becomes evident and is clearly expressed by Utian himself when he admitted to the “confusion and disarray that exists within the medical profession itself” (p. 55). This is also particularly obvious when he extols readers to “remember the old joke that everything nice was either illegal, immoral or fattening? Well, estrogen replacement treatment also carries a bad news side” (p. 55). One wonders about how funny this is meant to be.

However the bad news side, according to Utian, is that between 1964 and 1973 American women “spent four times as much money buying estrogen as they had in the previous decade”, and indicated “that dramatic new sales records were going to be set” (p. 55). However, he continued to enlighten us to the fact that “the pendulum is now in danger of swinging to the opposite extreme” (p. 55).

What is confusing for me is that the decrease rather than the increase of the sales records of estrogen now appear to be the standard for what is now considered dangerous. He then continues to blame the media for the confusion.

“Part of the confusion can be blamed on the media and the lay press. In the early days, particularly after the publication of Feminine Forever in 1965, the lay press was enthusiastic about the new estrogen therapy” (p. 55).

Again I find his next statement even more confusing: “[t]he media of course do little more than reflect the confusion and disarray that exists within the medical profession itself” (p. 55). Whilst Utian admitted to the confusion and disarray within the medical profession he also projected the confusion and disarray upon the media.
In addition, the following statement by Utian is an admission of the very faulty foundations for the recommendation of estrogen treatment to menopausal women, and which was also the foundation for the birth of the menopausal clinic. Utian comments that “*the problem about estrogen given for long periods of time, is that it was commenced with a fanfare of trumpets and a blast of promises before the basic necessary research had been completed*” (p. 56).

Although Utian referred to it being given for long periods of time, the main point is that estrogen was commenced before appropriate research had been completed. But he continued, and in an effort to minimize the fault he said:

“*Looked at another way, virtually no medication exists in the world today that does not carry some risk in addition to the desired effect. But considerable animal and human research is undertaken first to find out what the risks and benefits are*” (p. 56).

Here he admitted that risk is expected, whilst adding that considerable research is needed to be undertaken first. However we now know by his previous admission that this did not occur in the case of the prescribed medicalization and treatment of estrogen for menopause, and its appropriate appliance, the menopausal woman.

Prior to listing items in “the debit column of the balance sheet to be drawn up concerning the risk to benefit ratio of estrogen therapy”, Utian made the following statement: “*Estrogen, like acid, has potential dangers, but both have numerous practical values and uses. Provided due respect and control is observed there is no reason to withhold it from treatment*” (p. 56).

The statement is problematic in light of his admission of confusion and disarray that exists within the medical profession regarding estrogen replacement treatment resulting in a shaky basis for the menopausal clinics. His ultimate recommendation was to apply it to the appliance anyway. This hormonal treatment and so called ‘hero’ is currently still the only one that is sanctioned and supported as the most appropriate therapy for menopausal women in our society today. It is supported by the PBS system in Australia.
MY LAST THOUGHT

I wish to conclude my discourse analysis of this book here as enough contradictions and reasons for confusion have already emerged. However, before doing so, I briefly refer to chapter thirteen as it presents a slightly different slant.

Chapter Thirteen: Life after Menopause

Here Utian (1978) described a “Get up and Go” philosophy (p. 87). He listed the following principles:

1. “You are important, you are wanted and needed’. ‘Included here is that the man in your life has problems in his life too and needs a positive influence’. ‘Your children too need you as much as ever, even just to boost their egos’. ‘You need yourself’.
2. ‘You have more experience’.
3. ‘You owe something to yourself’.
4. ‘You are as old as you allow yourself to feel’.
5. ‘Time flies- each day passing is one less left to live’.
6. ‘If you have the money, then spend it on yourself’.
7. ‘Ignore societal attitudes that are outdated’.
8. ‘Enjoyment of life is not a sin’” (p. 87-89).

Point number seven that refers to societal attitudes is worthy of reflection. The dominant paradigm for the menopausal woman in our society has been presented by Utian himself. It is very negative. He has named a life-cycle process as a disease and therefore the menopausal women as chronic patient. He then said, regarding societal attitudes:

“You should by now be fully aware that virtually all negative attitudes to menopause within a society are fallacies. Therefore ignore them. More than that, discredit them by your very actions. Show them to be the untruths that they are. Use your influence within the community to change the media and urge them towards a positive image of older people” (p. 89).
The negative diagnosis of menopause as disease would be, according to this statement of Utian above, a fallacy. However, Utian colludes with his own professional group. He supports the medicalization of menopause and the negative images of the menopausal woman, but on the other hand asks women to reject the images created by the media. Utian himself advertises the woman as very negative, that of a diseased patient for the rest of her life. This is what he himself promotes to all women, and also to any other person who reads his influential text, ‘The menopause manual: A woman’s guide to the menopause’.

**MY CONCLUSION**

In concluding this section, I refer briefly to a later article published by Utian (1990), entitled ‘The menopause in perspective: From potions to patches’ regarding the menopausal clinics which had been conceived from his crackpot idea. He notes:

> “Traditional ‘menopause clinics’ have been generally unsuccessful in initiating broad programs of preventive medicine, although their research roles have been extremely productive and justify their further existence” (p. 7).

Ultimately, these clinics did not serve women well. They did, however, serve researchers and research well. I believe the clinics and Robert Wilson’s book which Utian refers to, together with Utian’s book were the impetus that gave the drugs estrogen and progesterone (the two heroes), pride of place in the scientific medical profession, rather than the woman herself, and in turn, her particular needs on various other levels at this time of menopause. This is a discrepancy that I believe needs to be addressed. Utian (1990) also in one of his later articles, continued to name menopause as disease and gives evidence to support the contention of menopause as endocrinopathy” (p. 2). Yet another pathological label.

**How Wilson and Utian Weaved their arguments**

This research has revealed that through Wilson’s medical gaze and also his authoritarian text he was able to advise women that by submitting to medicalization they could continue to look younger and beautiful, thereby appealing to the image of the beautiful woman as the reason to remain feminine forever. This served to promote menopause as threatening to women’s
femininity and their beauty. It also served to influence the women’s decision to medicate with HRT/HT.

The dictate for the achievement of remaining beautiful was that women should never change, but remain looking young and beautiful, to always identify with their previous feminine roles and remain appealing to males by remaining feminine. Limited information was promoted through this text as femininity does not define women. As argued by Bartky (1990), “[w]e are born male or female, but not masculine or feminine. Femininity is an artifice, an achievement …” (p. 65). Therefore it was an artificial and fake achievement that Wilson promoted to women, through his usage of the term femininity to weave his argument. Further his denial of the increase in hormones to the brain added to the fabrication.

The work of Irigaray (chapter 4 of this thesis) is more instructive as her knowledge of woman and females provides revelations and insights that both Wilson nor Utian ignored when they were instructing women to stay feminine forever. Irigaray points us to female knowledge that these men did not possess.

Weedon (1997) notes in her book *Feminist Practice and Poststructuralist Theory*, “[i]n the work of the French psychoanalyst, Luce Irigaray, femininity as it currently exists is male-defined” (p.61), and to correct this Irigaray herself “offers a theory of the ‘female’ rather than the ‘feminine’”. In Irigaray’s text *This Sex Which Is Not One* (1985), Irigaray’s main argument is “that the otherness of female sexuality has been repressed by patriarchy, which seeks to theorize it within masculine parameters” (p.61). Further:

> The realization of an alternative female-defined femininity requires a transformation of the patriarchal symbolic order. Yet it can be anticipated through the organization of female desire in a female libido. Female libido is not constitute by a lack, as in Freud, but by female sexuality which is fundamentally other to male sexuality (Weedon, 1997, p. 61).

Although Irigarary is arguing for female sexuality as different from male sexuality, it is also true that female libido is different to male libido. Female libido is not constituted by a lack; it is female libido that has the ability to support new life and birthing new human beings. In
addition, it has the ability through transformation of the hormonal balance to support new life within the woman herself when she no longer has the ability to birth the human race. Wilson uses the word feminine rather than female to define how a woman should be and remain. The term female would indicate that menopause is a normal female function and should be addressed as such. By telling women they should stay feminine forever he denied their femaleness, which carries their evolutionary potential. Utian agreed with Wilson and set up clinics to administer HRT/HT even though he admitted Wilson’s faults.

Therefore, “[t]he realization of an alternative female-defined femininity requires a transformation of the patriarchal symbolic order” (Weedon, 1997, p. 61). It is the untransformed patriarchal order through which Wilson birthed his text, therefore allowing him to preach to women that they should remain feminine forever. This enabled both Wilson and Utian to ignore, restrict and conceal women’s transformational potentiality through the normal life cycle developmental process.

Table 3.1 Biomedical Gaze: Assumptions of Menopause and Menopausal Women, identifies the negative language arising from the discourse analysis of both medical texts.
### Table 3.1 Biomedical Gaze: Assumptions of Menopause and Menopausal Women

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Robert Wilson</th>
<th>Wulf Utian</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hormone deficiency disease: loss of fertility</td>
<td>Menopause as pathological: Endocrinopathy</td>
<td></td>
</tr>
<tr>
<td>menopause as castration and mutilation</td>
<td>Lack of oestrogen and progesterone</td>
<td></td>
</tr>
<tr>
<td>sexually dysfunctional: frigidity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of essential womenhood: physically unfeminine</td>
<td>Physical deterioration: Loss of hair, changes in the breasts and sex organs</td>
<td></td>
</tr>
<tr>
<td>decay, suffering &amp; incapacity</td>
<td>Menopausal women as decaying property</td>
<td></td>
</tr>
<tr>
<td>ovaries as factories</td>
<td>Estrogen &amp; progesterone as building contractors and interior designers</td>
<td></td>
</tr>
<tr>
<td>catastrophic change in whole organism</td>
<td>Aging women as deteriorating</td>
<td></td>
</tr>
<tr>
<td>lack of youthfulness</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sociological</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>un-feminine</td>
<td>Menopausal women as ‘patient’</td>
<td></td>
</tr>
<tr>
<td>un-attractive</td>
<td>Women as an appliance</td>
<td></td>
</tr>
<tr>
<td>lower-social class women suffer</td>
<td>Males doctors and hormone therapy as heros</td>
<td></td>
</tr>
<tr>
<td>more-cow-like passivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>maritally maladjusted</td>
<td>Poor self-image socially constructed</td>
<td></td>
</tr>
<tr>
<td>non-compliant</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychological</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>menopause a state of mind</td>
<td>Ignorance &amp; Distorted thinking</td>
<td></td>
</tr>
<tr>
<td>mentally disturbed</td>
<td>Low mood</td>
<td></td>
</tr>
<tr>
<td>psychologically non feminine</td>
<td>Mood swings</td>
<td></td>
</tr>
<tr>
<td>non-adaptable</td>
<td>Apprehension/irritability</td>
<td></td>
</tr>
<tr>
<td>ill tempered</td>
<td>insomnia</td>
<td></td>
</tr>
<tr>
<td>difficult to live with</td>
<td>Frigidity</td>
<td></td>
</tr>
<tr>
<td>women’s breasts are psychological organs</td>
<td></td>
<td></td>
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</tbody>
</table>

### BIOPOLITICS OF MENOPAUSE

In summary, both Wilson and Utian defined menopause pathologically as a disease, indicating ovary dysfunction, decline, depletion, lack and loss. Both authors acknowledged that the
brain (headquarters) played a major role in producing large amounts of additional hormones, GRH, FSH and LH, but then both marginalized, ignored and omitted this factor from their conclusion and diagnosis. Their main focus was the ovaries and the loss of estrogen only. In addition, Utian’s idea to open a clinic whereby he could apply this new female hormonal drug to all women, he describes as a ‘crackpot’ idea. He also revealed that sufficient research had not been carried out. And because the diagnosis of disease is objective, reductionist, positivist and limited in nature, it also limits the portrayal of the menopausal woman.

Further, regarding the medical consultation process for women, Roe Sybylla (1997) relates that the consulting room experience for the woman is one that disciplines or shapes the woman “to suit masculine and medical professional requirements” (p. 201). In addition:

For her part, through no fault of her own, the woman lacks the knowledge that would enable her to become more autonomous in relation to herself. By this I mean that she would relate to herself as a possibility for self-creation, an activity of conscious choice, rather than as a set of truths that are to be accepted, not transformed (p. 201).

Further, Komesaroff refers to Ivan Illich and others who argue that the development of modern medicine has been associated with profoundly malign social consequences (Illich cited in Komesaroff, 1995).

According to this view, medicine has been responsible for a degradation of intimate and meaning-endowing human experiences by transforming them into mere technical events. Rather than enhancing the knowledge and understanding of laypersons, these are actually diminished as a result of the transfer of decision-making power to a small group of often wealthy, usually socially conservative, and predominantly male individuals (Komesaroff, 1995, p. 2).

The above discourse analysis on texts authored by male medical practitioners presents the limitations and biopolitics of the discursive practice of the scientific biomedical paradigm indicating the need for a new paradigm that includes and integrates other sources and all of knowledges as relevant and critical to the phenomenon of menopause. What has emerged from these biomedical men’s texts are the limitations of above model. These limitations can
be seen in the underlying philosophy. This is the philosophy of body/mind separation as developed by Rene Descartes, and is revealed in both Wilson’s and Utian’s texts as both admit to the head being implicated in menopause, but then they both ignored the dynamics of the internal connections for the woman of body and mind. Scientific, objective, reductionist, technical practices together with Descarte’s philosophy of body/mind separation, although valuable in some situations, I believe in the case of menopause are psychologically limiting, socially oppressive, and can possibly hinder the positive adult development of the menopausal and postmenopausal woman.

Limitations of Descartes Method

Descartes deletion of a body/mind connection has been described as limiting by various other researchers, as it “isolates the body from the essential self and its context” (Leder, 1984, p. 37). Descartes separated mind from body and defined the body as “merely a machine driven by mechanical causality” (Leder, 1984, p. 29). This philosophy of separation was instrumental in ignoring and deleting the role of anybody/mind connection, including any sense of the self as experienced by the human person herself.

Elizabeth Grosz (2005) states that Descartes instituted a dualism and “established an unbridgeable gulf between mind and matter” (p. 48). Further to this Grosz has stated that “[t]his separation of course, has its costs … not only is consciousness positioned outside of the world, outside its body, outside of nature; it is also removed from direct contact with other minds and a sociocultural community” (p. 49). In addition, Elisabeth Porter (2007) describes a dualism as “an extreme opposite … and … a dualistic framework is stark, as it allows for no intermediate positions” (pp. 43-45). More importantly, she describes the “extreme ethical harm in divisive dualisms” (pp. 43-45). Porter lists four interconnected reasons why dualism is harmful:

1. A dualistic worldview assumes a self-righteous rightness about the dominant position.
2. This worldview is dogmatic and closed-minded.
3. It sets up an oppositional framework that precludes dialogical relationships.
4. A dualistic mindset is exclusivist, so in ethical terms, it works against the reconciliation of difference (p. 44-45).
Porter also explains that “the harm of dualism is a moral harm” (p. 45) as it does not include and respect ‘the other’ and does nothing to support collaborative relationships. This is particularly true in the case of menopause as defined by the biomedical model. Within the biomedical model there is no meaningful acknowledgement and acceptance of the connective relationship and dynamic flow between the loss and the gains in hormones, or the value, meaning, significance and potential of the other increased hormones. In addition, the collaboration between the body and mind is ignored and deleted. Fiona Mackie describes the body of modernity as “crucified upon a cross that ensures both its ongoing co-modification and the breakdown of its potential as flow. Governing directional codes carve into the psyche and bodily experience, partitioning it into…” (Mackie, 1997). She goes on to state:

In each of those interlocking polarities, one half is denigrated, silenced, exiled, and put out of play. That lost side, as Derrida has so eloquently conveyed,… serves only to effect the elevation of the preferred pole, at the exiled’s expense – up over down, high over low, right over left, outer over inner. The consequences of this in embodiment are drastic (p. 19).

Scientific, objective, reductionist, technical practices together with Descartes’ philosophy of body/mind separation, although valuable in many situations, in the case of menopause, it is psychologically limiting, socially oppressive, and can possibly hinder the positive adult development of the menopausal and postmenopausal woman. Descartes’ philosophy and the method he created is described below.

**DESCARTES’ METHOD**

It is now relevant, to note the work and method of Rene Descartes himself. I refer initially to Descartes text, ‘Discourse on the Method’ 3rd ed. (1998), originally published 1637, with a translation by Donald A. Cress. I believe Descartes method is a limited one as it designs and produces reductive truths and limiting realities.

According to the Editors Preface (no name provided) in the above book Descartes was born 1596 in France. He attended the Jesuit Educational College Henri IV at La Fleche, a centre for academic training in Europe. After he left La Fleche in1614, he studied civil and cannon
law at Poitiers and received degrees in law. According to the editor, although trained as a lawyer, it seems Descartes marvelled at mathematics. In Germany in 1619 while in a state of meditation he had a flash of knowledge which he decided was the method for providing a solid foundation for all knowledge and science. At the same time he also concluded that one person’s opinion is superior to opinions from many different people. To quote Descartes himself:

… I remained for an entire day shut up by myself in a stove-heated room, where I was completely free to converse with myself about my thoughts. Among them, one of the first was that it occurred to me to consider that there is often not so much perfection in works composed of many pieces and made by the hands of various master craftsmen as there is in those works on which but a single individual has worked (Descartes, 1637/1998, pp. 6-7).

Descartes believed very strongly in the superiority of one man’s work over the work of others. To support his argument, he cites the work of the architect who singly designs buildings which are superior to those architects who have tried to “patch up old walls” (Cress, 1998, p. 7). He argued that cities which are well designed by an engineer are well-ordered places. In contrast, ancient cities having previously been mere villages then become large towns are very poorly laid out. In addition, his following examples also indicate superiority. He states:

I imagined that peoples who, having once been half savages and having been civilized only little by little, have made their laws only to the extent that the inconvenience due to crimes and quarrels have forced them to do so, could not be as well ordered as those who, from the very beginning of their coming together, have followed the fundamental precepts of some prudent legislator. Likewise, it is quite certain that the state of the true religion, whose ordinances were made by God alone, must be incomparably better ordered than all the others (Descartes, 1637/1998, p. 7).

Unordered change, especially by those of lower status, seems problematic for Descartes. He further states, “I could in no way approve of those troublemaking and restless personalities who, called neither by their birth nor by their fortune to manage public affairs, are forever
coming up with an idea for some new reform …” (Descartes, 1637/1998, p. 9). Multiple viewpoints worried Descartes and he could not approve of other people who had differently evolved ideas than his own. Regarding opinions of other men he states:

> It is true that, so long as I merely considered the customs of other men, I found hardly anything there about which to be confident, and that I noticed there was about as much diversity as I had previously found among the opinions of philosophers (Descartes, 1637/1998, p. 6).

Descartes did not value philosophers and was not confident with diversity of thinking and therefore planned a method against this. His plan was to build “upon a foundation which is completely my own” (Descartes, 1637, trans Cress, 1998, p. 9). He wanted to first spend sufficient time “planning the work I was undertaking and seeking the true method for arriving at that knowledge of everything of which my mind would be capable” (Descartes, 1637/1998, p. 10). This can be seen as what a male mind is capable of. His thinking and therefore his true method conceived and birthed form male thinking was lacking a female dimension. Its ‘truth’ therefore was limited, especially in relationship to issues related to women.

Descartes limited method, conceived from himself only, represents a sameness of himself. Ann Game has referred to the male conception of knowledge only by “the term ‘phallogocentric’, which refers to conceptions of truth as consisting in self-presence, or the unmediated knowledge of self, of a masculine subject” (1991, p. 14). Therefore I believe regarding a more wholistic conception of knowledge generation, Irigaray’s words are worthy of note. She stated:

> For what is important is to disconcert the staging of representation according to exclusively ‘masculine’ parameters, that is, according to a phallocratic order. It is not a matter of toppling that order so as to replace it – that amounts to the same thing in the end – but of disrupting and modifying it … (Irigaray, 1985, p. 86).

Descarte’s limited method emerged also in reaction to his dissatisfaction with philosophy, because, philosophy to him did not offer one certain truth. He downgraded philosophy because in philosophy “one can argue on both sides of any question” and “few search for the
truth” (Moriarty 2008, p. 5). Also as noted by Anscombe, Geach & Koyre, with regards to philosophy and the sciences, Descartes believed that all sciences received their principles from philosophy, “[a]nd is not philosophy itself is a realm of confusion, uncertainty, and doubt?” (Anscombe et.al., 1959, p. xvii). According to Descartes it was that in “[m]athematics alone [he] found some recognition because of the certainty and self-evidence of its reasonings” (Anscombe et.al.1959, p. xvi). Descartes then follows on with his faith in mathematics and mathematicians to provide him with truth. He said:

And considering that, of all those who have hitherto searched for the truth in the sciences, only mathematicians have been able to find any demonstrations, that is to say, certain and evident reasonings, I did not at all doubt that it was with these same things that they had examined (that I should begin); although I expected from them no other utility but that they would accustom my mind to nourish itself on truths and not to be content with false reasonings (Descartes, 1637 / 1998, p. 11).

Descartes then decided to build his own method based upon the ‘logic’ aspect of philosophy, and from mathematics, geometrical analysis and algebra. His limited aim was a “science that cultivates the mind” rather than the abstract matters that “greatly fatigue the imagination” (Descartes, 1637/1998, p. 10). On this point he stated:

That is why I thought it necessary to search for some other method embracing the advantages of these three yet free from their defects. And since the multiplicity of laws often provides excuses for vices so that a state is much better ruled when it has but very few laws and when these are very strictly observed; likewise, in place of the large number of precepts of which logic is composed, I believed that the following four rules would be sufficient for me, provided I made a firm and constant resolution not even once to fail to observe them (Descartes, 1637/ 1998, pp. 10-11).

Descartes believed his method was the safest, as long as his following rules were observed.

**Descartes’ Four Rules for His Method**

1. “*The first was never to accept anything as true that I did not plainly know to be such ... and to include nothing more in my judgments than what presented itself to*
my mind so clearly and so distinctly that I had no occasion to call it in doubt” (Descartes, 1637/1998, p. 11).

Therefore Descartes does not consider or contemplate anything beyond that which does not ring true to himself.

2. “The second, to divide each of the difficulties I would examine into as many parts as possible and as was required in order better to resolve them” (Descartes, 1637/1998, p. 11).

Descartes would separate and reduce a phenomenon into many parts to enable him to solve the problem rather than consider the connections and the dynamic between the parts, or the parts and their environments.

3. “The third, to conduct my thoughts in an orderly fashion, by commencing with those objects that are simplest and easiest to know … and by supposing an order even among those things that do not naturally precede one another” (Descartes, 1637/1998, p. 11).

Therefore his thinking is hierarchical and linear and makes orderly connections where none may exist.

4. “And the last, everywhere to make enumerations so complete and reviews so general that I was assured of having omitted nothing” (Descartes, 1637/1998, p. 11).

Descartes then believed that systematic thoroughness and attention to detail would ensure he could account for everything.

Having explored other writings of Descartes, particularly his Meditations on First Philosophy, it becomes obvious that Descartes had been very strongly influenced by his Jesuit upbringing, and the importance of a one true God (Anscombe, 1959, p.xvii). It is also obvious that his relationships during both his education at the Jesuit Educational College, discussions on his meditations, communications with supervisors and mentors were limited mainly to men of the church. Descartes discussions with religious churchmen whilst living in Paris and Holland can be evidenced in his letters as published in Descartes Philosophical Writings, 1959. Paralleling this is Gunew’s observation that “Descartes’ famous dictum ‘I think therefore I am’ was fleshed out according to a masculinist and Eurocentric model” (1993, p. 10).
Descartes thinking and discussions with men in religious orders reinforced the certainty of one true God, and in turn one true method, mathematics. According to Anscombe et al., regarding these so called two certainties, “Let us note this. It is of great importance. As a matter of fact, Descartes will attempt in his metaphysics to link together these two certainties, and in such fashion as to make them support each other” (1959, p. xvii).

It is critical that Descartes one true method, Cartesian dualism conceived and birthed from male thinking, that of body/mind split, has been the springboard for the scientific biomedical pathological definition of menopause as disease, whilst at the same time denying other positive perspectives including the connection with the other half of the process that occurs for the woman herself.

The fact is that existing science is based on male experience. While it may not be intentionally sexist, it does not recognize its own biases about women, nor does it regard criticism from any perspective other than its own as legitimate (Prescott and Foster, 1978, cited in Dan, 1982, p. 379).

And as stated by S. Greer, “[t]he rigid separation of mind from body propounded by Descartes 350 years ago remains a powerful, though usually unacknowledged, doctrine within medicine” (Greer, 1991, p. 3).

It is relevant to consider the significance of paradigms in the construction of the phenomenon as Descartes philosophy and his method underpin the dominant Western biomedical paradigm of menopause.

**SIGNIFICANCE OF PARADIGMS**

According to Kuhn (1970), a paradigm is a theoretical model that reflects current social, cultural, and scientific structures and serves to integrate beliefs, values, and attitudes with observation and interpretation. As such, paradigms are an appropriate context for the study of phenomena that are clearly associated with multiple conceptual domains (Gannon & Ekstrom, 1993).
Over time and throughout history, paradigms of menopause have varied dramatically. Historical and cross-cultural research gives evidence to this. Anthropological research indicates that views of menopause and menopausal women vary throughout cultures, and in many cultures postmenopausal women experience a sense of liberation, where they are granted higher status. As Gannon & Ekstrom (1993) state:

The importance of the particular paradigm of menopause in determining the actual experience of menopause is emphasised in a theoretical model proposed by Bowles (1990). According to this model, the beliefs and expectations inherent in the prevailing sociocultural paradigm are responsible for the formation of specific attitudes toward menopause, which in turn influence the actual experience of menopause (1993, p. 276).

In addition to the obvious negative connotations associated with the ‘disease’ label and the fostering of dependency on physicians, the medical paradigm of menopause encourages women to ascribe their experiences to biology rather than to gender inequality in the social, economic, and political arenas (Kaufert, 1982; Strong, 1979). Reissman (1983) noted that some women, believing that medical intervention would free them of their biological destinies, may endorse the medical model of menopause only to find that medicalization places physicians rather than themselves, in control of their experience (Gannon & Ekstrom 1993, p. 276).

It is the reductionist model and its exclusions that define the phenomenon of menopause in our time and represent a historically and culturally located scientific paradigm. This model has set the tone of ageing women as dysfunctional, deteriorating, deficient and lacking. Reductionist methods, objectification processes and a positivist philosophy declaring the universality of menopause as disease, and menopausal and postmenopausal women as chronic patients underpin this dominant pathological model. These processes contribute to the dominant discursive formations of scientific practices of our time where the normal life-cycle process of menopause has been medicalized. Gannon and Ekstrom (1993) note that because of the obvious negative connotations of medicalization, together with the accompanying dependency on physicians, this medical paradigm limits women’s experiences to their
biology only. It ignores understandings regarding context, social, economic, political and spiritual aspects.

**SUMMARY OF REDUCTIONIST PHILOSOPHY AND BIOPOLITICS OF MENOPAUSE**


These texts were influential in defining the dominant medical paradigm of menopause as disease. In summary, both Wilson and Utian define menopause pathologically as a disease, an estrogen deficiency disease indicating ovary dysfunction, and loss and lack of estrogen. Their main focus was the ovaries and the loss of estrogen only. In addition, Utian revealed that sufficient research had not been carried out. This scientific diagnosis is objective, reductionist, and positivist and therefore limited in nature. And whilst both authors acknowledged that the brain (headquarters) played a major role in producing large amounts of additional hormones, GRH, FSH and LH, but then marginalized, ignored and omitted this factor from their conclusion and diagnosis. This also limits the portrayal of the menopausal woman.

Emerging from these biomedical men’s texts are limitations of the above model. The main limitation can be seen in the underlying reductionist philosophy. Emerging from these medical texts is the separation of body from mind where the focus has been on ‘loss’ only, of ovarian functions. Equally relevant should be consideration of the increased in other hormones. Both authors admit to the head being implicated in menopause, but then ignore the dynamics of the connection. Ignoring the dynamics of the connection is predicated upon the philosophy of Cartesian dualism, the separation of body from mind, developed by Rene Descartes which underpins this model, and this is revealed in both Wilson’s and Utian’s texts. Capra (1983) has stated that Descartes method is useful but the limitations need to be recognized. This is especially relevant regarding the phenomenon of menopause as disease, where the body/mind connection was rejected.
Descartes separated mind from body and, according to Leder, defined the body as “merely a machine driven by mechanical causality” (Leder, p. 29). This philosophy of separation was instrumental and resulted in the ignoring and deleting the role of any body/mind connection. Deleting the body/mind connection includes deleting any sense of the self as experienced by the human person herself.

As Leder (1984) has stated, it is to the overcoming of the “mind-body antinomy that the paradigm of lived embodiment may be of greatest interest to medicine” (p. 38). I believe therefore that it is the paradigm of the lived body that we need to turn; as it is more appropriate for menopause, the menopausal and postmenopausal woman, rather than Descartes’ limited philosophy of the mechanistic body that biomedical western science utilizes to diagnose the phenomenon of menopause. I believe it is the body that has ‘lived’ through the embodied experience that can contribute valuable knowledge.

The above points are very relevant and also serve to highlight the imbalance of the dominant position, and the closed-mindedness. Further, an oppositional framework is not collaborative, and most importantly dualism, Descartes’ body/mind split in this case of menopause, prevents any reconciliation with any (other) function that is connected, or interconnected regarding the phenomenon of menopause, e.g the increase in other hormones. I now turn to four postmenopausal women’s texts where through their own embodied experiences; they describe a phenomenon that addresses the mind/body connection, not separation.
CHAPTER FOUR – WOMEN’S TEXTS
“As women our relationship to the past has been problematical. We have been every culture’s core obsession (and repression); we have always constituted at least one-half, and are now a majority, of the species; yet in the written records we can barely find ourselves. Confronted with this “Great Silence”, we have apparently had two paths to follow: the path of anatomizing our oppression, detailing the laws and sanctions ranged against us; and the path of searching out those women who broke through the silence, who, though often penalized, misconstrued, their work neglected or banned, or though tokenized in lonely and precarious acceptance still embodied strength, daring, self-determination; who were, in short, exemplary” (Rich, 1986, p. 84).

Introduction

Having explored how the particular discourse of menopause as disease was conceived and born from the thinking of biomedical science and how it constructs and sustains the pathological construct of the phenomenon of menopause other contesting discourses too have been noted, particularly feminist perspectives which have emerged from postmenopausal women’s experiential narratives and theories.

Feminist perspectives acknowledge thinking that is different or alternative to the thinking of the dominant paradigm. These postmenopausal women’s experiences have legitimacy in contesting the dominant paradigm. These women’s authentic voices birthing from their own embodied menopausal experiences are legitimate. In addition, they stand as new and meaningful local knowledges within an affirmative postmodern perspective.

This chapter explores the texts of four postmenopausal women who through their published texts have articulated the very personal internal transitional and often transformational journeys they have each experienced. I believe these texts and the postmenopausal women’s personal experiences are critical to a more extensive and wholistic understanding of the women’s health issue of menopause. Feminist perspectives acknowledge thinking that is different or alternative to the thinking of the dominant paradigm. To support this belief, I refer first to female philosophers.

Female Philosophers

Menopause is a women’s issue, and because it is women only who experience the internal changes, a woman-centred perspective through a feminist lens would be appropriate. Not only appropriate, but I believe necessary. A woman-centred perspective, specifically from
postmenopausal women who have embodied the experience can shine a light on the internal body/mind/soul/spirit levels that occur within the female body. These would be in addition to, and may differ from the masculine perspective that speaks to women from outside. By ‘outside I mean objective and outside the wholistic real experience, which is grounded in the individual woman’s body, mind, soul and spirit.

This chapter continues with the discourse of female women philosophers of our age. Rather than speaking from the standpoint of patriarchal society and the education system these philosophers have written and have spoken from the perspective of their body, mind, soul and spirit to enable us all to have a deeper understanding of the omissions in the construction of who we are as women.

Firstly I refer to female women philosophers de Beauvoir, Irigaray, Kristeva and Cixous as these philosophers have through their writings, enriched our lives as women. They have challenged the thinking of patriarchal male philosophers, particularly those that define women as lacking, and therefore articulating the inferiority of women. These women have chosen to write into history and more importantly into philosophical discourse, their thinking and feelings as women in response to the patriarchal male’s philosophical discourse. Even more so, they passionately implore us as women to also write our lives into history. Their works are extensive but I refer only to their work that is relevant to the thesis topic.

Secondly, this research continues to bring forth the voices of postmenopausal women who have taken on the task of writing through their body, mind, soul, spirit their experiences of the menopausal phenomenon. In doing so they give to all women a broader and deeper understanding of the phenomenon, which moves beyond a western scientific biomedical pathological diagnosis of lack and loss. Firstly to the words of the female philosophers.

**Simone de Beauvoir - Women Defined as Inferior to Men**

Female Philosopher, Simone de Beauvoir, born 1908, Paris. De Beauvoir’s argument, is that we as women have historically and culturally been defined as inferior. To support this argument, in her book *The Second Sex* (1989), she relates extensively throughout history by drawing on anthropology, literature and philosophy to show how patriarchal power through the ages and throughout time have shaped women as lacking and lesser in relationship to men,
by placing women in an inferior position. De Beauvoir draws on many historical examples and significantly, *The Second Sex* is a text of central historical importance in feminist discourse and literature. I believe we would be deficient in realms of knowledge without de Beauvoir’s text.

This thesis, through the critique on the limitations of the biomedical reductionist diagnosis of menopause as disease also provides an historical perspective on how women have been narrowly defined as biologically lacking. It is therefore also congruent with de Beauvoir’s thinking. In de Beauvoir’s words:

> We must view the facts of biology in the light of an ontological, economic, social and psychological context. The enslavement of the female to the species and the limitations of her various powers are extremely important facts; the body of woman is one of the essential elements in her situation in the world. But that body is not enough to define her as woman;...Our task is to discover how the nature of woman has been affected throughout the course of history; we are concerned to find out what humanity has made of the human female (1989, pp. 36-37).

For the purpose of this thesis, it is de Beauvoir’s own words that wake us up to the selective, limited perspectives of men’s definitions of the human female; which is selective, objective and limited in perspective because men do not inhabit women’s bodies. In the introduction to her text, de Beauvoir states that as women:

> We know the feminine world more intimately than do the men because we have our roots in it, we grasp more immediately than do men what it means to a human being to be feminine; and we are more concerned with such knowledge (1989, p. xxxiii-xxxiv).

Whilst de Beauvoir (1989) refers to women as holding more knowledge of the feminine, I also add that even more so, women hold more knowledge of the female.

A most critical point by de Beauvoir is that, “[i]t is significant that books by women on women...are an effort toward clarity and understanding” (1989, p. xxxiv). I concur with de
Beauvoir, and add women writing their own experiences also. Ultimately then, it is towards further clarity and broader and deeper understanding regarding the woman’s issue of menopause beyond the scientific biomedical diagnosis that this thesis seeks to understand.

Therefore to achieve this understanding an exploration of books published by postmenopausal women on their female bodies, minds, souls and spirits follows later in this chapter.

**Irigaray – The Importance of Equity**

Female philosopher, Irigaray born 1932, pays tribute to de Beauvoir for the significance of her writing and its contribution to modern feminism. However Irigaray makes clear the differences between herself as a feminist and that of de Beauvoir as that being the difference in their attitudes towards psychoanalysis. Irigaray, as practicing psychoanalyst trained in Freudian psychoanalytical theory, and as a woman, sees the necessity to challenge Freud’s patriarchal cultural theory in which women have also been defined as lacking and inferior.

Irigaray takes up the idea of woman as other, as de Beauvoir does, but extends it. “Whereas de Beauvoir emphasizes access to the work of men (equality), Irigaray is suggesting the creation of difference, therefore she takes up de Beauvoir’s idea of Woman as Other and develops it further” (Whitford, 1992, p. 24). Rather than equality (women equal to men), Irigaray believes in the value of the differences between men and women and how the feminine as a gender has been absent from discourse, and therefore the valuing of women’s theories of difference in discourse is non-existent.

Importantly this would mean that woman would be able to contribute equitably based on their differences in social, cultural and political relationships rather than just attempting to be equal. Such attempts to gain equality results in women being absorbed into western patriarchy thus erasing the positive difference that women’s thinking could bring. Most importantly Irigaray emphasises the importance of language and how in language women have been absorbed and therefore discounted, deleted and ignored as partners in discourse.

This absence of the feminine as a gender representing half of all interlocutors leads to a failure to identify women as subjects who can be addressed. The feminine no longer has any status as an existing valid interlocutrix. Women are entities or things,
earth, depths, reserves which give birth, mother, do housework, with whom one makes love, etc., but not partners in discourse (Irigaray 1994, p. 43).

In addition and of critical importance, Irigaray explains how language continues to maintain the cultural philosophical thinking of the time and how it can erase women and therefore shape cultural relationships. Irigaray states “[l]inguistic order …. devalues the feminine generically. It overvalues the masculine” (Irigaray, 1994, p. 45). Irigaray gives us an example in her text Thinking the Difference. For a Peaceful Revolution, (1994, pp. 42-43).

A further explanation is given by Weedon (1997) stating that in the work of Irigaray, “femininity as it currently exists is male-defined” (p. 60) … and also “[i]t offers a theory of the ‘female’ rather than the ‘feminine’” (p. 61). Further Weedon refers to Irigaray’s argument that the “otherness of female sexuality has been repressed by patriarchy, which seeks to theorize it within masculine parameters” (1997, p. 61). In the case of menopause, I also argue that ‘the otherness’ of the menopausal phenomenon has been repressed by patriarchy, ‘which seeks to theorize it within masculine parameters’. Weedon refers further to the work of Irigaray noting that, “[t]he realization of an alternative female-defined femininity requires a transformation of the patriarchal symbolic order” (Weedon, 1997, p. 61).

Irigaray therefore brings to our notice the lack of status of women and the feminine, and therefore the inferior status of women because they have been absorbed into patriarchal theories through the power of language. This is due traditionally to psychoanalysis defining women in terms of ‘lack’ and inferiority, based on Freud’s theory of women lacking a penis. The inferiority and lack of status of women and therefore their inability to transform the patriarchal symbolic order through their feminist discourse is a gender issue, one that this research addresses. The necessity of postmenopausal women as partners in the discourse on the phenomenon of menopause is revealed.

Kristeva – The Effect of Interpretation

I now turn to female philosopher Kristeva. Kristeva born 1941, also focuses on the effects of writing and language. She contends that throughout history the process of interpretive theory produces what it preselects an object to be. This can be seen in male interpretations and male theories of women. Regarding interpretation, Kristeva states:
… throughout the history of interpretive disciplines up to hermeneutics consists in enclosing the enigmatic (interpretable) object within the interpretive theory’s pre-existent system. Instead of creating an object, however, this process merely produces what the interpretive theory had preselected as an object within the enclosure of its own system. Thus it seems that one does not interpret something outside theory but rather that theory harbours its object within its own logic (Kristeva, 1982, p. 79).

Therefore this harbouring occurs, particularly in the case of menopause, through the pre-existent theory of pathological diagnosis of lack and loss. It actually dominates and represses woman’s meanings, which lie beyond male theories and language. Also as ‘within the enclosure of its own system’, the diagnosis of menopause ‘harbours its object within its own logic’, the logic of the biomedical discourse; it therefore leaves no space or place for the logic of the subject.

Elizabeth Grosz pays tribute to both Kristeva and Irigaray, stating:

….have each undertaken the more or less preliminary task of clearing a conceptual terrain of the sexist, patriarchal and imperialist territorialisations, and of mapping sites which may now be appropriate for feminine and feminist occupation. This seems less a form of colonisation than the search for a place in which to live, to inhabit, to cultivate, to produce in ways undreamed of before. This occupation is not a proprietorial seizure but more a stake in and commitment to the kinds of intellectual struggle and productivity feminists today recognise is necessary in the transvaluation of existing knowledges (Grosz, 1989, p. 231).

The intellectual struggle against existing scientific knowledge regarding menopause based on male theories only, especially Descartes body/mind separation, which provides one interpretation of the phenomenon as disease, should not really be necessary as menopause is not a disease. However the struggle is necessary as Weedon (1987) states:

However, like Cixous, Kristeva argues that there are feminine forms of signification which cannot be contained by the rational, thetic structure of the symbolic order and
which therefore threaten its sovereignty and have been relegated to the margins of discourse (p.69).

For menopause, I believe it is female signification rather than feminine that is definitely beyond male interpretation. The women’s female signification is to be shifted from the margins, brought to, and made central. It is to Cixous that I now turn.

**Cixous - Women to Write Their Own Experiences**

French female philosopher, Helene Cixous born 1938. Her belief is in the power of ‘women’s writing’. She speaks further about it:

> Women must write her self: must write about women and bring women to writing, from which they have been driven away as violently as from their bodies – for the same reasons, by the same law, with the same fatal goal. Woman must put herself into the text – as into the world and into history – by her own movement (Cixous, 1976, p. 875).

Women must replace the false lacking and depleted woman that males have created. Importantly Cixous states regarding woman, “[h]er speech, even when ‘theoretical’ or political, is never simple or linear of ‘objectified’, generalized: she draws her story into history” (Cixous 1976, p. 881).

The post-menopausal women’s narratives that follow in this chapter draw these women’s stories into our history, into the history of women, which have not been included in the male discourse of the dominant paradigm of menopause. Herstory is wholistic. Significantly it is postmenopausal women’s experiences and theories, through their published texts (writing), which acknowledge and reclaim the lost aspects, those which have been deleted and discounted due to the Cartesian dualistic method. At the same time these women’s writings decentre the simple, linear and objectified, thereby bringing significant and critical connections to the fore. And, as Cixous states, “[i]t is in writing, from woman and towards woman … that woman will affirm woman somewhere other than in silence” (Cixous, 1986, p. 93).
In addition, from the words of this great lady regarding woman, it is to the “emancipation of the marvellous text of herself that she must urgently learn to speak (1976, p. 880). Cixous describes woman’s writing as:

An act that will also be marked by woman’s seizing the occasion to speak, hence her shattering entry into history, which has always been based on her suppression. To write and thus to forge for herself the antilogs weapon. To become at will the taker and initiator, for her own right, in every symbolic system, in every political process … It is time for women to start scoring their feats in written and oral language (Cixous, 1976, p. 880).

This gives us a chance to resurrect that which we have lost; being marginalized, ignored, suppressed and deleted from history through ‘his story’. I believe Cixous gives us as women, much courage and empowering inspiration to write of our experiences. In her own words: “I write woman: woman must write woman. And man, man” (Cixous, 1976, p. 887).

As Cixous passionately pleads with us to write ourselves into history. I believe also that with herstory – our own women’s experiences, written through our own female bodies, minds, souls and spirits, will gift not only other women, but will be a contribution to the already existing knowledges of our culture, and in turn to the world. Therefore, a final word from this female philosopher of our time, “[w]riting is precisely the very possibility of change, the space that can serve as a springboard for subversive thought, the precursory movement of a transformation of social and cultural structures” (Cixous, 1976, p. 879).

It is to those postmenopausal women who have put their menopausal experiences in writing that I now turn. Emerging from these postmenopausal writings is evidence of an adult developmental process occurring. Significantly, noted too by Cavanaugh & Whitbourne, “[c]hanges in biological, behavioural, sociocultural or life-cycle processes in primary aging are an inevitable part of the developmental process” (1999, p. 4).

INTRODUCTION TO THE POSTMENOPAUSAL WOMEN’S TEXTS
I believe the voices of these postmenopausal women and their experiences have legitimacy in contesting the dominant paradigm. Having critiqued the philosophy of Descartes Cartesian dualism, which underpins the scientific biomedical model it is now appropriate to explore the
philosophy that emerges from the postmenopausal women’s own texts. The postmodern approach is one that enables the revelation of the women’s authentic voices.

As I commenced writing this chapter of this thesis, the women’s narratives, I was feeling very uneasy and tentative. To tell someone else’s story did not sit very easily with me as I realized I am not the originator of the words. Not wanting to distort, change or manipulate in any way the words of these postmenopausal women, I have initially presented the writer’s words as written by them as I will be locating the author’s words as my data without any interpretation. This enables as little distortion and misinterpretation as possible. Regarding the importance of the inclusion of personal experience I concur with the following:

The inclusion of personal experience in feminist work is also a way of addressing the critique of false universalism, and as such is closely allied with the emphasis on diversity and particularly in women’s experience. Acknowledging the personal sources of our work, rather than writing about women’s experience abstractly and in the third person may save us from false generalizations, from defining women’s experience in a univocal way. As Carol says in another context, if we are more clear about why we each think the way we do, we may be less likely to label or dismiss or misunderstand the work of other feminists whose work comes from different histories (Plaskow & Christ, 1989, p. 5).

Whilst attempting to stay true to each woman’s words by presenting their words exactly, I also employed a reflection, when for me, the women’s own words held some new significant information. This reflection allowed me to incorporate the new information. Reflections, when appropriate are presented once again in the author’s own words, but in bold italic, Times New Roman font 12 and indented 8cm from the left hand margin. Secondly, if the new information instigates a new image for me, I will present my own image, which will be presented in bold italics reduced text font to 10 pin indented, 10cm from the left hand margin. They present in smaller pin to ensure that my subjective image does not dominate the women’s words, as I wish them to stand just as written by the women themselves and therefore to remain the main focus rather than my secondary image or interpretation. Thirdly, I will present contrary concepts from the women’s own words as these are what I am particularly seeking to uncover. The contrary concepts are bolded, capitalized, italicised 10
point bullet point, and indented from the left hand margin. In addition I am choosing to call this process just described, a new method and have named it ‘Without Interpretation’.

**Women’s Texts**

It is against the backdrop of the western scientific pathological diagnosis together with Cartesian dualism, postmenopausal women’s embodied experiences and theories provide us with insights and stark revelations that conflict with the pathological diagnosis. These narratives disrupt the dominant paradigm as they present alternatives or, better still and more importantly, additional possibilities, perspectives and theories of the phenomenon. Postmenopausal women’s perspectives, theories, and needs are revealed as they describe their own menopausal process. Significantly too, these particular women writers are professional women who occupy positions as experts in their diverse fields of practice. They are well placed to bring understandings beyond the biomedical diagnosis. Their narratives now follow.

It was through these following postmenopausal women’s narratives that I was able to obtain a depth of insight, detail and knowledge beyond any that I had received from any medical male doctor. It also enabled me to place my own experience of menopause into, not only a satisfactory perspective, but also within a very positive, significant, honourable and holy one, requiring one’s engagement with oneself.

I commence firstly with obstetrician Christiane Northrup, M.D.’s text (2001). This is followed by Marian Van Eyk McCain (1991), Social Worker and Psychologist’s text, followed then by the text by Christine Downing (1987), Psychotherapist, and finally Judy Hall (1994), Counsellor and Women’s Health Educator’s text. These women have all been educated in and through different tertiary disciplines. However, they present very similar concepts to describe their menopausal experiences. I find their writings very rich and deeply insightful. I commence now with Dr. Christiane Northrup’s text.
WOMEN’S TEXT ONE:
THE WISDOM OF MENOPAUSE - CHRISTIANE NORTHRUP

and

Author Background

I refer to Christiane Northrup, MD (2001), obstetrician and gynaecologist, and to her book ‘The Wisdom of Menopause’.

Dr. Northrup’s (2010) social networking page states: “Dr. Christiane Northrup is an internationally known expert on women’s health and wellness and of medicine and healing that acknowledges the unity of the mind and body” (Northrup, 2010). The Hayhouse website (n.d) makes the following comment about the author in relation to her publications.

Christiane Northrup, M.D. is a visionary pioneer and beloved authority in the field of women’s health and wellness. A board-certified OB/GYN physician who graduated from Dartmouth Medical School and did her residency at Tufts New England Medical Center, Dr. Northrup was also an assistant clinical professor of OB/GYN at Maine Medical Center for 20 years. Recognizing the unity of body, mind, and spirit, Dr. Northrup helps empower women to tune in to their innate inner wisdom to transform their health and truly flourish. Dr. Northrup is the author of two New York Times best-selling books, Women’s Bodies, Women’s Wisdom and The Wisdom of Menopause. Her third book, Mother-Daughter Wisdom, was a 2005 Quill Award nominee and voted Amazon’s #1 book of the year in both parenting and mind-body health in 2005.

In her text The Wisdom of Menopause, Christiane shares her own experience, not only as a medical doctor, but also as a woman. Her experience of menopause, its effects for her and the consequences that occurred for her because of a society’s lack of wisdom regarding the phenomenon of menopause is well articulated. As well, she continues to educate us through the remainder of the book regarding our bodies and our body/mind connections and how we can care for them more sensitively and caringly. She also gave advice on Hormone
Replacement Therapy. Her book is a great reference for any woman. However, in this thesis, I have considered mainly her experience only, and her own interpretation of her experience of menopause, as this is what I have discovered is ignored, and lacking in the medical texts I have studied to date. It is postmenopausal women’s experiences and perspectives of the phenomenon of menopause that is absent in the medical texts. It is through these postmenopausal women’s writings on their own experiences, that contrary concepts have emerged. Because copyright regulations put limits on the amount of material that can be presented from the book I am unable to convey her section of risks and benefits of HRT/HT.

**Christiane Northrup’s Reasons for Writing Her Book Now**

The following are Christiane’s own words.

> “Society in general, and the medical profession in particular, admonishes doctors to keep our personal stories to ourselves, especially when they involve difficult emotions like fear or anger - allegedly because to appear too human would undermine our authority. Yet I’ve found over the years that nothing illustrates a point quite as effectively or is as helpful to my patients as an honest personal story. Telling the truth of my own humanness and vulnerability is also helpful to me” (p. 5).

**Reflection:** Society and the medical profession prefer doctors to keep their personal stories and difficult emotions quiet. It has been helpful both to herself and to her patients to honestly share her truth with them and others.

**My Image:** Sharing one’s own experiences when they contradict the medical diagnosis makes one vulnerable. It is the telling of the truth of her ‘own humanness and vulnerability’ that is helpful to Christiane, and her patients, rather than silencing her truth, humanness and vulnerability.

> “For some people, it’s surprising to hear a doctor revealing anything of her personal life. But I’ve always been comfortable with the idea that what I have to offer as a
woman, wife, and mother is every bit as valuable as what I have to offer as a trained medical professional – that they are equally valid as teaching tools, and that one can augment the other ... This is why, throughout my professional career as a clinician, surgeon, and teacher of women’s health issues, I’ve approached my patients and students from the fullness of who I am, in all my roles...” (p. 5).

**Reflection:** Sharing her personal life is equally valid as teaching tools, and she says that one can augment the other. Throughout Christiane’s professional career as a clinician, surgeon and teacher of women’s health issues, she has approached her patients and students from the fullness of who she is, in all her roles. She acknowledges her personal, human self in all her roles, professional as well as personal.

**My Image:** Christiane presents more as a whole person.

“Though I have worked closely with menopausal women for over 20 years, I vowed I wouldn’t write a book on this subject until I entered the process myself. I knew that I would learn something through the direct experience of this transition (my emphasis) that I couldn’t possibly learn any other way. My personal approach to pregnancy and birth, for example, was completely transformed and deepened when I had my two daughters. The same has been true for the menopausal transition and its attendant challenges” (p. 5).

**Reflection:** Regarding writing on the subject of menopause Christiane waited until she had experienced herself, what she calls this ‘transition’. Also Christiane considered that her authority to write about the menopausal transition was dependent upon her own direct experience.
My image: Waiting until one has experienced the transition before publishing anything on menopause – Only women can do this.

“By sharing both the joy and the pain of my own transition (my emphasis), I hope that I can help to illustrate and also demystify the surges of creative energy that erupt in so many of us at midlife”. “As we break this silence we are also breaking cultural barriers, so we can enter this new life phase with eyes wide open…” (p. 6).

Reflection: Sharing one’s transition, can illustrate and demystify the surges of creative energy that erupt in so many of us at midlife. And very importantly, Christiane says, that as we break this silence we are also breaking cultural barriers. This also enables us to enter this new phase of life with eyes wide open as this is a time of transition.

My Image 1: Demystification of creative energy changes through giving voice with others to the phenomenon.

My Image 2: Postmenopausal women by speaking out, in their own words, can present the positive dynamic wholistic aspects and counter the reductionist pathological diagnosis, attitude and control of the biomedical model of disease. This enables us to see, in a more real way, the other aspects that have been marginalized and ignored in the biomedical model as men are limited in defining the phenomenon because they do not have the internal experience themselves.

CONTRARY CONCEPTS-
- OWN TRANSITION
- THIS TRANSITION,
- ONE’S TRANSITION
The term ‘perimenopause’ is used by Christiane throughout her book, to identify the ‘ten years or so’, in which our hormones during this transition time, are urging us to make changes (p. 38).

Christiane referred to menopause as “one’s transition” and “threshold of total transformation” and “developmental stage” (p. 2). These and other contrary concepts emerged from her text as I moved along through her narrative.

CHRISTIANE NORTHRUP’S OWN STORY

“As I approached menopause, I found myself unable to tolerate distractions like my eighteen-year-old asking me ‘When is dinner?’ when she could clearly see I was busy. Why, I wondered, was it always my responsibility to turn on the stove and begin to think about my family’s food needs, even when I wasn’t hungry and was deeply engrossed in a project? Why couldn’t my husband get the dinner preparations started? Why did my family seem to be almost totally paralysed when it came to preparing a meal” (p. 1).

Reflection: Why did my family seem to be almost totally paralysed when it came to preparing a meal?

My Image: questions about her role in family life are coming up for her.

“The same thing occurred when it was time to get into the car and take off on holiday. Only when I myself made a definitive move towards the door did my family mobilise. It felt as though my presence caused them to lose their own personal initiative to take charge of a situation be it dinner or a family trip. Still, during my childbearing years I accepted this, mostly good-naturedly, as part and parcel of my role as wife and mother. And in so doing, I unwittingly perpetuated it, partly because it felt so good to be indispensable” (p. 2).
Reflection: Accepted mostly good-naturedly, as part and parcel of my role as wife and mother.

“During perimenopause I lost patience with this behaviour on all levels, whether at home or at work. I could feel a fiery volcano within me, ready to bust, and a voice within me roaring ‘Enough! You’re all able-bodied, capable individuals. Everyone here knows how to drive a car and boil water. Why is my energy still the organising principle around here?’ My indignation grew as I mumbled to myself, ‘If I were a man in the prime of life and at the pinnacle of his career, I wouldn’t be interrupted like this. Everyone would be wondering how to help me, instead of the other way around!’” (p. 2).

Reflection: Change occurring, feeling of fiery volcano within, ready to burst, and a voice of protest roaring ‘enough’.

My Image: Energy rising.

Patience and good-natured acceptance of role of the all-helping hand to others around the house did not feel so good anymore. Previous role felt uncomfortable.

“Little did I know that these little bursts of irritability over petty family dynamics were the first faint knocks on the door marked Menopausal Wisdom, signalling that I needed to renegotiate some of my habitual relationship patterns. Nor did I know that by the time I began to actually skip periods and experience hot flushes, my life as I had known it for the previous quarter of a century would be on the threshold of total transformation. As my cyclic nature rewired itself, I put all my significant relationships under a microscope, began to heal the unfinished business from my past, experience the first pangs of the empty nest, and established an entirely new and exciting relationship with my creativity and vocation” (p. 2).

Reflection: The need to renegotiate old relationship patterns to enable and support her changes.
Menopause: The Need for a Paradigm Shift from Disease to Women's Health
Margaret T.C. Harris

My Image: Establish an entirely new and exciting relationship with creativity and vocation and her menopausal wisdom.
Transformation of conditioned patterns, to relationship patterns that reconnect to the woman’s own wisdom.

CONTRARY CONCEPTS:

- THRESHOLD OF TOTAL TRANSFORMATION

“All of the changes I was about to undergo were spurred, supported, and encouraged by the complex and intricate brain and body changes that are an unheralded – but inevitable and often overwhelming – part of the menopausal transition. There is much, much more to this midlife transformation than ‘raging hormones’. Research into the physiological changes taking place in the perimenopausal woman is revealing that, in addition to the hormonal shift that means an end to childbearing, our bodies – and, specifically, our nervous systems are being, quite literally, rewired. It’s as simple as this: our brains are changing. A woman’s thoughts, her ability to focus, and the amount of fuel going to the intuitive centres in the temporal lobes of her brain all are plugged into, and affected by the circuits being rewired. After working with thousands of women who have gone through this process, as well as experiencing it myself, I can say with great assurance that menopause is an exciting developmental stage – one that, when participated in consciously (my emphasis), holds enormous promise for transforming and healing our bodies, minds, and spirits at the deepest levels” (p. 2).

Reflection: Complex & intricate brain & body changes that are unheralded. Our nervous systems are being rewired. Our brains are changing. A woman’s thoughts, her ability to focus, and the amount of fuel going to the intuitive centres in the temporal lobes of her brain all are plugged into and affected by the circuits being rewired.
Menopause: The Need for a Paradigm Shift from Disease to Women’s Health

Margaret T.C. Harris

Chapter Four – Women’s Texts

My image: Body/Mind/Spirit intricate brain and body changes, instigating developmental stage.
The spirit moving and prompting one to a new stage, through a body/mind transition from the previous stage to the next.

CONTRARY CONCEPTS:

- BRAIN & BODY CHANGES
- MIDLIFE TRANSFORMATION
- HORMONAL SHIFT, BRAIN & BODY
- NERVOUS SYSTEM BEING REWIRED
- OUR BRAINS ARE CHANGING
- EXCITING DEVELOPMENTAL STAGE
- TRANSFORMING AND HEALING BODY/MIND/SPRIT.

“My personal experience tells me that the perimenopausal lifting of the hormonal veil – the monthly cycle of reproductive hormones that tends to keep us focused on the needs and feelings of others – can be both liberating and unsettling. The midlife rate of marital separation, divorce, and vocational change confirms this. I, for one, had always envisioned myself married to the same man for life, the two of us growing old together. This ideal had always been one of my most cherished dreams. At midlife I, like thousands of others, have had to give up my fantasies of how I thought my life would be. I had to face, head on the old adage about how hard it is to lose what you never really had. It means giving up all your illusions, and it is very difficult. But for me the issue was larger than where, and with whom, I would grow old. It was a warning, coming from deep within my spirit that said, ‘Grow…or die’. Those were my choices. I chose to grow” (p. 3).

Reflection: Both liberating and unsettling.

CONTRARY CONCEPTS:

- DEVELOPMENTAL TRANSITION
Christiane Northrup’s Narrative:

“Our brains actually begin to change at perimenopause. Like the rising heat in our bodies, our brains also become fired up! Sparked by the hormonal changes that are typical during the menopausal transition, a switch goes on that signals changes in our temporal lobes, the brain region associated with enhanced intuition. How this ultimately affects us depends to a large degree on how willing we are to make the changes in our lives that our hormones are urging us to make over the ten years or so of perimenopause” (p. 36).

Reflection: Our brains begin to change at perimenopause

My Image: Rising heat fires the brain. Changes in brain occurring enhancing intuition, often causing new thinking and new ways of being.

CONTRARY CONCEPTS:

- ENHANCED INTUITION

“There is ample scientific evidence of the brain changes that begin to take place at perimenopause. Differences in relative levels of oestrogen and progesterone affect the temporal lobe and limbic areas of our brains, and we may find ourselves becoming irritable, anxious, and emotionally volatile. Though our culture leads us to believe that our mood swings are simply the result of raging hormones and do not have anything to do with our lives, there is solid evidence that repeated episodes of stress (due to relationship, children, and job situations you feel angry about or powerless over, for example) are actually behind many of the hormonal changes in the brain and body. This means that if your life situation—whether at work or with children, your husband, your parents, or whatever—doesn’t change, then unresolved emotional stress can exacerbate a perimenopausal hormonal imbalance” (p. 38).

My image: Hormonal balance changing, exacerbated by stress, signalling the woman to make things different and better, by making changes to reduce stress.
“Until midlife, it is characteristic for a woman’s energies to be focused on caring for others. She is encouraged to do so, in part, by the hormones that drive her menstrual cycles — the hormones that foster her instincts for nurturing, her devotion to cohesion, and harmony within her world. But for two or three days each month, just before or during our periods, there is a hormonal interlude when the veil between our conscious and unconscious selves is thinner and the voice of our souls beckons to us, subtly reminding us of our own passions, our own needs, which cannot and should not always be subsumed to the needs of those we love” (p. 43).

**Reflection:** Veil between our conscious and unconscious selves is thinner and the voice of our souls beckons to us.

**My Image:** Voice of soul is heightened temporarily before menstruation. Need to nurture self.

“Biologically, at this stage of life you are programmed to withdraw from the outside world for a period of time and revisit your past. You need to be free of the distractions that come when you are focusing your mothering efforts solely on others. Perimenopause is a time when you are meant to mother yourself “ (p. 46).

**Reflection:** Programmed to withdraw from the outside world for a time and revisit your past. This stage of perimenopause a time to mother your self, free of distractions.

**My Image:** Similar to the menstruation cycle, the voice of our souls beckons at perimenopause, but not temporarily this time, but permanently.

“It may be no accident that the word menopause invites the association ‘pause from men’. In truth, you are being urged, biologically, to pause from everyone, - from mankind in general – in order to do important work on yourself. Perhaps as a result
of this, one of the most common threads running through women’s descriptions of how they feel during the menopausal transition is the longing for time alone, for a refuge that provides peace, quiet, and freedom from distractions and demands” (p. 46).

**Reflection:** Time to pause in order to do important work on oneself – different from looking after others. Longing for peace, quiet and freedom from distractions and demands.

*My Image:* It is O.K. to focus on self. But this very often can be judged as selfish.

“Though we tend to blame perimenopausal symptoms on hormonal shifts in the body, their origins are far more complex. Several women in my practice, for example, have experienced symptoms such as hot flushes and mood swings in their later forties – despite having been on full hormone replacement for over twenty years as result of having undergone hysterectomies and removal of their ovaries while still in their twenties. Clearly, changes in reproductive hormones alone do not account for these symptoms. They are signals from our mind and body that we have reached a new developmental stage – an opportunity for healing and growth” (p. 42).

**Reflection:** Hormonal shifts are more complex, and may not be the whole story. The symptoms indicate that we have reached a new developmental stage of healing and growth.

*My Image:* New developmental stage of growth rather than decline.

**CONTRARY CONCEPTS:**
- **NEW DEVELOPMENTAL STAGE**

“As a woman enters menopause, she steps out of the primarily childbearing, caretaking role that was hormonally scripted for her. This is not to say that the postmenopausal woman is no longer an effective nurturer. Rather, she becomes freer
to choose where she will direct her creative energies, freer to ‘color outside the lines’. Many of the issues that had become blurred to her when the hormones of puberty kicked in may suddenly resurface with vivid clarity as those hormones recede. This is why so many midlife women recall, and decide to confront past abuses. The concern with social injustices, the political interests, and the personal passions that were sublimated in the childbearing years now surface in sharp focus ready to be examined and acted upon. Some women funnel this heightened energy into new businesses and new careers. Some discover and cultivate artistic talents they never knew they had. Some women note a surge in their sexual desire, to heights never before experienced in their lives. Some report changes in sexual preference” (p. 53).

**Reflection:** This is why so many midlife women recall, and decide to confront past abuses. The concern with social injustices, the political interests, and the personal passions that were sublimated in the childbearing years now surface in sharp focus ready to be examined and acted upon. Some women funnel this heightened energy into new business and new careers. Some discover and cultivate artistic talents they never knew they had.

**My Image:** Making new creative futures. Redirecting the childbearing and nurturing energy of the potential to create the human race, to nurturing her own passions, desires and needs, and concern for social injustices.

**CONTRARY CONCEPTS:**

- **SHIFTING ENERGIES**
- **NEW CREATIVE ENERGIES.**

Christiane explains further:
“It has long been known that our female hormones are not involved solely with reproduction. They are connected with our moods and with the way our brains work” . . . Part of the reason for this has to do with the complex interaction between the hypothalamus, the pituitary gland, the ovaries, and the multiple hormones that are produced in and interact within these key areas. These key hormones are: GnRH, FSH, Oestrogen, and Progesterone” (p. 48).

Chrisitiane also explains the connections between the ovaries and the other multiple hormones, which interact and are also involved in menopause.

“The hypothalamus regulates the production of all of these hormones and is in turn regulated by them – and by many others. It has receptors on it not only for progesterone, oestrogen, and androgens (eg. DHEA, testosterone), but also for noradrenaline, dopamine, and serotonin, neurotransmitters that regulate mood and that are affected in turn by our thoughts, beliefs, diet, and environment” (p. 49).

“If oestrogen, progesterone, and androgen had no other role in the body besides driving reproduction, your levels of these hormones would drop to zero after menopause. But they don’t. Similarly, if Gonadotropine Releasing Hormone, Follicle Stimulating Hormone, and Luteinizing Hormone suddenly were without purpose after menopause, one might expect that there would cease to be any of these hormones circulating in your system after that time. In fact, quite the contrary is true” (p. 49).
“During perimenopause GnRH levels begin to rise in the brain, causing FSH and LH to surge to their highest levels ever. A popular explanation is that this is the body’s attempt to ‘kick-start’ the ovaries into resuming their original function, which might make sense if it weren’t for one eloquent fact: those elevated FSH and LH levels stay elevated, permanently, well after it is physiologically obvious that the ovaries (which have, essentially, run out of eggs) have no intention of jumping back onto the reproductive bandwagon. It would seem that your body, in its wisdom, has ulterior motives for continuing to produce the so-called reproductive hormones, and reproduction no longer is the point. In fact, evidence is mounting that at least one of the roles for this off-the-charts production of FSH and LH, and of the GnRH that precipitates this rise, is to drive the changes taking place in the midlife woman’s brain” (p. 49).

**Reflection:** GnRH levels begin to rise in the brain, causing FSH and LH to surge to their highest levels. Those elevated FSH and LH levels stay elevated permanently.

*My Image:* Changes taking place in the midlife woman’s brain due to surges in high hormonal levels.

*Wisdom of the Body:* reproductive hormones now driving brain changes.

**CONTRARY CONCEPTS**

- **HORMONAL INCREASES**

“For biological reasons, females of the human species are often easier to control – intellectually, psychologically, and socially – during their childbearing years than they are before puberty (from birth to the age of eleven) or after menopause. When we are creating a home and building a family our primary concern is to maintain balance and peace. We seem to know instinctively that when we’re bringing up a family, it’s better for all if we compromise and maintain whatever support we have, even if it’s less than ideal, rather than risk going it alone. Though this may mean we lose sight of
our individual goal, our ability to ‘go with the programme’ is in fact protective” (p. 49).

**My Image:** More peaceful emotions and behavior when building a family, and females easier to control, intellectually, psychologically, and socially during their childbearing years and women compromise rather than pursuing own individual goals.

**BUT**

“The GnRH pulses associated with menopause prime the brain for new perceptions – and, subsequently, for new behaviour. It is very common for women to become more irritable, even downright angry, about things that were more easily overlooked before. Long before we begin to feel hot flushes from changing hormonal levels, our brains undergo changes in the hypothalamus, the place where GnRH is produced. This same brain region is key for experiencing, and ultimately expressing, emotions such as anger. It is well known that hormones modulate both aggression and anger. Our midlife bodies and brains fully support our ability to experience and express anger with a clarity not possible prior to midlife” (p. 53).

**Reflection:** Our midlife bodies and brains fully support our ability to experience and express anger with a clarity not possible prior to midlife. It is very common for women to become irritable and angry at this time.

**My image:** Less peaceful emotions, new perceptions and behaviour due to change in hormonal balance. These new emotions of anger etc. are not unusual, and maybe about injustices that have occurred for the woman.
“GnRH is just one of several hormones that support the changes occurring in the brain. Oestrogen and progesterone molecules bind themselves to areas such as the amygdala and hippocampus, which are important for memory, hunger, sexual desire, and anger. Changing levels of these and other hormones may well help to bring up old memories accompanied by strong emotions, especially anger. This is not to say that anger is caused by hormonal change. Rather, it means that the hormonal changes simply facilitate remembering and clearing up unfinished business” (p. 53).

Reflection: Hormonal changes facilitate remembering and clearing up unfinished business.

My image: Clarification of old injustices highlighted through facilitated remembering.

I continue here with more of Christiane’s perspective, as it is significant because women in our culture are not normally encouraged to be angry. For some women, anger arising internally can be very frightening, as they believe they should not be angry.

“Many women are disturbed or frightened when they feel this anger arising. Maybe you don’t feel angry. Maybe you’re ‘just’ irritable, grouchy, aggravated, envious, overwhelmed, or depressed, or you ‘just’ have high cholesterol or high blood pressure. Believe me, all these emotions and physical conditions are associated with the same thing: anger. Anger in women has a bad press in general unless that anger arises in the service of others. This probably accounts for the fact that although anger has been studied exhaustively in men, the gender in which it is acceptable, the only kind of female anger that has received a great deal of study is maternal anger, the function of which is to protect a child who is threatened. It is also culturally acceptable for women to express their personal anger by fighting for social justice, which too often becomes a platform for releasing personal anger. Though we’re socialised to believe that our anger arises from observing the injustice done to others,
the political is always personal: our anger is ultimately about ourselves, and its energy is always urging us towards self-actualisation” (p. 53).

**Reflection:** Many women are disturbed or frightened when they feel this anger arising.

**My Image:** According to Christiane, it is culturally acceptable for women to express their personal anger by fighting for social justice.
But the anger can be about oppression and suppression that oneself has suffered. One becomes more aware of it if one can accept the anger and more importantly pinpoint the cause.
Lots of feelings emerging due to socialising processes that have devalued women’s self-actualisation. The political is personal.

“That doesn’t mean we should abandon social protest, reform, and a quest for justice. It simply means that we must bear in mind our personal motivation for participating in these arenas, not allowing them to distract us from self-transformation and self-healing - processes that always render us even more effective as agents for social change” (p. 54).

**Reflection:** Self-transformation and self-healing are the processes that render us even more effective as agents for social change.

**My Image:** Older women as agents for social change. Self-transformation and self-healing is important.

**CONTRARY CONCEPTS:**
- SELF TRANSFORMATION,
- SELF HEALING,
- EFFECTIVE AGENTS FOR SOCIAL CHANGE.
“We need to claim our anger. Especially during midlife, it can play an important role in improving the quality of our lives and our health. It is a powerful signal from our inner wisdom – one we should learn to listen to and act on. It often arises from:

Being unable to count on promises or commitments made to us  
Losing power, status, or respect  
Being insulted, undermined, or diminished  
Being threatened with physical or emotional pain  
Having an important or pleasurable event postponed or cancelled to suit someone else’s convenience  
Not obtaining something we feel should legitimately be ours” (p. 54).

My Image: Origins of anger within social factors. Social factors are implicated.

“If, before menopause, a woman hasn’t learned to identify her anger and what it is telling her (and this describes many women), perimenopause is her best remaining opportunity to do so. At perimenopause, the rewiring of her brain makes her vision clearer and her motivations easier to identify. Using anger as a catalyst for positive change and growth is always liberating” (p. 54).

Reflection: Using anger as a catalyst for positive change and growth is always liberating.

CONTRARY CONCEPTS:
• REWIRING OF BRAIN MAKES FOR CLEARER VISION

“In the early stages of perimenopause, the irritability you feel may be subtle. Irritability is a low-voltage form of anger that doesn’t usually lead to lasting change – or any change. Irritability is like keeping a pan simmering but always adding more water or turning down the heat just before it boils. If we do not attend to the things in our lives that irritate us, nature will turn up the flame on the burner in an attempt to mobilise us” (p. 54).
This completes the section on Christiane Northrup’s story. But it does not complete Christiane’s story. More of Christiane’s story, her knowledge and experience are written in her own book. I have referred to a minor portion of her text only. I recommend that every woman read this book to stimulate, challenge, and confront, when appropriate and necessary, epistemological negative orientations and the reductionist, pathological diagnosis of the biological dysfunction that we have culturally inherited.

**MY SUMMARY**

Christiane Northrup’s work is not in denial of biology, but rather biology serves its rightful place as a mediator in a more complex model of menopause. In summary what I have presented, highlights a more inclusive and evolutionary thinking approach regarding menopause and the menopausal woman. I have explored textual material that could present as a catalyst for further philosophical thinking, to enable viewing menopause and the menopausal woman beyond the Western scientific/biomedical projection, prescribed by technological processes only, where the real woman disappears, and where the value of the ageing woman is also lost to our society and our culture. What is scientific and biomedical ‘truth’ can be supplemented and added to by different realities, which I believe should not be denied, repressed and shunned any longer. This information will greatly assist women to make this transition, transformation, and new developmental stage with eyes wide open.

Thank you Christiane Northrup.

As I continue with this project, more postmenopausal women’s texts will be explored in a similar manner. I conclude here with the following point: “[c]onsidering the dominance of the biomedical model, women are offered no alternative on how to perceive themselves, and it can be argued that their complete disassociation from the experience is a product of patriarchal society” (Shore, 1999, p. 176).
CONTRARY CONCEPTS AND IMAGES FROM CHRISTIANE NORTHROP’S STORY

The concepts I have noted in Dr. Christiane Northrop’s story regarding the menopausal woman, that are contrary to the scientific biomedical model of disease, are listed below.

Table 4.1: Contrary Concepts emerging from Christiane Northrop’s narrative

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<td>MIDLIFE TRANSFORMATION</td>
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The following Figure 4.1 graphically represents the contrary concepts emerging from Christiane Northrop’s narrative as applied to Chinn and Kramer’s (1999. p. 55) representation of the Continuum of Empiric Abstraction.
Figure 4.1: Contrary Concepts emerging from Christiane Northrup’s narrative
WOMEN’S TEXT TWO:
TRANSFORMATION THROUGH MENOPAUSE MARIAN VAN EYK MCCAIN


Author Background
Marian Van Eyk McCain, BSW (Melbourne, Australia), M.A, East-West Psychology (C.I.I.S. San Francisco) writes on a number of subjects, including wellness, stress management, psychology, psychotherapy, personal development, women’s health and spirituality, ageing, ecofeminist philosophy, Deep Ecology, environmental politics, voluntary simplicity, organic food production and alternative technology. She has lived and worked on three continents. At the time of publishing this text (1991) she was living in Melbourne working as a Social Worker and Psychotherapist. She now resides in a tiny eighteenth century cottage near the sea in Devon, England.

Marian McCain’s Narrative
Marian McCain’s (1991) text is the story of her own search for understanding what menopause is. It becomes evident that the definition of menopause as a biological event only, was far too limiting for McCain. She commences chapter one with the question, what is Menopause? Her following questions and words from the first chapter orient us to her thinking and also sets the scene for her book. I believe she gives us insightful knowledge of menopause and a menopausal transformation. As this transitional process is a very difficult process to define, I recommend her book as essential for any women interested in the menopausal experience. In addition, the inclusion of her own story is a very personal one. Firstly, Marian McCain’s own words from chapter one, followed by more from the text.

“What is menopause? Is it only that my monthly periods cease, my fertility ends, and my body begins to dry out and grow old?
Is menopause merely something that happens to my body? Or are there changes, also, in my thinking and my feeling, in my way of being in the world and in the meaning
which my world holds for me? And if so, how do I deal with them and what lies at the end of it all?

These were the questions whirling in my mind as I entered this strange new phase of my life journey.

I thought about it a lot. I looked it up in books, for that was the way I had learned in my childhood. If you want to know something, look it up. Start with the dictionary” (p. 9).

CONTRARY CONCEPT

- NEW PHASE OF MY LIFE JOURNEY

“‘My dictionary defined menopause simply as ‘the physiological cessation of menstruation’. I discovered that the word had arrived in our language around 1872, and literally means ‘cessation of the menses’, from the Greek words for ‘month’ and ‘cease’. The word was an import from France, where it was apparently coined, and where it had been used in medical literature early in the 1800s. It did not appear in an English dictionary until 1887” (citing Leguin, 1976).

So that was it? No more blood – was that all? What was all my fuss about? Were all the strange new feelings, ideas, and dreams that erupted in me at this midpoint of my life a genuine part of menopause, or were they the symptoms of neurosis or worse?” (p. 9-10).

Marian McCain then further goes on to say that for her now:

“For me, menopause has now come to mean much more than simply the physical ending of menstruation. It has become a special and very rich word – a word which denotes not merely a biological process, but rather a whole stage in a woman’s life. It includes all that is happening within and around her. I am not simply ‘having’ my menopause, I am living it. Thus all my living is a part of it, either actually or potentially” (p. 10).
CONTRARY CONCEPT:
- WHOLE STAGE IN A WOMAN’S LIFE

“In the way I shall use it in this book therefore, the word menopause describes a holistic experience which encompasses not only the dwindling away of the monthly bleed but all the other phenomena which cluster around this very basic fact of life, and the subjective feelings which may accompany it” (p. 10).

CONTRARY CONCEPT:
- HOLISTIC EXPERIENCE

“This experience may include hot flashes, strange new emotions, dreams, depression, elation, bodily changes, alterations in thinking patterns, and much, much more. Or it may include absolutely none of these. It is an experience which may last for many years, which may begin long before the periods actually cease at all and continue long after their ceasing, or it may be over and done with in a matter of months, or hardly even noticed. It is this wide variation which, for me, makes the whole subject so fascinating” (p. 11).

CONTRARY CONCEPTS:
- ALTERATIONS IN THINKING PATTERNS

“In the chapters which follow, when I speak of menopause, my emphasis will be not on the physical cessation of periods, but on the time of life which surrounds and contains this phenomenon, a ‘change of life’ rich with opportunities for self-awareness, understanding, and growth” (p. 10-11).

CONTRARY CONCEPTS:
- CHANGE OF LIFE
- SELF-AWARENESS
- UNDERSTANDING AND GROWTH.

“What then is this experiences of which I speak? What is menopause if I do not simply accept the biological facts as central and everything else as a side effect? In other words, what is menopause if we look at it holistically and yet maintain that it is something essentially female?” (p. 19)
Marian McCain goes on to tell us that her book is an attempt to answer this last question. She refers to experiences from other women, those who have taken part in her research studies, those who have taken part as her psychotherapy clients, and friends. However, it is to Marian McCain’s own experiences that I focus on and follow, as I believe they give valuable insights as to what occurred for her when brain changes, as referred to by Christiane Northrup. This is Marian McCain’s experience and she states:

“In my own searching, I began with medicine. In fact, when I first began my reading I, too, accepted the conventional wisdom that menopause was a medical ‘condition’, with ‘symptoms’. I accepted that all the other things commonly associated with menopause were simply side effects of the physical, and thus, naturally, that the people who knew most about all this were the doctors” (p. 20).

“My Image: Marian accepting negative, pathological, medical knowledge because doctors claim to have all the knowledge.

“However, the more deeply I read into the available literature, the wider my mind opened to other ways of understanding the whole phenomenon of menopause. The first thing I discovered was that the way a woman experiences menopause is to a great extent defined by the culture in which she lives” (p. 20).

“My Image: In our culture, we are culturally bound by the Western scientific, negative, pathological diagnosis.

“In our culture, the language of menopause nowadays is medical language. Rejecting the dusty remnants of folk wisdom that hint darkly at the horrors of ‘the change of life,’ we turn thankfully toward the bright, fluorescent light of medicine to make sense
of the happenings within us. Even if we choose not to intervene in the hormonal processes, our very decision is more than likely informed by medical knowledge. We turn to medicine with all our questions” (p. 14).

**Reflection:** Rejection of folk wisdom by turning to medicine for advice.

**My Image:** Because of our cultural biomedical knowledge, rejection of the holistic change of life has occurred.

“Medicine, as always, obliges us with neat, scientific explanations, inviting us to use its clean, sterile words, its language of sign and symptom, cell and system, biology and biochemistry, diagnosis and prognosis” (p. 14).

**Reflection:** Medicine responds with a diagnosis. Medicine is sterile.

**My Image:** Objective, reductionist processes dominate.

“So easy to fall in line. Yet such a trap. For if we are not very careful, language can lead us away from our experience. The map can be mistaken for the territory. Our thinking, feeling, experiencing life can become a catalog of symptom and solution, condition and cure, a two-dimensional living that can no longer deeply satisfy. A loss, perhaps, of soul. For the medicine of the West does not speak the language of the soul” (p. 14.)

**Reflection:** Language leading us away from our experience. Medicine of the West does not speak the language of the Soul.

**My Image:** We can get LOST if we seek medicine of the West only, as it does not speak the language of the soul.
“Language is so much more than a convenient way of communicating with others. It is a potent force which shapes the way we think. And in its turn, the way we think shapes our experience. The way we think and speak of menopause defines its meaning for us and defines the limits of what it may teach each of us in her own life. This is why, in the following chapters, I have deliberately chosen to speak of menopause not in the language of medicine but in the language of my own body and my own soul, and I invite you to do the same” (p. 14-15).

**Reflection:** Language of the deficient body shapes and limits our thinking and experience.

**My Image:** Marian, not speaking the language of medicine, but the language of her own body and soul. Therefore, language conceived and birthed from Marian’s own body and soul.

“That is not to say that medicine has nothing to offer. It has much indeed. However, I believe that in order to live our lives fully we have to remind ourselves to go within as well as without, to seek for wisdom as well as for knowledge, and to learn to blend the two in order to answer our own deep questions” (p. 15).

**Reflection:** Go within to seek the wisdom.

**My Image:** The external and the internal both create wisdom.

“Out of habit, the habit of our schooling in society, it may be that pile of received knowledge to which we first turn, rather than to our own inner wisdom. Do we seek out the wise old woman who lives in a cave under the hill, saying, ‘Please tell me about menopause, now that my time has come?’ Or is it more likely to be a clean-looking medical graduate in a white coat who ushers us politely into his or her consulting-room and hears our first uncertain questions?” (p. 15).
Reflection: Choice of wise woman or medical graduate without internal embodied experience.

My Image - The wise old woman is the wisdom teacher who holds the internal experience.

“Any woman brought up in our modern Western culture, regardless of her formal schooling in the physical sciences, is likely to seek some level of ‘scientific’ knowledge in seeking to learn about menopause. She may seek it from a friend or from a magazine article or from a radio or TV program. She may buy or borrow a book of some kind, whether it be a popular book or a medical or biological text. She may consult someone whose level of scientific knowledge she perceives to be higher than her own, such as a physician or other health professional” (p. 15).

Reflection: In Western culture, because of the dominance of scientific knowledge, and the deletion of alternative knowledge that is where we automatically turn.

My Image - Woman believes she is inferior because she lacks the scientific, objective, reductionist, knowledge.

“She almost certainly believes that if she is fully to comprehend the changes taking place within her she needs a basic understanding of the menstrual cycle. The books and articles she reads and the people she consults will usually oblige that belief. Most books on menopause devote considerable space to exploring this complex interplay of body chemicals, usually in the first chapter. In this book, I have deliberately avoided doing that. Not that these facts are not important or worth knowing. On the contrary, they are fascinating, and we should know them. But I believe that they are masking something even more fascinating. I want to take us beyond hormones” (pp. 15-16).
Reflection: Marian avoids chemical facts only as they are masking and preventing something more fascinating beyond hormones.

My Image – Marian is interested in dealing with other more wholistic perspectives of the phenomenon.

Although Marion McCain is avoiding writing in detail about hormones, she is admitting that something is occurring for her that goes beyond just the lack of hormones. She is talking about something new and different that is happening inside her. She describes this as a ‘stirring’.

“I must admit that when I first decided not to include a chapter on hormones, I was not clear about my reasons. I love knowledge and have always sought it greedily. I have university degrees, a whole wall of crowded bookshelves, and a curiosity as insatiable as any two-year-old’s. Yet, as I go through menopause, I feel the stirring of something new and different inside me that does not arise out of knowledge or from the medically defined facts of my body, though it is intimately connected with them” (p. 16).

Reflection: Marian has a great deal of external knowledge but she feels the stirrings of something new and different emerging from inside her not connected to the external medical facts.

My Image - Something different arising, new knowledge and energy rising, signified by rising heat: heat rising = hot flush. Representing new knowledge not yet formulated.
Although Marian McCain knows this new stirring is immediately connected to the medically defined facts of her body she is noting that this new something is something that wants to displace knowledge that she has already, like a usurper.

“I do not know what this new something is, and yet, to my dismay, it seems almost to want to displace my knowledge at times, like a young usurper of the throne” (p. 16).

**Reflection:** Something new wants to displace knowledge, a young usurper of the throne.

_My image_ – Something new rising and emerging to displace old previous external knowledge.

“The days when I feel the presence of this strange something usually happens to be those days when my knowledge has chosen to desert me unexpectedly, inexplicably, leaving me floundering. Days when my mind goes blank and questions go unanswered. Days when I blush and panic at my inability to respond, wondering why my mental filing cabinet is suddenly jammed shut, my inner computer ‘down’ and silent” (p. 16).

**Reflection:** Her inner computer (which stores all the old external knowledge) is down and silent.

_My Image_ – Old knowledge is displaced.

Floundering or instability experienced.

“At first, when I began to have such days, I struggled and fought, trying vainly to my knowledge systems up and working again. It was only when I gave up the fight and settled into a strange new inner silence that I began to feel little stirrings of that new way of being that still has no name. And because of my wish to honor and explore this new way of being, I decided to approach the whole question of menopause from a slightly different angle. This is the angle of surrender. Surrender, that is, to a natural process, in order to learn its deepest lesson” (pp. 16-17).
Reflection: Initially wanted the old familiar external knowledge back on throne but surrendered to the silence of the empty throne.

My Image - Surrender to the natural process to hear one’s own voice, the stirrings of that new way of being that still has no name. Surrender to a natural process to learn its deepest lessons.

CONTRARY CONCEPTS:
- NEW WAY OF BEING
- NATURAL PROCESS WITH DEEP LESSONS

“How we have relished the straight line, the soaring graph, the ladder to the sky. Gross National Product, economic growth, development, personal growth, spiritual growth, any kind of growth, no matter what, as long as it onward and upward like a flower. Then the flower dies and falls and we say, ‘What a shame,’ and look for another. We never watch it fall the way we watched it grow. Once past its prime, it is finished, forgotten, its usefulness gone. Time to replace it” (p. 3).

Reflection: External linear progress. Soaring onwards and upwards, youthfulness and vigour required. Once past youth and less vigorous, considered obsolete.

My Image: 1. Socialisation in the world. 2. Ego driven. 3. External progress valued. Linear progress drives the outside world’s values. Linear progression means competing and valuing more not less, more of the same.

“All our favourite metaphors for growth seem to be like that—linear. Mine certainly were. Until I too, like the flower, reached my ‘prime’. Unlike the flower, which probably does not wonder, I wondered what lay beyond ‘prime time’ ” (p. 3).
Reflection: Questioning beyond prime time.

My Image - We become obsolete too soon.

“My first reaction to this wondering was to plan to extend prime time indefinitely. That is easy to do on our society. People, especially women, have been reacting that way for a long time now. I set to work to ensure that my life was full and fascinating, my body supple, slim, strong, and healthy, and my lifestyle a model of enviable wellness. I determined to live to 100, and ate the diet of Hunzas, Himalayans known for their longevity, to ensure that I would. Yoga, exercise, postgraduate studies, personal growth, spiritual awakening, you name it, I was there, not only doing it but teaching others how to do it as also; modelling humility, too, just in case anyone should that my ego was in any way involved with all of that! That, too, was as it should be. We learn our lessons in a certain order” (p. 3).

Reflection: In our Western culture, we learn to live to the world’s external ways.

“The crunch comes to different people in different ways, but for me the crunch was menopause. Menopause unglued me. Menopause, and the events that coincided with it in my life, melted away every self-image, every mode, every vision of who I thought I was left me with nothing. Nothing, that is, except the sweet, light, wonderful promise of infinity” (p. 3).

Reflection: Menopause brought the external ways of living to a stop.

My Image – 1. The world’s ways did not work anymore. 2. Potential space emerged. 3. Beginning of Transformation

Marian McCain also talks about the three stages that are involved in a transitional process. Referring to Bridges she states that every transition begins with an ending. Something ending automatically causes a change. Accordingly:
“Between the ending and the new beginning, there is a third place. That is the place which Bridges calls ‘the neutral zone’. It is the place in which our hearts and minds dwell as we do all the necessary work involved with endings and beginnings. It is a vital stage in most processes of transition. It may be long or short. It may take years or minutes” (p. 86).

**My Image:** Time in the neutral zone varies.

**CONTRARY CONCEPT**
- NEW BEGINNING.

“Sometimes we are fully aware of what is ending and what is beginning and what needs to be done. At other times, we seem to be stuck, lost in a fog, uncertain of our direction. We may not even know what the new will be, nor even clearly understand what has ended, what has to be let go or completed. The neutral zone may feel like depression. We may feel alienated from the past and not yet connected to the future. It may seem like limbo” (p. 86).

**Reflection:** Depression may occur because we feel alienated from both the past and the future.

“I have found this three-stage way of viewing transitions a very useful one in the study of menopause. As menopausal women, we are all working through a transitional process” (p. 86).

**CONTRARY CONCEPT:**
- TRANSITIONAL PROCESS

“This is taking place on the physical plane, as our bodies reach the end of their reproductive phase and prepare for a new existence with drastically reduced levels of hormones” (p. 86).

**CONTRARY CONCEPT:**
- NEW EXISTENCE
“On a mental and emotional level, we are adjusting to a new way of thinking and feeling, a new definition of ourselves as nonfertile women whose ways of being in the world and contributing to it are no longer tied to the possibility of creating children. We may also be concurrently involved in other transition processes which have a bearing on these definitions” (p. 86).

**CONTRARY CONCEPT**
- **A NEW DEFINITION OF OURSELVES.**

“Spiritually, we are likely to be in the transitional phase of which Jung spoke, a turning away from our preoccupation with the outer world of the ego and a beginning of the inner journey of exploration, the journey toward the true self and what lies beyond it” (p. 86-87).

**CONTRARY CONCEPT**
- **JOURNEY TOWARD THE TRUE SELF.**

Marian McCain tells us this book is about that process, she suggests:

“This book is about that transformational process and how I think it works” (p. 3).

**CONTRARY CONCEPT:**
- **TRANSFORMATIONAL PROCESS**

“I knew what was happening to me on a physical level, but mentally, emotionally, and spiritually I felt confused and tortured at times. Not always, just on the dark days. There were many dark days at first, until I began to explore the process and to learn to flow with it instead of contracting against it in fear. I felt an urgent need to understand the new feeling I was having. They were like premenstrual syndrome (PMS) in some ways - And that was a familiar-enough syndrome for me - they had no regular, predictable rhythm. Rather they seemed random and unsettlingly frequent. Feelings of confusion, of rage, of fear; feelings of inadequacy, sadness and doubt. All these, and more, were the feelings that now seemed to besiege me” (p. 4).
Reflection: There were many dark days at first, until I began to explore the process and learn to flow with it instead of contracting against it in fear.
New feelings, unsettling feelings, besieged by feelings.

My Image: Feelings were important to be heard as part of the process.

“I worked hard to process them. Sometimes, bits of understanding came from dreams. Sometimes nothing came and I found myself bogged down in a confusion and depression. At those times, I began to act out my fears and feelings in a number of experimental ways. I began to try singing them or dancing them, and frequently I picked up crayons and drew them” (p. 4).

Reflection: Processing feelings - Bits of understanding come from dreams.
Singing, dancing and drawing to act out fears and feelings.

My Image – Working with the feelings were helpful, and therefore beneficial.

“Some days would be palpably physical. Fatigue, such I had never experienced before, would overcome me and I would lie down in the middle of the afternoon. There would be a strange, fuzzy mental sensation and sometimes feelings of vertigo. Closing my eyes, I would let myself go into the feeling. My thoughts would start to spin out of control. A whirling craziness would seem to envelop me, becoming stronger and stronger, crazier and crazier. Eventually, I would drift into sleep. Half an hour or so later, I would awake with a sort of ‘ping’ and feel refreshed and light” (p. 4).

Reflection: Strange mental sensations.
Menopause: The Need for a Paradigm Shift from Disease to Women’s Health

Chapter Four – Women’s Texts

My Image: Unsettling processes which would pass.

“At first the experience frightened me, but as I grew accustomed to it, it began to feel comforting. I realized that at the centre of my spiral was not a deadly vortex after all, but rather a cocoon. A safe cocoon in which I could sleep” (p. 5).

Reflection: A safe cocoon.

My Image - New safe space to rest.

“I began to explore the nature of the spiral. What is a spiral? Remember how, as a child, you used to have fun asking people to describe a spiral staircase without using their hands? It is such a three-dimensional concept that it is hard to describe in a flat, two-dimensional language. I used to think of psychological growth in the way, as a kind of spiral staircase. I noticed that people—myself included—seemed to return to the same old psychological problems and issues again and again, even though they had previously ‘resolved’ them. It seemed that although they had been resolved at one level, they kept reappearing at new, perhaps higher, levels. I found this is a satisfactory explanation at the time, and for that time it was satisfactory” (p. 5).

Reflection: Using a spiral as a tool for reflection.

My Image – Repeatedly addressing psychological problems from the past, at different levels, was helpful.

“I realize now that it is in the nature of the Western mind to think in linear terms. In Eastern thought, everything revolves in circles. But in the West we always have to be going somewhere. Up or down, straight ahead or backward, it does not matter which, as long as there is a direction to it. The spiral of growth seems to have been our way of incorporating linear, forward movement with the Eastern concept of circularity” (p. 5).
Reflection: Western minds think in linear processes. Eastern thought is a circular process.

My Image - The spiral thinking seem to bring the two together for Marian.

“These days I no longer have such certainties about the issues of growth, progress or evolution. I simply know that we must fully enter into whatever is our experience in the moment and see what that moment brings. However, I know that somewhere in my mind, the notion of the spiral growth is still a guiding paradigm. I am, after all, a westerner, steeped in Western ways of thinking. Though I may have studied Eastern ways, I can never turn myself into what I am not. I have to accept that my mind has been shaped by notions of linearity and progress. At the same time, it is important to accept that linearity is only one way to construct reality. Once we fully accept that both concepts are equally valid, we can view the world in a new and more open way” (p. 5-6).

Reflection: The Western mind has been shaped by linear thinking and progress and cannot think totally in Eastern ways. Both are reconciled for Marian in the spiral image.

My Image - Spiral is a new satisfactory symbol for Marian both are equal symbolising new thinking where both ways are equal.

CONTRARY CONCEPT:

- NEW WAYS OF THINKING.

“By acknowledging the relativity of all ways of thought, we can see a world in which linearity is simply a choice among other choices, a perception of reality that differs from other perceptions, a preference of one particular culture. We can feel free to use our own culture’s modes of thought, its metaphors and concepts, without being constricted by them” (p. 6).
My Image: Do not be constricted by our Culture’s one way of thinking.

CONTRARY CONCEPT:
- ACCEPTANCE OF OTHER WAYS OF THINKING.

“I speak of these things so that you will remember that we are speaking of here is a metaphor for experience, not a description of reality. Moreover, it is a metaphor for my experience, and for the experience of some other women I have interviewed, but it is not necessarily an experience you will have shared. I offer it to you, but I do not wish to impose it on you. Treat it, if you will, as a myth, or a teaching story, which may hold some meaning you can harvest for your own life. Let me speak to you of the inward spiral and the cocoon, and see if there is anything in these images which may be useful to you in your own journey through menopause or in your own understanding of others who are making that journey” (p. 6).

Reflection: Metaphor for Marian’s own experience only, not reality.

My image – Marian does not impose upon others, as universally true, her perspectives and theories. Uses her experience as an example only.

“The discovery of the cocoon was a surprising one. Once I envisioned the spiral with a cocoon at its centre, everything began to change. A cocoon, in a way, a place of rest, almost a place of death, for it is a place where some creatures go in order to die out of their previous form. Thus it is also a place of rebirth, a place from which the new form, in its own time, will emerge. As I read and talked to other women and explored my own process, I gradually began to discover that the experience of this time of life, for a woman, is like a death and rebirth” (p. 6).

Reflection: Cocoon, a place of rest and death to old forms, therefore also place of rebirth. Menopause, a death and rebirth experience.
Menopause: The Need for a Paradigm Shift from Disease to Women’s Health


text:

Chapter Four – Women’s Texts

Margaret T.C. Harris

My Image - Not progressing in linear fashion onwards, upwards progression, but a surrendering to a death of the old and a rebirth experience.

CONTRARY CONCEPT:
• REBIRTH EXPERIENCE

Ursula LeGuin said: “The woman ... must become pregnant with herself at last. She must bear herself, her third self, her old age, with travail and alone. Not may will help her with that birth”’ (as cited in McCain, 1991, p. 6).

Reflection: Pregnancy and new birth.
Conceived and birthed by woman alone.

My Image – A new creation of herself.

CONTRARY CONCEPT:
• PREGNANT WITH HERSELF

“As I share with you their experiences and my own, I invite you now to explore with me the idea of menopause as a spiritual adventure, a journey, maybe even a transformation of the deepest kind” (p.7).

CONTRARY CONCEPTS:
• SPIRITUAL ADVENTURE JOURNEY
• TRANSFORMATION OF DEEPEST KIND

“It seems a pity to have a built-in rite of passage and to dodge it, evade it, and pretend nothing has change” (LeGuin as cited in McCain, 1991 p. ix-x).

My Image - Women’s rite of passage – to change.

CONTRARY CONCEPTS:
• WOMEN’S RITE OF PASSAGE
• CHANGE
“When I was a child, menopause was usually referred to as ‘the change of life’. The more I think of that, the more it seems to me a far better term than ‘menopause’ to describe this important life phase” (p. ix-x).

My image – The change of life describes the phenomenon and is a preferable term for her.

CONTRARY CONCEPT:
- CHANGE OF LIFE

“When I first began to think of menopause as a rite of passage, it seemed like an original thought. At that stage, I had never heard it referred to in that way; nor had I read of such a definition. The idea came from within me, as though from some long-forgotten knowledge, and burst into my waking consciousness like a meteor, trailing ideas and insights as it flashed across my mind (p. ix-x).

My Image: Marian experiencing shooting new insights.

“It was with some trepidation that I first began mentioning this notion to others. Even to speak of menopause seemed slightly embarrassing to me way back then. I wondered if they would think me ridiculous” (p. ix-x).

Reflection: Embarrassing for Marian to talk about menopause in above terms.

My image: Embarrassing because this is not encouraged or supported in our culture.

CONTRARY CONCEPT:
- NEW INSIGHT

“Looking back now, at those early beginnings, I can scarcely believe that was me. However, it was. That younger self, the one who plunged through embarrassment, and began to express ideas, thoughts, feelings, and dreams, was the same person who
set this whole book in motion. The ‘me of today’ is grateful to the ‘me of yesterday,’ who dared take a risk” (p. ix-x).

**Reflection:** By expressing her ideas, thoughts and feelings and dreams Marian was taking a risk.

*My Image* - Ideas, thoughts, feelings and dreams all good material for an insightful text.

“As I talked more to others about my ideas concerning menopause and learned to reveal my own inner experience of the ‘change of life’ without shame or embarrassment, more revealed to me. I discovered other women who were exploring the same paths, thing the same thoughts, and feeling the same feelings. Furthermore, I discovered writings that gave form and voice to the inchoate messages within” (p. ix-x).

**Reflection:** Change of life. Discovered other women had similar thoughts and feelings. Discovered writings were helpful.

*My Image* - Writing gave voice to messages coming through from her internally, from both body and soul.

**CONTRARY CONCEPTS:**

- CHANGE OF LIFE
- INSIGHTS FROM BOTH BODY AND SOUL.

“Without the validation that came from discovering shared experience, I would not have had the courage to begin my own writing. It is therefore to those others, in who responses I heard my first echoes, that I must now give thanks” (p. ix-x).

*My Image:* Women sharing ones’ experiences through writing give validation to each individual’s experience for the women and to each other.
Writing experiences also indicates the healing quality of valuing and sharing one’s personal experience in addition to contributing new knowledge to the fabric of women’s realities. Provides courage for other women.

**CONTRARY CONCEPT:**
- WRITING AS HEALING.

As I conclude following Marian McCain’s journey I include the following paragraphs from her text as I believe this is what Marian is endeavouring to relay to us through her book. Unfortunately, as I am limited as to how much can be repeated from her book, I recommend and suggest that this book be read by all women who are interested in their own menopausal experience.

“As women we are no strangers to change, for we are constantly in flux. We are, above all, cyclic creatures. Esther Harding, the Jungian analyst, writes of the psychic energy in women which waxes and wanes with the moon: ‘These energy changes affect her, not only in her physical and sexual life, but in her psychic life as well. Life in her ebbs and flows, so that she is dependent on her inner rhythm’. Yet we are taught to ‘overcome’ our cyclic natures – as though it were possible!’ (p. 37).

In addition, I believe, through my own embodied experience of menopause that the following is a most appropriate description of what the phenomenon of menopause is about. Marian McCain calls on the power of the crone saying:

“Our power, at menopause, is shifting within us. From henceforth it will manifest differently in the world. Eventually, when the process is complete, each of us will be a crone, and crone power is a formidable force. Since it is an integral part of the whole, it is of course within us at any age, as potential, but it is after menopause that crone power is most strongly embodied, if we can allow it to come through us” (p. 137).

*My Image: It is essential then, that policy, education and health promotion for menopause, menopausal and*
postmenopausal women should be designed and developed by postmenopausal women who have consciously defined the wholistic aspects of the transition, transformational process. This is critical to the adult developmental processes for all women so that women are not deprived of this knowledge. This is essential for all women’s transitional and transformational processes.

And now a last reflection from Marian McCains’s words and a final image from myself. Before sharing one aspect of her personal experience of menopause Marian McCain reminds us that Descartes, the famous French philosopher convinced our culture to value thinking as the superior mode of being. By doing this, he divided mind from body, and thinking from feeling and “in his view it is thinking that defines us as human beings” (p. 48).

**My Image 1:** Both Wilson and Utian, whist employing the underpinning philosophy of Descartes’ dualism, body/mind split, in the case of their diagnosis of menopause, not only did they ignore the body/mind connection, but they focused totally on the body symptoms, thereby rejecting, ignoring and deleting any role that the brain/mind, (the headquarters) played, and therefore any new thinking due to increased hormones, and therefore any positive role the woman had to play in the phenomenon.

**My Image 2:** Wilson & Utian by separating and ignoring the mind connections of the woman in their diagnosis, employed their own male brains to define, diagnose and declare menopause as a disease. In doing so they beheaded the women herself.

However, in Marian’s wise words:

“A new powerfulness is stirring. There is a new sense of confidence in the air, and intimations of the hidden richness of postmenopausal life. I have found
this sense of power and confidence and this deep and unexpected richness in the words and pictures of so many women” (p. 167).

Each of us is changing. Each of us is discovering, in her own way, what lies beyond prime time. Each of us is finding her own means to embody the qualities of the crone and to bring them into the world. It is an ongoing journey of discovery for us all” (p. 168).

CONTRARY CONCEPT:

- ONGOING JOURNEY OF DISCOVERY

My final image: It is the ongoing journey of discovery and change that I find is so very fascinating and exciting. This is knowledge that we have not learned from medical scientific biomedical science, and have therefore been deprived off.

Thank you Marian for directing us to our potential as Crones, and also then the potential abilities we also have for bringing them into the world.
CONTRARY CONCEPTS AND IMAGES FROM MARIAN MCCAIN’S STORY

The contrary concepts emerging from Marian McCain’s narrative follow below in Table 4.2.

Table 4.2: Contrary Concepts emerging from Marian Van Eyk McCain’s narrative

<table>
<thead>
<tr>
<th>NEW PHASE OF LIFE JOURNEY</th>
<th>NEW WAYS OF THINKING</th>
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<tbody>
<tr>
<td>WHOLE STAGE IN A WOMEN’S LIFE</td>
<td>ACCEPTANCE OF OTHER WAYS OF THINKING</td>
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<tr>
<td>HOLISTIC EXPERIENCE</td>
<td>REBIRTH EXPERIENCE</td>
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<tr>
<td>ALTERNATIONS IN THINKING</td>
<td>PREGNANT WITH HERSELF</td>
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<tr>
<td>PATTERNS</td>
<td>SPIRITUAL ADVENTURE</td>
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<tr>
<td>CHANGE OF LIFE</td>
<td>JOURNEY</td>
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<tr>
<td>SELF AWARENESS</td>
<td>TRANSFORMATION OF DEEPEST KIND</td>
</tr>
<tr>
<td>UNDERSTANING &amp; GROWTH</td>
<td>WOMEN’S RITE OF PASSAGE</td>
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<tr>
<td>SOMETHING ESSENTIALLY FEMALE</td>
<td>CHANGE</td>
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<tr>
<td>NEW WAY OF BEING</td>
<td>CHANGE OF LIFE</td>
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<tr>
<td>NATURAL PROCESS WITH DEEP</td>
<td>NEW INSIGHT</td>
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<tr>
<td>LESSONS</td>
<td>CHANGE OF LIFE</td>
</tr>
<tr>
<td>NEW BEGINNING</td>
<td>INSIGHTS FROM BOTH BODY AND SOUL</td>
</tr>
<tr>
<td>TRANSITIONAL PROCESS</td>
<td>WRITING AS HEALING</td>
</tr>
<tr>
<td>NEW EXISTENCE</td>
<td>ON GOING JOURNEY OF DISCOVERY (As Crones)</td>
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<td>A NEW DEFINITION OF OURSELVES</td>
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<tr>
<td>JOURNEY TOWARD THE TRUE SELF</td>
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<tr>
<td>TRANSFORMATIONAL PROCESS</td>
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The following Figure 4.2 graphically represents contrary concepts emerging from Marian McCain’s narrative as applied to Chinn and Kramer’s (1999, p. 55) representation of the Continuum of empiric abstraction.
Figure 4.2: Contrary concepts emerging from Marian McCain’s narrative
WOMEN’S TEXT THREE:  
JOURNEY THROUGH MENOPAUSE: A PERSONAL RITE OF PASSAGE - CHRISTINE DOWNING

Christine Downing (1987)  
_Journey Through Menopause: A Personal Rite of Passage_  

**Author Background**
I now refer to another woman’s story. This woman Christine Downing, Jungian  
Psychotherapist shares with us through her text (1987) _Journey Through Menopause: A Personal Rite of Passage_ , her intimate personal journey through this transitional journey of menopause. Her narrative, I believe, allows us in depth insights from a woman’s own experience in relation to what this life cycle change is about beyond the physical event. Downing draws our attention to the symbolic significance of the phenomenon throughout her personal story. I consider this text a valuable contribution to the knowledge base of menopause.

**Christine Downing’s Narrative**

“On my fiftieth birthday I realized: if I live to be as old as my mother already is, I am now just beginning the second half of my adult life. I knew myself to be at the point of transition from early to late adulthood. I know that because I am a woman this turning would be definitively marked by the physiological phenomenon of menopause. I suspected that the social, psychological, and spiritual dimensions of my experiencing this life-change were all likely to be so affected by the biological event as to make what had been written about mid-life crisis by men (for whom aging is a continuous process) seem mostly beside the point. Yet I knew almost nothing of the distinctively female ways of navigating this passage and felt myself to be confronting a transition for which my culture had somehow conspired to keep me unprepared. I felt alone, uninformed, somewhat afraid – and yet also curious and expectant. I was at the brink of a centrally important life-change and had no knowledge of the myths or rituals that had helped women throughout history live this transition with hope, dignity, and depth” (p. 3).
Reflection: Physiological phenomenon, but social, psychological and spiritual dimensions implicated. Knew nothing of the distinctively female ways of navigating this passage, uninformed, unprepared, afraid as well as curious and expectant.

CONTRARY CONCEPTS:
- TRANSITION
- SOCIAL PSYCHOLOGICAL AND SPIRITUAL DIMENSIONS
- PASSAGE
- CENTRALLY IMPORTANT LIFE CHANGE

“...for a more symbolic connection to these mysteries of feminine life. Our relation to these profoundly life-transforming transitions (and thus to ourselves and to our sisters) seems so obviously diminished when we live them as though they don’t really matter very much, when we experience them as degrading, as isolating and isolated events, as taboo” (p. 13).

Reflections: Hunger for a more symbolic connection.

My Image: Menopause has regarded as taboo, therefore indirectly isolating the experience as a silent event, and in turn restricting women’s shared knowledge.

CONTRARY CONCEPT:
- LIFETRANSFORMING TRANSITION
“I understand why some have called for a demythologizing of menopause – that is, for its dissociation from a long-familiar congeries of coincidentally or subjectively associated phenomena – but what I believe we really require is a remythologizing of it. I would wish us to learn to view menopause developmentally rather than pathologically, as a life phase rather than a degenerative or deficiency disease, and to see it not only as a physiological event but as a psychological one, as a soul experience” (p. 13).

Reflections: Re-mythologizing of menopause developmentally rather than pathologically.

CONTRARY CONCEPTS:
- LIFE PHASE
- A PSYCHOLOGICAL EVENT AS A SOUL EXPERIENCE

Christine Downing then goes on to express what she considers as significant to the midlife female experience as a life process. She refers to “The threefold cycle of the initiation process:

“birth, life, death;
separation, initiation, return;
conception, growth, emergence;” (p. 14)

“as having always seemed to me the most appropriate description of the life process, as it also did to the ancient Greeks. Their mythology included three Horae, three seasons: ‘Thallo, Karpo, and Auxo - growth, flowering, ripeness’. To express her relation to all the phases of female life, they represented the goddess, Hera, in her three aspects: ...as maiden, wife, and post-connubial woman” (p. 14).

CONTRARY CONCEPT:
- THREEFOLD CYCLE OF THE INITIATION PROCESS

“Persephone’s life, too, is divided into thirds and Hekate, the goddess of crossroads and transitions, is known as three-faced Hekate. The underworld (which is for the Greeks the realm of the soul) is ruled by the Eleusinian triad – maiden, mother, and crone. There are, it now seems obvious, three seasons to a woman’s life, irrespective of whether she is
heterosexual, homosexual, or celibate, quite apart from whether she has ever conceived or borne or nursed a child: from birth to menarche, menarche to menopause, menopause to death (and within each a threefold initiatory structure as well)” (p. 14).

Reflection: A threefold initiatory structure.

“It is my conviction that the phases of a woman’s life are different from those of a man’s and that the female mid-life transition is different from the male. Because for women the transition is inevitable associated with the physiological marker, menopause, it is apt to come somewhat later, more likely as it fifty than at forty. Rather than suddenly coming upon us, it seems to be naturally connected to our own internal rhythms. It may involve less in the way of radical reversal than often seems true for men. Certainly the image of having at mid-life to kill and then bury an old self, which Murray Stein finds central to the male transition is too violent, too dramatic, to express my own experience” (p. 14).

Reflections: For women the transition is inevitable. Mid-life transition associated with the physiological marker of menopause as we are connected to our own internal rhythms.

Contrary Concept:

- Female Midlife Transition

“It seems odd that the social experience of external mid-life readjustments and the biological experience of menstrual termination are treated so separately in most published accounts of contemporary women’s own explorations – and odder still how little the inner psychical aspect is considered at all” (p. 15).

Reflection: Separation of the external social adjustment and biological experience, how little the inner psychical aspect is considered at all.

My Image: And most psychological texts written on women’s midlife issues and readjustments do not make the connection...
Menopause: The Need for a Paradigm Shift from Disease to Women’s Health  
Margaret T.C. Harris

with the wholistic aspects of menopause. Body and mind are also split.

Christine Downing goes on to quote Lillian Rubin’s book ‘Women of a Certain Age: The midlife Search for Self’, as an example of this split (p. 15). Christine states that Rubin, in her book on midlife does omit the issue of menopause as she “doesn’t even include ‘menopause’ in its index” (p.15). She goes on to say that:

“The medical research suggests that for most women ... the only physical indicators explicitly associated with menopause (and not with aging per se) are hot flashes and that only a small proportion of women who experience such flashes find them troubling. Nevertheless the most distinguishing characteristic of menopause from a medical perspective seems to be the likelihood that some therapeutic measures are being employed...

In our culture, especially among middle-class Caucasians, a majority of women are given tranquilizers or estrogen and a high proportion some gynecological surgery, often despite the lack of specific symptoms necessitating these measures ... I suspect that viewing the physical signs as symptoms in need of medical treatment is yet another domain in which the meaning of female experience has been defined by males. I cannot help but wonder if it might not be some other form of therapeia (attention of the kind one gives the sacred) that is really required. Understanding menopause as primarily a physical experience may block access to its spiritual significance” (p. 15).

**Reflection:** Spiritual significance, but blocked by male construction of menopause.

**My Image:** Restricting menopause to a physical experience is limiting.

**CONTRARY CONCEPT:**
- **SPIRITUAL SIGNIFICANCE**
Downing goes on then, indicating that one way for a woman of attending to and focusing on one’s experience of menopause is the importance of talking to one another about our experiences. She states:

“I am persuaded that it is time for us to begin telling one another of our inner experience of menopause. I think of the power of Audre Lorde’s testimony in *The Cancer Journals* of the importance of our talking to one another about taboo experiences.

‘For other women of all ages, colors, and sexual identities who recognize that imposed silence about any area of our lives is a tool for separation and powerlessness, and for myself, I have tried to voice some of my feelings and thoughts about the travesty of prothesis, the pain of amputation, the function of cancer in a profit economy, my confrontation with mortality, the strength of women loving, and the power and rewards of self-conscious living’.”

(Lorde as cited by Downing, 1987, p16)

“I too, would like to speak of how it has been for me in a way that would be of service to other women. Thus, I have written this book as an account of my journey through menopause, in the hope that it will initiate a new openness among us about this area of our lives” (p. 18).

**Reflection: Breaking the silence and finding voice.**

**My Image:** Women writing and publishing texts on their experiences are sharing with other women, therefore resisting and breaking the taboo.

Christine Downing then continues to share some of her own experience, giving voice and breaking the taboo. She acknowledges firstly, that her experience is her experience only, and that she cannot know, because of the silencing of women’s experiences, how much will be typical of others experiences, or on the other hand, how illuminating her story maybe to others. She acknowledges that it is by taking one’s own passage, as well as preparing oneself for a passage, that one can understand more profoundly the meaning of the passage. On this point she states:

“My experience is inevitable to some degree idiosyncratic. It is part of the cost of the imposed silence that I cannot know how much of it is typical or how much of it will be
illuminating to others as they prepare themselves for a passage still before them or as they seek to understand more profoundly the meaning of a passage already taken. My journey took place over a three year period and followed the typical pattern of the rite of passage:

preparation,
transition, and
return.

The preparatory phase was initiated by a dream which announced that it was time for me to make ready and which thus sent me to examining what psychology, mythology, and my own dreams could tell me about the transition I was about to undergo. The task of writing ‘Come and Celebrate with Me’ was itself a work of purification and the beginning of my separation from the assumptions and attachments of my premenopausal self. Dreams were for me the primary vehicle of preparation” (p. 16).

Reflection: Beginning of a separation from the previously held assumptions and attachments of my premenopausal self as the preparatory phase of rite of passage.

CONTRARY CONCEPTS:
- RITE OF PASSAGE
- JOURNEY

“A year later I found myself undertaking a journey around the world which turned out to be my literal passage through menopause. Van Gennep had written that traditionally the passage from one social position to another is identified with a territorial passage:

‘This identification explains why the passage from one group to another is so often ritually expressed by passage under a portal, or by an ‘opening of doors’. These phrases and events are seldom meant as ‘symbols’; for the semi-civilized the passage is actually a territorial passage’” (p. 17 citing van Gennep).

My Image: Christine undertook an external journey as well as an internal journey, both signified a change.
CONTRARY CONCEPT:

- A TERRITORIAL PASSAGE FROM ONE SOCIAL POSITION TO ANOTHER.

“I had not foreseen this would be true for me. Yet the journeying did serve to emphasize the ritual aspect of the transition. The trip functioned as a publicly visible event which insured that others would know I was returning as a different person. My preparations seemed in large measure irrelevant, except that they had opened me to live the menopausal transition consciously and symbolically. Where I had hoped to have communion, I found myself undertaking a radically solitary journey; where I had expected to be immersed in feminine reality, I found myself engaged in a struggle with the masculine; where I had anticipated being taught by dream and myth, I found myself learning from strangers, events, and landscapes met in an outer though utterly unfamiliar world. I would not expect that others would embark on a similar voyage but do believe that my journey brought into view in magnified form the motifs and challenges that belong to the ‘normal’ experience of menopause – much as psychopathology in its exaggerations reveals the structure of normal consciousness. The whole trip was like a myth or highly elaborated dream. It took me out of the everyday world and everyday temporality into liminal spatiality, a sacred arena where each person, place, and incident was charged with meaning. That attunement to the soul dimension of this worldly event may in itself have been the most important lesson of the journey. Menopause initiates one into a time of life when symbolic consciousness is appropriately part of everyday experience – at home as well as on the road, in waking life and not only in dream. But there were other lessons also: the discovery that I was at last done with the heroic quest, the acceptance of physical weakness and vulnerability, the recognition of my dependence on other women; the revelation that I am loved enough” (p. 17-18).

Reflections: Returning as a different person, found myself undertaking a radically solitary journey and engaged in a struggle with the masculine. Menopause initiates one into a time of life when symbolic consciousness is appropriately part of everyday experience. Christine was at last done with the heroic quest, the acceptance of physical weakness.
and vulnerability, and the recognition of my dependence on other women; the revelation that I am loved enough.

My Image: Christine’s journey was mainly about her internal changes, out of this there were new realizations for her.

“The journey brought me home, and at home I found myself a postmenopausal woman engaged in the tasks of the reincorporation phase: assimilation, integration, and finding a way to share what I had experienced. I found myself in tutelage to a divinity not even considered in the preparatory phase: Hestia, the Greek goddess of hearth and home. I found myself not in quest of home but: home. For the first time I felt I truly understood the sacredness inherent in the simple fact of being home. Yet having completed my journey through menopause, I know myself to be standing at the beginning of another life-stage. From the day of birth to that of death…” (p.18).

Reflections: A journey towards finding the true self, the sacred within. This in turn is the beginning of another life-stage … of that of death.

My Image: Being at home with sacred self.

CONTRARY CONCEPT:
- BEGINNING OF ANOTHER LIFE-STAGE

This concludes Christine Downing’s ‘Premable’ section. From this section, I suspect that she had some prior knowledge of deeper aspects of menopause, and some idea of what she intended to do to help her through her transition. Christine cites Muriel Rukeyser poem of celebration:
“Now that I am fifty-six
Come and celebrate with me –
What happens to song and sex
Now that I am fifty-six?

They dance, but differently,
Death and distance in the mix;
Now that I am fifty-six
Come and celebrate with me” (p. 21).

Christine Downing then goes on to explore dreams and the symbolic gestation of the menopausal self. In a long passage she explains:

“Shortly before my fiftieth birthday I had a dream in which my former husband and I were walking among steeply sloping sand dunes like those I remember from my childhood. From time to time we could see the ocean, waves breaking high. The wind was blowing enough to make talking difficult; the dune grass cut into our calves; the sand shifted underfoot. We were intent on our walking, giving one another a hand now and then at a particularly tricky spot, thoroughly enjoying being together. At some point along the way, when we had slowed our pace a bit, I said, ‘You know, dear, I think I’m pregnant again, and this time I don’t even know who the father is’. ‘Will we keep it?’ he asked. ‘We always do, don’t we?’ I replied. When I awoke, I asked, as one would, ‘Now where did that come from?’ I realized that without having particularly noticed it, I had gone several weeks beyond the time when I would ordinarily have begun to menstruate. In my dream life I was pregnant; in waking life I was probably experiencing the first signs of menopause” (p. 21-23).

But in waking life, too I felt myself pregnant with something, my menopausal self, perhaps. The dream image needed to be attended to not dismissed as a regressive, evasive fantasy nor severed from what was going on in my body. Sometimes women of nearly fifty do conceive; if I, too, were literally pregnant, then that would become evident soon enough. Meanwhile it felt important to live with the dream image, honoring its reality. I found I loved especially that this dreamchild would have no known father
would be entirely my child. One morning I awoke knowing her name: Melissa, a name I
didn’t particularly like and with which I had no conscious associations, but which was
indubitably the dreamchild’s name. I learned that to the Greeks Melissa was a bee whose
honey induced madness and cured disease, was used in libations for the dead, and fed to
infants to impart to them such numinous qualities as wisdom and eloquence. In Greek
mythology Melissa was the first priestess of the great mother, the first human to sacrifice
to the gods; priestesses of Demeter and Artemis were called by her name. That she was
named after Melissa, the priestess who honors both Demeter, the goddess of motherhood,
and Artemis, the goddess of self-sufficient womanhood, thus implied that my dreamchild
was singularly well fitted to initiate me to the mysteries of menopause” (p. 23).

Reflection: Herself pregnant with something, my
menopausal self, this fatherless dreamchild born of
herself would have no known father, would be entirely
my child.

CONTRARY CONCEPTS

- REBIRTH OF THE MENOPAUSAL
  SELF
- RENAMING OF THE
  MENOPAUSAL SELF

“I missed another period and then began to flow at fairly regular intervals again. But the
dream marked the beginning of my preparation for menopause” (p. 23).

Reflection: The above symbolic dream heralded the
beginning of Christine’s preparation for menopause.

My Image: Christine was open to listening and working
symbolically with her dreams.
It seems this was important as it gave her some direction.

“It seemed appropriate to devote the Mother’s Day weekend of my fiftieth year to trying
to understand as best I could the soul meaning of the transition in which I was soon to be
engaged, as several winters earlier at the time of my divorce I had given a weekend to
Hera. I had wanted then to come to terms as wholly as I could – ritually and mythically,
personally and archetypically – with all that wifehood had meant to me, as blessing and as curse, and all that leaving it behind would mean, as release and as loss. Now it was time for another such sorting through. Again I surrounded myself with books of poetry and myth, with dream journals and letters. I mused and scribbled, read and remembered, smiled and wept, saw and was mystified” (p. 23-24).

**Reflection:** *The soul meaning of the transition.*

**My Image:** Christine is trying to consciously work through who and what she would be letting go of. She is also attempting to honor what has been her past journey as she sorts through it before moving on. However she still seems unsure of the significance of the journey as yet, as she says she is mystified.

“The setting was different. I began outside in the sun, surrounded by irises and roses; hummingbirds and butterflies were flitting nearby; a gentle breeze carried a bit of the ocean to me; the sky was a cloudless blue. It was a spring scene, as the scene of that other denouement had been a winter one. It felt like that, too, as though this transition would have more to do with beginnings than ending. But before I was done, I had moved inside, night had fallen. I had discovered again that to speak honestly meant truly honoring the darkness: fears, regrets, uncertainties. It meant attending to the dreams of dismemberment and death, not only to the dreams of pregnancy and rejuvenation with which I had innocently begun. Spring seems always to return me to the unsullied maidenly aspect of Persephone but menopause connects to darker dimensions of the Eleusian cult, to the dread goddess of the underworld and to her fearsome sister-self, Hekate, goddess of thresholds. Song and sex now dance with ‘death and distance in the mix’” (p. 24).

**Reflection:** *This transition would have more to do with beginnings than ending but also the dream aspects of death and dismemberment as well as dreams of pregnancy and rejuvenation. Song and sex now dance with ‘death and distance in the mix’.*
My Image: Christine was experiencing aspects of both birth and death. For her to speak honestly, it was important that she wrote about the darkness and the fears, regrets, uncertainties that were also part of the experience, and the attendance to the dreams of death and dismemberment. The realization of the greater closeness to death as one realizes the prime of life is now behind one, the first half of life has gone, and now the movement is to the later half. There is also the dying to the old self, but unsure as to what one needs to yet go through yet as part of the transition to the new or to the new self.

Christine Downing then elaborates a little more on the significance of Mother’s Day for her. She continues to tell us that this Mother’s Day had significance for her oncomg menopause and explains it thus:

“...the first to be celebrated in this house between mountains and sea in which I hope to live for the rest of my years, a celebration which culminated in the conception of a child I knew from the beginning could only live imaginally. Even then, though menopause itself still lay several years ahead, I consciously experienced that conception as an initiation into a period of life when literal mothering had become beside the point” (p. 25).

Reflection: The conception of a child I knew from the beginning could only live imaginally. Consciously this conception was an initiation into the period of life when literal mothering was beside the point.

My Image: Initially, consciously Christine thought this would be an imaginary child as an initiation, and as literal mothering no longer held the same importance, a literal child was not even considered.

“This Mother’s Day eve, while still immerse in my reflections about the meaning of menopause, my menstrual flow began – undeniable reminder that I was still in the preparatory phase of this transition. That bodily reminder called me back to my body and
to an hour or more spent with and as the changing body that is me - seeing, touching, caressing. I realized then how important it is to me to speak of the body and from the body” (p. 25).

Reflection: Christine is called back to her body by her body away from her imagining, to focus on the body that she is.

My Image: This was her reminder to stay connected with her body and to pay attention to the body, to hear and to speak from the body. This indicates a very strong body/mind connective process that is occurring, a wholistic process. This interconnection is so important.

“The weekend set aside as the beginning of my preparation for menopause led me to this passionate affirmation:

“I know menopause is not just a trivial little change whose rough spots can be eased with a little hormone treatment, on the other side of which I will still have a good figure and a good mind, still be sexy and sexual, as the books on the drugstore rack aim to assure me. I don’t want to get around it. I want to live it. I don’t want to ‘treat’ it or ‘cure’ it, though I do want to honor it with curiosity, and with ‘therapy (therapaeia), attention of the kind one devotes to sacred mysteries. I want to allow menopause to be a soul event, which means really letting go of some still cherished old ways, accepting that some things are really over – though I may wish they weren’t and may know I did not live them as fully, honestly, or courageously as I wish I had” (p. 25-26).

Reflection: I don’t want to ‘treat’ it or ‘cure’ it, though I do want to honor it with curiosity and with ‘therapy (therapaeia), attention of the kind one devotes to sacred mysteries. I want to allow menopause to be a soul event’.
Christine then rejects the reductionist separation as she speaks of connection saying:

“To learn ever more deeply that body-event is soul-event that the two belong together, lies for me at the very heart of what this transition signifies. Most of what I have read about menopause disappoints precisely because it does not recognize that, speaks only of body or only of soul. I want to speak of the soul of the body, it within-ness, to go into the bodily events, the changes, the ‘symptoms,’ and discover their inherent symbolic meaning. I am persuaded that the soul meaning is not added on, not found through some movement of transcendence but within the physical experience itself” (p. 26).

**Reflection:** That body-event is a soul-event that the two belong together, lies for me at the very heart of what this transition signifies. I want to speak of the soul of the body.

**My Image:** Christine believes that the soul meaning is connected to, is embedded within, and emerges from the physical experience of menopause. This indicates a wholistic experience. Therefore the symbolic will be revealed through listening to the significance of the symptoms as well as listening to the dreams.

**CONTRARY CONCEPT:**
- **BODY-EVENT IS SOUL-EVENT**

“The Greek recognition of the distinction between spirit, pneuma, and soul, psyche, is relevant here. Spirit seeks to free itself from the body; its direction is upward, transcending. Distance, clarity, abstraction, purification are spiritual values. Whereas soul is that which gives life, human life, to the body; it is the embodied self. The soul is the double, the eidolon, the image of the body that persists after death” (p. 32).

**Reflection:** The spirit (pneuma) and soul (psyche) are different.
My Image: Spirit and soul are connected with the body. Whilst the spirit is reaching up imagining (taking distance), the soul stays closer to the body.

CONTRARY CONCEPT:
- BODY, SOUL, SPIRIT CONNECTION

“To understand menopause as a soul-event means attending to it imaginally, regarding its symptoms as symbols, and not being surprised at its close association with underworld experience” (p. 32).

Reflection: To understand menopause as a soul-event means attending to it imaginally.

My Image: How the body is experiencing the menopause is important as it may be speaking symbolically.

CONTRARY CONCEPT:
- SYMBOLIC SIGNIFICANCE

“...I also believe that the physical symptoms which often accompany the transition to irregular menstrual flow and its eventual complete cessation (the hot flashes, headaches, dizziness, neuralgia) may have quite specific imaginal significance. As de Beauvoir says: ‘The dangerous age’ is marked by certain organic disturbances, but what lends them importance is their symbolic significance” (p. 11).

Reflection: Christine draws on de Beauvoir’s point that [t]he dangerous age is marked by certain organic disturbances, but what lends them importance is their symbolic significance.

My Image: Therefore to understand menopause as a soul event means to value and attend to the body and the organic disturbances for their symbolic significance.
Although Christine Downing continues to focus on and concentrate more specifically on the connection between the physiological and psychological aspects of the menopausal phenomenon, she acknowledges that particular cultural stresses and values are also implicated. However, the particular emphasis in her book, is attempting to uncover the symbolic significance of the particular symptom we may be experiencing.

To help uncover this symbolic significance, Christine Downing refers to Stein stating that we may need to learn to view the somatic symptoms very much as we would view them if they had appeared in a dream. She then goes on to share her own experience drawing on a poem by Dalessio. She relates her experiences saying:

“In my own case this demanded reconsideration of headaches by which just prior to my fiftieth birthday I was devastated night after night in a way that seemed to push me to the very limits of my endurance. A very matter-of-fact physician had given me a pamphlet about headaches which begins with a quotation from an ancient Mesopotamian manuscript:

‘Headache roameth over the desert,
blowing like the wind,
Flash ing like lightning, it is
Loosed above and below ...
It wasteth the flesh of him
Who hath no protecting goddess’

As I tried to learn where the inexorable pain was coming from, a voice seemed to say, ‘Headaches come from the mother’. I remembered my mother’s headaches when I was a child, remembered how the joyous, brave young woman usually present would periodically be abducted while a pain-ridden, frightened, exhausted wraith took her place. In retrospect I wonder if my father’s so evident valuing of rationality, dispassion, clear headedness often left much menses, with being female, with the one time each month when it was acceptable to be emotional, vulnerable hurting ... And perhaps my headaches had something to do with the need for me, so proud of never having been troubled with
menstrual discomfort, now to be forced to accept more fully that my femininity, too, encompasses vulnerability, fears, anger” (p. 33).

**Reflection:** Femininity encompasses vulnerability fears, anger.

**My Image:** Any woman may experience these feelings too which is quite OK.

“Yet although I see value in attending to the particular somatic difficulties that may accompany our individual experiences of menopause I am still persuaded that the more important ‘symptoms’ are those provided by our dreams and fantasies, nightmares and hallucinations. If we do not understand them as integral to the full experiencing of menopause or do not discern the symbol in the symptom, then the dreams are, indeed, likely to appear to us as nightmares” (p. 34).

**My Image:** Dreams, fantasies, nightmares and hallucinations may produce symbolic significance.

“Because there is little in our culture to support such a symbolic understanding of menopausal dream and symptom, I found myself looking once again to Greek mythology, hoping it might provide some guidance. My search for menopausal rituals yielded little; fortunately, however, there are myths which can help us to an appreciation of the symbolic significance of the passage” (p. 34).

**Reflection:** Symbolic significance of the passage.

**CONTRARY CONCEPT:**
- THE PASSAGE.

Christine Downing then explains the significance of the goddesses, particularly Hestia (or Hekate) who is herself a postmenopausal goddess, the one who represents the Crone. I chose to end with Christine Downing’s following words as I believe these words and the image of the
book with blank pages can be a guiding tool for many women as they too transverse this significant passage that menopause provides for us. She tells us:

“My journey through menopause has brought me to Hestia. She comes bearing none of the usual attributes of the goddess but carrying a book with blank pages, the unwritten volume of the new. I am only beginning to sense what will be written there” (p. 155).

MY FINAL IMAGE

To me, it seems, and also to Christite, as further in her book indicates, that menopause is a work of depth, and may also indicate an attempt within us to connect with a goddess or goddesses. The notion of the goddess is much neglected in our times. In our culture individuals have been conditioned to praise, honor and give thanks and to acknowledge a male god. In our everyday lives, culturally the goddess has been repressed. The repression of the goddess energy has to be held somewhere, as it does not exist on or above the surface, equally acknowledged with a male god in this world. It therefore exists in the ‘underworld’, the other world and has a right to, and needs to, be reclaimed not only for women themselves but also for our society/culture/planet. The male and female energies need to be balanced.

At the time of menopause this female energy starts to surface from our unconscious. It can feel strange to us or we may feel strange, as in our culture we have not have been prepared and sufficiently educated in the wholistic knowledge regarding the body, mind, soul, and spirit aspects of the menopausal phenomenon. In particular the role the increase of hormones in the brain play and therefore the body/mind/soul/spirit connection is often neglected.

Unfortunately and sadly because of word limits on text, I cannot continue with Christine’s story, this, her own beautifully written and insightful journey. However, my recommendation is that many women would be more knowledgeable after reading this very significant menopausal text.

Thank you Christine Downing
CONTRARY CONCEPTS AND IMAGES FROM CHRISTINE DOWNING’S STORY

Table 4.3 Contrary Concepts emerging from Christine Downing’s narrative

| TRANSITION                                                                 |
| SOCIAL PSYCHOLOGICAL AND SPIRITUAL DIMENSIONS                              |
| PASSAGE                                                                    |
| CENTRALLY IMPORTANT LIFE CHANGE                                           |
| CONFRONTING A TRANSITION WITH HOPE, DIGNITY, AND DEPTH                     |
| LIFE TRANSFORMING TRANSITION                                               |
| LIFE PHASE                                                                 |
| A PSYCHOLOGICAL EVENT AS A SOUL EXPERIENCE                                 |
| THREEFOLD CYCLE OF THE INITIATION PROCESS                                  |
| FEMALE MID-LIFE TRANSITION                                                 |
| SPIRITUAL SIGNIFICANCE                                                     |
| RITE OF PASSAGE                                                            |
| JOURNEY                                                                   |
| TERRITORIAL PASSAGE FROM ONE SOCIAL POSITION TO ANOTHER                    |
| BEGINNING OF ANOTHER LIFE-STAGE                                             |
| REBIRTH OF THE MENOPAUSAL SELF                                             |
| RENAMING OF THE MENOPAUSAL SELF                                             |
| BODY-EVENT IS SOUL-EVENT                                                   |
| BODY, SOUL, SPIRIT CONNECTION                                               |
| SYMBOLIC SIGNIFICANCE                                                      |
| THE PASSAGE                                                                |

The following Figure 4.3 graphically represents the contrary concepts emerging from Christine Downing’s narrative and applied to Chinn and Kramer’s (1999, p. 55) representation of the Continuum of Empiric Abstraction.
Figure 4.3: Contrary concepts emerging from Christine Downing’s narrative
WOMEN’S TEXT FOUR - MENOPAUSE MATTERS:
A PRACTICAL APPROACH TO MIDLIFE CHANGE – JUDY HALL


*Menopause Matters: A Practical Approach to Midlife Change*

Element Books, Shaftsbury

Author Background

Judy Hall (1994), counsellor, has been running workshops in healing and complementary medicine for many years. Drawing both from personal experience and from her training as a counsellor, she runs a successful private practice and regular workshops with her partner, Dr. Robert Jacobs, where they help many women through their midlife transition.

Robert Jacobs MRCs, LRCP is a medical doctor. He trained in conventional medicine at the Middlesex Hospital Medical School, a college of London University and graduated in 1976. Dr. Jacobs has also studied Chinese Herbal Medicine in England and at the Nanjing College of Traditional Chinese Medicine in China. With his wife Judy Hall he has co-authored number of books on the natural management of the menopause.

Introduction

This book on menopause is an interesting text for many reasons as it offers very different perspectives on the phenomenon. Not only does it offer the positive aspects, it also brings our attention to the sacredness of this woman’s process, including respect for, and honour for the blood mysteries of women’s bodies. It does this through acknowledging that women have, and hold within themselves and their blood, the mysteries to birth new human beings and therefore the power to nurture new life.

In addition it gives insights into the philosophy that underlies the menopause in Chinese Medicine, this Eastern philosophy presents a process where a new balance of energies is required and therefore represents a more wholistic model than the reductionist pathological biomedical model. From this Chinese perspective, alternative interventions beyond HRT/HT can be seen as appropriate and even necessary for some women.
Of particular interest also, is the fact that Judy’s husband works with her, and in practice he supports her with the wholistic aspects and model of menopause. This male doctor has a very good understanding and plays a supportive role. This is an excellent example of male doctor working to support the woman practitioner as it is the woman who has experienced the embodied internal experience. They both have a very good understanding of the process. However, it is Judy’s story that I commence with now.

**Judy Hall’s Narrative**

Judy Hall, in the introduction to her book talks about the need for a book such as hers:

“When I first wrote this book, early in 1991, the menopause was in the air but not yet ‘come out’. Hormone Replacement Therapy (HRT) was being hailed as the panacea for menopause, but little was offered for those women whom it did not suit or who did not wish to artificially prolong their periods. More importantly, almost everything I read focused solely on the physical aspects of ‘The Change’ and ignored the fact that it was part of the natural unfolding cycle of life. I felt there was an urgent need for women of all ages to understand the physical, emotional, mental and spiritual processes involved in this important transition. My co-author and I were, through our different approaches, seeing many women for whom ‘The Change’ was an, often unacknowledged, emotional experience just as much as a physical event. Little support was being given to them by their family or their physician” (p. 1).

**Reflection:** Almost every everything Judy read focused solely on the physical aspects of ‘The Change’. Judy felt the urgent need for women of all ages to understand the physical, emotional, mental and spiritual processes involved. The Change was an, often unacknowledged, emotional experience just as much as a physical event and little support was being given to them by their family or their physician.
Menopause: The Need for a Paradigm Shift from Disease to Women’s Health  
Margaret T.C. Harris

Chapter Four – Women’s Texts

My Image: Support from family and doctors for the medically marginalized wholistic changes we experience were very minimal or absent.

CONTRARY CONCEPTS:

• THE CHANGE

• PART OF NATURAL UNFOLDING CYCLE OF LIFE.

• WHOLISTIC PROCESSES INVOLVED IN THIS IMPORTANT TRANSITION.

“Two days after we handed the manuscript over to the publisher, Germaine Greer brought out her book, The Change: Women, Aging and the Menopause. She and ‘The Change’ were on radio, television and, it seemed, every major newspaper cover. Articles in women’s magazines proliferated. Suddenly the menopause was a major topic of conversation” (p. 2).

CONTRARY CONCEPT:

• THE CHANGE

“However, whilst Germaine Greer’s book explored the issues of the menopause with great thoroughness and raised many interesting questions, it seemed to me that there was still a need for a practical book to guide women through this major period of change. Something that would draw together the different threads into a coherent whole. This was confirmed by the many letters were received after publication of The Wise Woman and especially by the participants in the local radio phone-ins I undertook all around England. The women who phoned in felt isolated. They had friends with whom they could swap ‘symptoms’ but nowhere to turn for constructive advice and a positive outlook on the future. I also realized just how many women struggled on without seeking aide, often because they did not know that help was at hand. Germaine Greer to some extent redressed this, but nowhere did she say, ‘This worked for me’. Indeed, one woman wrote and said: ‘Thank you for your wonderful book, which tells me how to do all things Germaine Greer said I ought to do’” (p. 2).
Reflection: Nowhere to turn for constructive advice and a positive outlook on the future. Something was needed that would draw together the different threads into a coherent whole.

My Image: Judy realized the need for a practical book to guide the woman through this major period of wholistic change and to draw together different threads into a coherent whole.

CONTRARY CONCEPTS:
- MAJOR PERIOD OF CHANGE
- A COHERENT WHOLE

“It became clear that women did desperately want to know what alternatives there were to conventional treatment. Additional issues arose in the phone-ins, letters and the workshops; more research results were available and other complementary therapies were proving successful” (p. 2-3).

Reflection: More research results were becoming available and other complementary therapies were proving successful. Women wanted to know alternatives to conventional treatment.

My Image: Women requesting more information on alternative and complementary therapies.

CONTRARY CONCEPT:
- COMPLEMENTARY THERAPIES SUCCESSFUL
-
The book offers practical ways of increasing well-being, including alleviating physical symptoms and releasing from past patterns. As it looks at both “conventional” and “complementary” treatments (p. 5).

**Reflection:** This book looks includes both ‘conventional’ and ‘complementary’ treatments. It offers practical ways of increasing wellbeing.

**My Image:** This book is more wholistic as it is inclusive.

“Complementary remedies or HRT will alleviate a flush, whilst learning to recognize a trigger, be it dietary or psychological and emotional, may well prevent one from occurring at all. We are not intending to ‘sell’ any one particular type of therapy, but rather to present information in a dispassionate way in order to allow you to make an informed choice. It must be remembered that there is less hard scientific evidence in favour of the complementary therapies. This is only because they lack the backing of the powerful commercial vested interests which drive conventional research. On the other hand, some of the complementary therapies have been in use for hundreds and even thousands of years and they are backed by generations of practical experience as to their efficacy and safety” (pp. 5-6).

**Reflection:** Complementary therapies have been in use for hundreds and even thousands of years and they are backed by generations of practical experience as to their efficacy and safety. Complementary therapies offer more choices beyond HRT.

**My Image:** Learning to define a trigger to prevent a hot flush is important and would be of use to women. Also complementary therapies should be recommended as the intention is not to sell one.
Judy Hall talks honestly about her own experience of menopause and tells us her own menopausal experience was difficult initially, but short-lived due to her involvement and knowledge of complementary medicine and psychological counselling. And this book is a result of her own experience, as she had the urge to share her experience with others.

**Reflection:** Knowledge of complementary medicine and counselling helpful.

“The book arose out my own shock and horror at finding myself confronting a variety of bizarre symptoms, tenuously linked together by the theme of ‘It’s you age’ and tentatively diagnosed as premenopausal hormonal changes. Having had an adverse reaction to just one week on hormone treatment (undertaken out of urgent need and desperation) and having been involved with complementary medicine and psychological counselling for many years, I decided to seek a different solution. Complementary treatment revolutionized my energy and alleviated my symptoms. But from discussions with women who were undergoing the same experience, I realized that the changes now facing me arose not only the physical level but were also mental, emotional and spiritual and therefore required a truly holistic approach” (p. 3)

**Reflection:** Adverse reaction to hormone replacement treatment. Complementary treatment revolutionised her energy and alleviated symptoms. Changes were also mental, emotional and spiritual therefore requiring a truly holistic approach.

**My Image:** Complementary treatment was very appropriate.
CONTRARY CONCEPT:

• HOLISTIC APPROACH

“‘My own initial experience of menopause had been difficult, though fortunately shortlived as I soon found a way through the menopause maze. I wanted to share all that I had learned’” (p. 1).

My Image: Judy through her own experience had the urge to share what she had learned as a result of her own experience.

“Each woman’s experience of the menopause is uniquely individual but there are common factors and knowing about these can mitigate the feeling of isolation which often accompanies the menopause. Many women never experience physical symptoms or discomfort, others can be totally devastated by them, but almost all women are affected to a greater or lesser degree emotionally and mentally and may face a crisis of identity or purpose which shakes them to their foundations. Whilst you will most certainly not encounter all the problems covered here, you may well find several that are relevant to your own particular circumstances and experience. The problems are covered in detail so that every woman can identify her own particular response to the hormonal changes and life challenges offered by the menopause. The book, however, also bring the message that these difficulties can be overcome and that there is life after menopause after all” (p. 3).

Reflection: The difficulties can be overcome.

“From my experience in running workshops and within my counselling practice, it is my belief that menopausal women may need a space to mourn lost fertility and heal psychic pain. We need an opportunity to discover, and reframe, the inherited beliefs that shape our attitudes. These include a sense of loss and cessation of function as a woman which has been passed down through the generations – and which can unexpectedly strike at the heart of even the most ardent feminist, the dedicated career woman or the contented housewife. As well as the conscious part of the mind, we have a subconscious which holds on to old, often outdated beliefs which we need to bring back into awareness, dust off and see how appropriate they are to our present life.
These beliefs are usually very different from what we think we believe and yet they may well be our strongest motivation and the source of our deepest fears. They are a basis for the conflicts and contradictions experienced during the menopause and may lie at the heart of some of the physical and emotional symptoms” (p. 4).

Reflection: Women need opportunities to reframe inherited beliefs that shape our attitudes including the sense of loss and cessation of function that has passed down through the generations.

My Image: Our inherited negative and pathological beliefs can cause conflict within us. They can increase symptoms. Women need to reframe the negative pathological perspective that we as women have inherited and the need for medicalization. One inherits the idea that one is really ill. This can cause conflict and the confusion that many women inherit.

“For many women, such as myself, these unsuspected beliefs remain hidden in the inaccessible parts of ourselves until they are triggered by the hormonal signals of the approaching menopause” (p. 5).

My Image: Changing hormones can stir up the negative and pathological beliefs that women have inherited.

“We therefore need to explore ourselves in the widest sense of the word, reaching the heights as well as the depths of our being. The menopause offers the possibility of fulfilling unused potential and thereby living a truly satisfying life, and the excitement of knowing ourselves as a person in our own right rather than as a mere appendage to our home, family or environment. Accessing a sense of purpose and creativity can empower regeneration and rebirth into new life for all women, but is particularly relevant during the rite of passage known as the menopause” (p. 5).
Reflection: Need to explore the heights and depths of our own beings – possibility of fulfilling unused potential. Accessing a sense of purpose and creativity.

CONTRARY CONCEPTS:
- UNUSED POTENTIAL.
- RITE OF PASSAGE.
- NEW OF SELF KNOWLEDGE
- REGENERATION AND REBIRTH

“When Jungian analyst Ann Mankowitz researched the menopause in the early 1980s, she found a curious ambivalence and a conflict between ‘the fear of knowing and the need to know’, together with a puzzling lack of positive literature on the subject. Menopause was, and still is, a topic most women avoided at all costs until they found themselves unable to ignore it any longer. Ambivalence has continued into the 1990s despite, or maybe because of, the proliferation of ‘self-help’ books, few of which discuss menopause as a natural and positive part of female life. With HRT treatment, this blinkered approach can continue indefinitely. Doctors have come to look on the menopause as a ‘deficiency disease’” (p. 8).

Reflection: Menopause, topic most women avoid because of the fear of knowing and the need to know as doctors have diagnose menopause as a deficiency disease. HRT results in a blinkered approach which can continue resulting in ambivalence.

My Image: Disease diagnosis with HRT as recommended intervention causing ambivalence and confusion for the woman.
“However, if the menopause can be seen as a natural staging post on the journey of life, then it can become a time of positive change and infinite possibilities. As author Barbara Walker points out, in ancient societies post-menopausal women were thought to be the most effective callers down of curses, as ‘Their ‘wise blood’ was retained in their bodies, giving them a numinous power to make their words come true’. This book seeks to use the potency of ‘wise blood’ to transform what may have been experienced as a curse into a blessing!” (p. 8).

Reflection: Menopause- if seen positively can be time of infinite possibilities. This book seeks to transform what has been negatively described into a blessing.

My Image: The potencies of the sacred blood mysteries when held have numinous power. This is a blessing. This book respects and honours the positive sacred blood mysteries of women’s bodies.

CONTRARY CONCEPTS:
- NATURAL STAGING POST ON THE JOURNEY OF LIFE.
- POSITIVE CHANGE AND INFINITE POSSIBILITIES
- NUMINOUS POWER.
- A BLESSING

According to Judy Hall, the poet, Ranier Maria Rilke:

“... suggests, women do have unique qualities to offer. The word ‘blessing’ comes from the Old English word bloedsen or ‘bleeding’ and indicates the intimate connection which has always existed between blood and religion. Blood was the link to the dark side of existence from which stemmed dreams and visions, and to the realm of magic and the numinous. Blood was the vehicle for the spirit and woman’s shedding of blood was inextricably linked to her mysterious capacity to create life. In The Great Cosmic Mother, women are portrayed as the heart and core of ancient matriarchal society; menstruating and meditating together at the dark of the moon,
intimately bonded by their shared blood rite and thus ensuring the fertility and continuance of the sacred earth” (p. 18).

Reflection: Both bleeding and blessing come from the old English ‘bloedsen’ indicating the connection to the numinous and also the ability to create life and nurture life, through their sacred blood.

My Image: Women have within them the energy of the retained sacred blood and its power and its numinous and mystery connections.

CONTRARY CONCEPT:
- CONNECTION TO THE NUMINOUS
- MYSTERY CONNECTIONS

“This situation was overthrown when the patriarchal religions moved in and menstrual taboos took over. At that time men, just as much as women, lost their participation in the mysteries and their connection with the earth. In this patriarchal society, the goddess and her consort were lost, women occupied an inferior role which was far from sacred and their menstrual blood (that remnant of the goddess) became the subject for taboo. Taboo once meant ‘set aside’ (or holy) and therefore sacred; now it became synonymous with ‘unclean’ and therefore untouchable and inferior” (p. 18).

My Image: Patriarchal religions took over and women’s sacred and mysterious connections with the earth were lost. Women’s blood mysteries were considered unclean and inferior.

CONTRARY CONCEPTS:
- SACRED AND MYSTERIOUS CONNECTIONS
“It’s in the blood’ has a very particular and special meaning when it comes to feminine gnosis and it is possible to move back beyond the historical experience into a more primal knowing that honours and values the wisdom of the post-menopausal woman. A knowing that could, perhaps, save ‘humanity’ from extinction” (p. 19).

Reflection: Primal knowing honours and values the wisdom of the postmenopausal woman. This wisdom is needed now.

My Image: Primal knowledge honours and values the wisdom of the postmenopausal woman, Western scientific knowledge does not. The primal knowledge and feminine gnosis of the postmenopausal women’s knowledge is critical in, and to our time.

CONTRARY CONCEPTS:
- PRIMAL KNOWING
- FEMININE GNOSIS

“There is an optimistic face of change, however, one which is positive and constructive: forward-looking, anticipating, unfoldment and expansion. It can be viewed as of the great rites of passage on par with birth, death, puberty and marriage, then the menopause becomes a time of transition into a new phase of existence, a manifestation of the inherent feminine wisdom in every woman. It becomes a ‘time of secret joy, spiritual growth, and super-exaltation (Eliza Farnham)” (p. 10).

My Image: Positive, powerful, dynamic adult developmental process.

CONTRARY CONCEPTS:
- OPTIMISTIC CHANGE
- POSITIVE & CONSTRUCTIVE
- FORWARD LOOKING
- UNFOLDMENT & EXPANSION
- RITE OF PASSAGE
Menopause: The Need for a Paradigm Shift from Disease to Women’s Health

Margaret T.C. Harris

Chapter Four – Women’s Texts

- TRANSITION INTO NEW PHASE
- INHERENT FEMININE WISDOM
- SECRET JOY
- SPIRITUAL GROWTH
- SUPER-EXALTATION

“Complementary therapies have a great deal to offer at the menopause. What these therapies have in common is that they all make use of naturally occurring rather than synthetic substances and they all utilize the human organism’s own capacity to heal itself. I use the term ‘organism’ to mean not just the physical body also the subtle bioenergetic regulatory mechanisms associated with it and the far subler energies of mind and spirit” (p. 41).

**Reflection:** Complementary therapies are appropriate as they utilise the human organism’s own healing capacities.

**My Image:** Subtle energies of mind and spirit are also involved with the bioenergetic regulatory mechanisms of menopause. Subtle energies of mind and spirit are involved with healing.

**CONTRARY CONCEPTS:**
- COMPLEMENTARY THERAPIES TRIGGER THE HUMAN ORGANISM’S OWN HEALING CAPACITIES.

“One other property these therapies have in common is age. Homeopathy, for instance, is some hundreds of years old, while herbalism and Chinese medicine have a history going back thousands of years. These therapies also treat the human organism as one whole, as opposed to modern western medicine which concentrates on treating the specific effects of disease” (p. 41).

**Reflection:** Complementary therapies have a long history, hundreds and thousands of years where
the organism is treated as a whole, whereas western medicine concentrates on treating the effects of disease.

*My Image:* Complementary therapies are more holistic and therefore more appropriate for menopausal and postmenopausal women as the phenomenon of menopause is a wholistic experience. Complementary therapies focus on the whole person and not the disease.

**CONTRARY CONCEPTS:**
- HOLISTIC TREATMENT.
- COMPLEMENTARY THERAPIES.

“As stated in the Introduction, it must be remembered that there is less available hard scientific evidence in favour of these therapies. This is only because the complementary therapies lack the backing of the powerful commercial vested interests, in the form of pharmaceutical companies and the chemical industry, which provide the funds to pay for conventional research. There is no incentive for them to research or promote the therapeutic properties of a naturally occurring herb, as a herb cannot be patented. Therefore conventional research, driven by the profit motive, is led mainly to study the therapeutic properties of synthetic chemicals. When it does research natural substances, it is in order to synthesize them; that is, to manufacture them artificially” (pp. 41-42).

*Reflection:* Complementary therapies lack research funding as they cannot be patented. Profit drives the manufacture of synthetic chemicals.

*My Image:* Complementary therapies and herbs are therefore not given equal status to manufactured artificial chemicals.
“By the same token, powerful voices within the medical profession and the pharmaceutical industry are led to decry the ‘complementary’ therapies as hopelessly lacking in scientific basis, conveniently ignoring what scientific work has been done, largely by interested individuals, and the fact that generations of experience attest to their efficacy and safety” (p. 42).

*My Image:* Complementary therapies marginalised as inferior, and excluded as equal to pharmaceutical chemical drugs.

“It is worth recalling here that since the time of Einstein, science has known that matter is energy. Science is also aware that fundamental particles, such as electrons, can behave both as particles (matter) and vibration (energy). Therefore, a scientist who is in tune with twentieth century physics should find the idea of a very dilute remedy carrying an energy pattern but no actual matter reasonably easy to deal with. After all, a science which can ascribe ‘strangeness numbers’ to fundamental particles, numbers which describe the extent to which the particles are ‘not there’, should not find the idea of active infinitesimal dilutions hard to accept. The only people who might have trouble with these concepts are those clinging to the notions of nineteenth century science and its insistence on an absolute distinction between matter and energy. Unfortunately this is the view of the majority of the medical profession today” (pp. 52-53).

*Reflection:* Particles (matter) is also energy vibration. The majority of the medical profession have difficulty with this notion.

*My Image:* A scientific biomedical reductionist diagnosis of menopause denies the connections and interconnections that exist between matter and energy and therefore this aspect is deleted and ignored.

This book also addresses homeopathy and menopause, remedies for hot flushes and night sweats, and other remedies including flower essences, and also recommendations for fear of
psychic power. Here a connection is made between the ovaries, the pituitary gland and FSH and LH. This is the same connection that Wilson and Utian omitted in their pathological diagnoses. And now a return to Judy’s words as she explains:

“Five Corners is indicated for fear of psychic phenomena or psychic powers. Many women find that their psychic powers are awakened or enhanced at the menopause and they may experience episodes of clairvoyance, telepathy and precognitive dreaming. There may be a physiological reason for this. We saw in the last chapter, when the ovaries cease producing oestrogen, the pituitary gland becomes very active in response and produces large amounts of hormones FSH and LH. In the philosophical and physiological systems of the east, the pituitary gland, which lies at the front of the brain between the eyes, is regarded as the physiological counterpart of a major centre of spiritual energy, known as the Ajna Chakra in Sanskrit and sometimes called the Third Eye. It is regarded in the eastern teachings as linked to both spiritual and psychic perception. It is possible to speculate that the physiology of women is so designed that, at a certain age, the ovaries are programmed to switch off with the result that the pituitary gland, and hence the Ajna Chakra, go into overdrive, leading to an enhanced spiritual and psychic awareness. States of spiritual and psychic awareness may still, unfortunately, be regarded with some suspicion in our culture and this can lead to fear … It is for women who experience such fear of what are, after all, natural changes that the remedy Five Corners is indicated” (p. 60).

Reflection: The interconnections that that occur within the woman, between the ovaries, pituitary gland, and increased hormones, FSH and LH have connections also with the Chakra and spiritual energy. This is regarded as suspicious in our culture which can lead to fear.

My Image: Postmenopausal women have potential for both spiritual and psychic perceptions. Because of the changes in the brain, the Ajna Chakra or third Eye can be triggered, which is not accepted in our culture, thereby instilling fear about something that
is not acceptable. Also women are kept ignorant and not educated regarding the impacts of these interconnections when they are diagnosed pathologically within the philosophy of Western reductionist scientific methods, and therefore told they are in need of chemicals. However this awareness can still occur.

CONTRARY CONCEPTS:

- SPIRITUAL ENERGY
- SPIRITUAL AND PSYCHIC AWARENESS

Chinese Medicine and Menopause

Judy Hall extends the knowledge base concerning the contribution of Chinese medicine to the understanding and management of menopause, explaining that:

“Unlike western medicine, which views every woman’s menopause as the same and always prescribes the same treatment for it, namely HRT, Chinese medicine recognizes a number of different energetic disturbances which can occur during the menopause, each one has different symptoms and is treated in a different way. Like homeopathic medicine, Chinese medicine tailors its therapies to treat the individual patient rather than the disease or condition from which they suffer, as western medicine tends to do” (p. 66).

Reflection: Chinese medicine utilizes therapies that are tailored to treat the individual rather than the disease condition.

My Image: The whole person is more important than the disease. Because menopause is not a disease so the whole person (the woman) should be the focus.

“The most important and common energetic disturbance which occurs at the time of the menopause is kidney Yin deficiency” (p. 66).
Elaborating further Judy Hall contends:

“As already mentioned, there is a general tendency for the body to become Yin deficient as it grows older so a natural state of kidney Yin deficiency is arrived at around the time of the forty-ninth year. We have seen from Figure 2 that the kidney transmits energy to the liver so if the kidney is deficient in Yin, then the liver becomes Yin deficient as well...Therefore what is more commonly seen in practice is a combined picture of kidney Yin deficiency and liver Yin deficiency rather than the pure kidney Yin deficiency” (p. 66).

**Reflection:** Kidney Yin deficiency and liver Yin deficiency.

**My Image:** Less feminine energy available

Bringing in another organ, the liver, Hall explains the connection between Kidney Yin and liver Yin Deficiency. She states:

“The deficiency of Yin in the kidney and the liver leads to a relative excess of Yang. As we have seen, Yang energy is hot and mobile and has a tendency to rise upwards as it is light in nature. This gives a clinical picture of heat rising upwards. The result is hot flushes and sweating, especially in the upper part of the body ...

As the liver rules the eyes according to Chinese medicine, there may be blurred vision, spots in front of the eyes and dizziness. Headaches and tinnitus may also occur. The lower back is the ‘palace of the kidneys’ according to the Chinese and the lack of kidney energy there may lead to low backache or pain in the legs. The deficiency of Yin (or fluid) may give a dry mouth and throat and constipation may also result. Insomnia and dream-disturbed sleep may also occur” (p. 67).

**Reflection:** Less Yin leads to relative excessive Yang. Clinical picture, heat rising upwards resulting in hot flushes and sweating, mainly upper body parts.
My Image: Hot flush has basis in, and is birthed from Yang energy not estrogen deficiency. Estrogen replacement only band-aids the real issue as it replaces estrogen deficiency, and in turn, does not support the process of, and the energetic impulses of, the connections between less Yin and increased rising Yang.

Speaking of the need for balance between energies, Hall elaborates on the rising of Liver Yang, saying:

“If the Yin deficiency is particularly severe, there may be a large relative excess of Yang in the liver, which then tends to flow upwards. This particularly occurs if liver Qi stagnation is present (see below). The clinical picture of liver Yang rising is more like a severe form of kidney and liver Yin deficiency: as well as the hot flushes and sweats due to rising Yang there may occur dizziness and vertigo, tinnitus and red eyes, migraines, a bitter taste in the mouth, irritability or loss of temper and profuse menstrual flow. The Chinese say that anger is an emotion associated with the liver, so the excessive liver Yang may cause irritability and sudden outbursts of anger. The excess Yang (heat) causes the blood to become overheated, leading to heavy menstrual flow” (p. 67-68).

Reflection: Effects of large excess of Yang energy.

My Image: The bioenergetic changes that are occurring in the woman’s bodies and minds, can be impeded by any external stresses and injustices present in her context and environment, such as poverty, domestic violence, past and present abuse, and any socio-economic and socio-political inequity and inequality. These injustices become very clear to women at this time.
“This is a situation which may complicate the bioenergetic state at the time of the menopause. As mentioned above, anger is an emotion associated with the liver and according to Chinese medical theory, an excessive amount of anger can damage the Qi of the liver, causing it to stagnate. Honora Lee Wolfe points out that menopausal and post-menopausal women have ample reason to be angry and frustrated as we live in a society in which older women are not valued and have no clearly defined social role. This, combined with the general high level of stress present in urban society, means that liver Qi stagnation is fairly common at the time of the menopause and may complicate other bioenergetic patterns which occur. Liver Qi stagnation may lead to distension and bloating, a feeling of oppression at the sides of the chest and emotional liability. It also may also predispose to the syndrome of liver Yang rising” (p. 68).

**Reflection:** Women may be angry due to lack of status and valuable social role.
Stress also impacts negatively on a changing body and mind and can cause Liver Qi stagnation to occur. This in turn results in symptoms of illness for the woman.

**My Image:** Social factors impact on a changing body and mind and are implicated in the process of menopause and may either hinder or inhibit her transitional and transformational journey.

**Contrary Concept:**
- **Social Factors Implicated**
MY SUMMARY

This concludes some of the important aspects of knowledge presented by Judy Hall as a result of her menopausal journey. This book gives rich insights and perspectives on the menopausal experience and phenomenon. It takes us way beyond the Western scientific biomedical model of menopause thereby challenging the beliefs we have inherited from the negative, pathological, reductionist philosophy. It can assist us to see and consider the phenomenon and to approach and embrace it as a wholistic.

As mentioned earlier in this thesis, women’s status has an impact on women’s mental health. With the numbers of patients with dementia increasing, I believe it would be worth exploring how a successful menopausal adult developmental process and an unresolved menopausal experience may affect women in later years.

In various societies postmenopausal women are valued and considered important and as status has been implicated in health for women, Judy Hall quotes examples from various researchers who have done cross cultural research on the status of older women in other cultures. These include Margaret Mead who has reported that in “many other societies’ postmenopausal women are given considerable power in the community” (Hall, 1994, p. 156). In addition, Judy Hall also refers to Richard Lee who describes the power of post-menopausal women in Kung society. In addition Judy Hall states:

"In some American Indian tribes, the event of menopause was marked by the woman moving into the ‘Grandmother Lodge’ where, free from chores, she was able to dream her visions to enrich the community” (p. 179).

I believe not only should the woman be free from chores, but also free of the influence of patriarchal perspectives to enable her own feminine gnosis to emerge to enrich the community, especially the community of all menopausal women.

As a final few words from Judy Hall, I refer to her chapter the Wise Woman in which she states that menopausal rites are important for women. She recommends Rites of Passage and I present these in her own words, she says.
“Rites of passage were undertaken at significant times, not only to mark out the importance of the event but also to bring the blessing of the gods (or goddesses) into the community at a crucial stage of life. Rites of passage are therefore, a link with the spiritual forces which the so-called ‘primitive’ person sees as pervading life” (p. 179).

*My Image:* Spiritual forces pervading life, is wholistic inclusive thinking.

**CONTRARY CONCEPT:**
- LINK WITH SPIRITUAL FORCES

“Ritual has an inner meaning, it is something private and internal. When viewed from outside, it is merely an enactment (or re-enactment) of a drama. Viewed from inside, it is the power of life itself” (p. 179).

**CONTRARY CONCEPT:**
- THE POWER OF LIFE ITSELF

Finally, for women who wish to explore the spiritual aspects of the phenomenon of menopause, I recommend the content of this text as a rich resource for the beginning of a spiritual search for each of us. As Judy has stated, as we are all different that “each woman must come to the Wise Woman phase in her own way and express the energy in her own unique experience of life”. I conclude now with Judy’s words once again.

“This book will have helped you to value yourself for who you are, to connect to yourself and inner wisdom. This will give you the confidence and the courage to make changes in your life and to define for yourself your Wise Woman role in society. It will have helped to towards the spiritual pregnancy which will, in due time, come to fruition as the Wise Woman” (p. 176).

**CONTRARY CONCEPT:**
- SPIRITUAL PREGNANCY.
This postmenopausal woman Judy Hall, in this text, has given us valuable insights into the body/mind/soul/spirit connections that are involved in the menopausal phenomenon.

Thank you Judy Hall
CONTRARY CONCEPTS AND IMAGES FROM JUDY HALL’S STORY

The list of contrary concepts from Judy Hall’s text follows in Table 4.4.

Table 4.4 Contrary Concepts emerging from Judy Hall’s narrative

<table>
<thead>
<tr>
<th>THE CHANGE</th>
<th>INHERENT FEMININE WISDOM.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PART OF NATURAL UNFOLDING CYCLE OF LIFE</td>
<td>SECRET JOY</td>
</tr>
<tr>
<td>WHOLISTIC PROCESSES INVOLVED IN THIS IMPORTANT TRANSITION</td>
<td>SPIRITUAL GROWTH</td>
</tr>
<tr>
<td>THE CHANGE</td>
<td>SUPER-EXALTATION</td>
</tr>
<tr>
<td>MAJOR PERIOD OF CHANGE</td>
<td>COMPLEMENTARY THERAPIES</td>
</tr>
<tr>
<td>A COHERENT WHOLE</td>
<td>TRIGGER THE HUMAN ORGANISM’S OWN HEALING CAPACITIES</td>
</tr>
<tr>
<td>COMPLEMENTARY THERAPIES</td>
<td>HOLISTIC TREATMENT.</td>
</tr>
<tr>
<td>SUCCESSFUL</td>
<td>COMPLEMENTARY THERAPIES</td>
</tr>
<tr>
<td>HOLISTIC APPROACH</td>
<td>SPIRITUAL ENERGY</td>
</tr>
<tr>
<td>UNUSED POTENTIAL</td>
<td>SPIRITUAL AND PSYCHIC AWARENESS</td>
</tr>
<tr>
<td>RITE OF PASSAGE</td>
<td>YANG ENERGY EMERGING</td>
</tr>
<tr>
<td>NEW KNOWLEDGE OF SELF</td>
<td>SOCIAL FACTORS IMPLICATED</td>
</tr>
<tr>
<td>REGENERATION AND REBIRTH</td>
<td>LINK WITH SPIRITUAL FORCES</td>
</tr>
<tr>
<td>NATURAL STAGING POST ON THE JOURNEY OF LIFE.</td>
<td>THE POWER OF LIFE ITSELF</td>
</tr>
<tr>
<td>POSITIVE CHANGE AND INFINITE POSSIBILITIES</td>
<td>SPIRITUAL PREGNANCY</td>
</tr>
<tr>
<td>NUMINOUS POWER</td>
<td></td>
</tr>
<tr>
<td>A BLESSING</td>
<td></td>
</tr>
<tr>
<td>CONNECTION TO THE NUMINOUS MYSTERY CONNECTIONS</td>
<td></td>
</tr>
<tr>
<td>SACRED AND MYSTERIOUS CONNEXIONS</td>
<td></td>
</tr>
<tr>
<td>PRIMAL KNOWING</td>
<td></td>
</tr>
<tr>
<td>FEMININE GNOSIS</td>
<td></td>
</tr>
<tr>
<td>OPTIMISTIC CHANGE</td>
<td></td>
</tr>
<tr>
<td>POSITIVE &amp; CONSTRUCTIVE</td>
<td></td>
</tr>
<tr>
<td>FORWARD LOOKING</td>
<td></td>
</tr>
<tr>
<td>UNFOLDMENT &amp; EXPANSION</td>
<td></td>
</tr>
<tr>
<td>RITE OF PASSAGE</td>
<td></td>
</tr>
<tr>
<td>TRANSITION INTO NEW PHASE</td>
<td></td>
</tr>
</tbody>
</table>
The following Figure 4.4 graphically represents the contrary concepts emerging from Judy Hall’s narrative and applied to Chinn and Kramer’s (1999, p. 55) representation of the Continuum of Empiric Abstraction.
Menopause: The Need for a Paradigm Shift from Disease to Women’s Health

Margaret T.C. Harris

Figure 4.4: Contrary Concepts emerging from Judy Hall’s narrative

- **Relatively Empiric**
  - Disease = Loss of hormones
  - Social Factors implicated
  - Increase in hormones
  - The Change
    - Natural Unfolding Cycle of Life
    - Natural Staging
    - Post on the Journey of Life
    - Optimistic Change

- **Relatively Abstract**
  - Holistic
  - A Blessing
  - Primal Knowing
  - Connection to the Numinous
  - Mystery Connections
    - Regeneration and Rebirth
    - Numinous Power
    - Link with Spiritual Forces
    - Sacred Connections
    - Secret Joy
    - Spiritual Growth
    - Super Exaltation
    - Spiritual Energies
    - Spiritual and Psychic

- **Indirectly Observable**
  - Yang Energy Emerging
  - Unfoldment and Expansion
  - Unused Potential
  - New Knowledge of Self
  - Feminine Gnosis
  - Inherent Feminine Wisdom
  - Positive Change and Infinite Possibilities
  - Forward Looking
  - A Coherent Whole
  - Spiritual Pregnancy

- **Inferred from multiple direct & indirect observations**

Complementary therapies trigger the human organisms own healing capacities

Dynamic Interconnections and Connections
All the contrary concepts revealed in each woman’s text have been brought together and are shown below in Table 4.5. The contrary concepts from the women’s narratives listed in this table all counter the biomedical model.

Table 4.5: Contrary Concepts by author of the text

<table>
<thead>
<tr>
<th>Northrup</th>
<th>McCain</th>
<th>Downing</th>
<th>Hall</th>
</tr>
</thead>
<tbody>
<tr>
<td>THIS TRANSITION</td>
<td>NEW WAY OF BEING</td>
<td>TRANSITION</td>
<td>THE CHANGE</td>
</tr>
<tr>
<td>OWN TRANSITION</td>
<td>NATURAL PROCESS WITH DEEP LESSONS</td>
<td>SOCIAL PSYCHO-LOGICAL &amp; SPIRITUAL DIMENSIONS</td>
<td>PART OF NATURAL UNFOLDING CYCLE OF LIFE</td>
</tr>
<tr>
<td>ONE’S TRANSITION</td>
<td>NEW BEGINNING</td>
<td>CENTRALLY IMPORTANT LIFE CHANGE</td>
<td>WHOLISTIC PROCESSES INVOLVED IN IMPORTANT TRANSITION</td>
</tr>
<tr>
<td>THRESHOLD OF TOTAL TRANSFORMATION</td>
<td>TRANSITIONAL PROCESS</td>
<td>CONFRONTING A TRANSITION WITH HOPE, DIGNITY, AND DEPTH</td>
<td>MAJOR PERIOD OF CHANGE</td>
</tr>
<tr>
<td>MIDLIFE TRANSFORMATION</td>
<td>NEW EXISTENCE</td>
<td>LIFE TRANSFORMING TRANSITION</td>
<td>COHERENT WHOLE</td>
</tr>
<tr>
<td>HORMONAL SHIFTS BRAIN &amp; BODY</td>
<td>A NEW DEFINITION OF OURSELVES</td>
<td>LIFE PHASE</td>
<td>COMPLEMENTARY THERAPIES SUCCESSFUL</td>
</tr>
<tr>
<td>EXCITING DEVELOPMENTAL STAGE</td>
<td>JOURNEY TOWARD THE TRUE SELF</td>
<td>PSYCHOLOGICAL EVENT AS A SOUL EXPERIENCE</td>
<td>HOLISTIC APPROACH</td>
</tr>
<tr>
<td>ENHANCED INTUITION</td>
<td>NEW WAYS OF THINKING</td>
<td>FEMALE MID-LIFE TRANSITION</td>
<td>RITE OF PASSAGE</td>
</tr>
<tr>
<td>NEW DEVELOPMENTAL STAGE</td>
<td>ACCEPTANCE OF OTHER WAYS OF THINKING</td>
<td>SPIRITUAL SIGNIFICANCE</td>
<td>NEW KNOWLEDGE OF SELF</td>
</tr>
<tr>
<td>SHIFTING ENERGIES</td>
<td>REBIRTH EXPERIENCE</td>
<td>RITE OF PASSAGE</td>
<td>REGENERATION AND REBIRTH</td>
</tr>
<tr>
<td>NEW PERCEPTIONS</td>
<td>PREGNANT WITH HERSELF</td>
<td>JOURNEY</td>
<td>A BLESSING</td>
</tr>
<tr>
<td>NEW BEHAVIOUR</td>
<td>SPIRITUAL ADVENTURE JOURNEY</td>
<td>BEGINNING ANOTHER LIFE-STAGE</td>
<td>POSITIVE CHANGE AND INFINITE POSSIBILITIES</td>
</tr>
<tr>
<td>SELF TRANSFORMATION</td>
<td>CHANGE OF LIFE</td>
<td>REBIRTH OF MENOPAUSAL SELF</td>
<td>NATURAL STAGING POST ON THE JOURNEY OF LIFE.</td>
</tr>
<tr>
<td>SELF HEALING</td>
<td>TRANSFORMATION OF Deepest Kind</td>
<td>RENAMING OF MENOPAUSAL SELF</td>
<td>NUMINOUS POWER</td>
</tr>
<tr>
<td>EFFECTIVE AGENTS FOR SOCIAL CHANGE</td>
<td>WOMEN’S RITE OF PASSAGE</td>
<td>BODY-EVENT IS SOUL-EVENT</td>
<td>CONNECTION TO THE NUMINOUS</td>
</tr>
<tr>
<td>NERVOUS SYSTEM BEING REWIRED</td>
<td>CHANGE</td>
<td>BODY, SOUL, SPIRIT CONNECTI</td>
<td>MYSTERY CONNECTIONS</td>
</tr>
<tr>
<td>TRANSFORMING AND HEALING OUR BODY/MIND/SPRIT</td>
<td>CHANGE OF LIFE</td>
<td>SYMBOLIC SIGNIFICANCE</td>
<td>SACRED AND MYSTERIOUS CONNECTIONS</td>
</tr>
</tbody>
</table>
As revealed in this exploration of the woman’s texts the adult developmental process is a transitional, transforming journey of rebirth of body, mind, spirit and soul connections. This adult development process reflects the concepts in Chinn and Kramer’s concept model at the relatively abstract end of the continuum. These concepts are indirectly measured or inferred. Some contrary concepts represent those that reflect the more concrete end of the continuum and are directly measurable.

This adult developmental process may not be the same for all women, in fact their journey may be quite different and may not reflect the experiences and thoughts of the women explored in the above texts.

Table 4.6 (below) identifies the aspects of this adult development phenomenon of menopause for the women in this research.
### Table 4.6 Components of the Wholistic Adult Life Transition Journey

<table>
<thead>
<tr>
<th>Transition</th>
<th>Transformation</th>
<th>Life Change/ Journey</th>
<th>Rebirth</th>
<th>Body/Mind/Spirit Connections</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSITION</td>
<td>LIFE TRANSFORMATION</td>
<td>THE CHANGE</td>
<td>A NEW DEFINITION OF OURSELVES</td>
<td>WHOLISTIC PROCESSES INVOLVED IN IMPORTANT TRANSITION</td>
</tr>
<tr>
<td>OWN TRANSITION</td>
<td>THRESHOLD OF TOTAL TRANSFORMATION</td>
<td>NATURAL PROCESS WITH DEEP LESSONS</td>
<td>JOURNEY TOWARD THE TRUE SELF</td>
<td>SOCIAL PSYCHO-LOGICAL &amp; SPIRITUAL DIMENSIONS</td>
</tr>
<tr>
<td>PROCESS</td>
<td>MIDLIFE TRANSFORMATION</td>
<td>CENTRALLY IMPORTANT LIFE CHANGE</td>
<td>REBIRTH EXPERIENCE</td>
<td>PSYCHOLOGICAL EVENT AS A SOUL EXPERIENCE</td>
</tr>
<tr>
<td>TRANSITIONAL PROCESS</td>
<td>SELF TRANSFORMATION</td>
<td>MAJOR PERIOD OF CHANGE</td>
<td>NEW WAY OF BEING</td>
<td>COHERENT WHOLE</td>
</tr>
<tr>
<td>INCREASE IN HORMONES</td>
<td>TRANSFORMATION OF DEEPEST KIND</td>
<td>RITE OF PASSAGE</td>
<td>NEW BEGINNING</td>
<td>HOLISTIC APPROACH</td>
</tr>
<tr>
<td>EXCITING DEVELOPMENTAL STAGE</td>
<td>TRANSFORMING AND HEALING OUR</td>
<td>RITE OF PASSAGE</td>
<td>NEW EXISTENCE</td>
<td>COHERENT WHOLE INSIGHTS FROM BOTH BODY AND SOUL</td>
</tr>
<tr>
<td>DEVELOPMENTAL STAGE</td>
<td>BODY/MIND/SPRIT</td>
<td>JOURNEY</td>
<td>NEW KNOWLEDGE OF SELF</td>
<td>A BLESSING</td>
</tr>
<tr>
<td>BEGINNING ANOTHER LIFE-STAGE</td>
<td>POSITIVE CHANGE</td>
<td>REGENERATION AND REBIRTH</td>
<td>BODY-EVENT IS SOUL-EVENT</td>
<td></td>
</tr>
<tr>
<td>FEMALE MID-LIFE TRANSITION</td>
<td>JOURNEY</td>
<td>NEW CREATIVE ENERGIES</td>
<td>BODY, SOUL, SPIRIT CONNECTION</td>
<td></td>
</tr>
<tr>
<td>CONFRONTING A TRANSITION WITH HOPE, DIGNITY, AND DEPTH</td>
<td>NATURAL STAGING POST ON THE JOURNEY OF LIFE</td>
<td>UNFOLDMENT &amp; EXPANSION</td>
<td>SPIRITUAL SIGNIFICANCE</td>
<td></td>
</tr>
<tr>
<td>LIFE PHASE</td>
<td>CHANGE</td>
<td>PREGNANT WITH HERSELF</td>
<td>SPIRITUAL ADVENTURE</td>
<td></td>
</tr>
<tr>
<td>NATURAL UNFOLDING CYCLE OF LIFE</td>
<td>CHANGE OF LIFE</td>
<td>SELF HEALING</td>
<td>NUMINOUS POWER</td>
<td></td>
</tr>
<tr>
<td>NEW PHASE OF LIFE JOURNEY</td>
<td>THE PASSAGE</td>
<td>REBIRTH OF MENOPAUSAL SELF</td>
<td>SYMBOLIC SIGNIFICANCE</td>
<td></td>
</tr>
<tr>
<td>TRANSITION INTO NEW PHASE</td>
<td>WOMEN’S RITE OF PASSAGE</td>
<td>RENAMING MENOPAUSAL SELF</td>
<td>CONNECTION TO THE NUMINOUS</td>
<td></td>
</tr>
<tr>
<td>OPTIMISTIC CHANGE</td>
<td>NEW PERCEPTIONS</td>
<td>MYSTERY CONNECTIONS</td>
<td>SACRED AND MYSTERIOUS CONNECTIONS</td>
<td></td>
</tr>
<tr>
<td>RITE OF PASSAGE</td>
<td>NEW BEHAVIOUR</td>
<td>ENHANCED INTUITION</td>
<td>FEMININE GNOSIS</td>
<td></td>
</tr>
<tr>
<td>CHANGE OF LIFE</td>
<td>NEW INSIGHT</td>
<td>PRIMAL KNOWING</td>
<td>ENHANCED INTUITION</td>
<td></td>
</tr>
<tr>
<td>SELF AWARENESS</td>
<td>PRIMAL INSIGHT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNDERSTANDING &amp; GROWTH</td>
<td>NEW WAYS OF THINKING</td>
<td>WHOLE STAGE IN A WOMEN’S LIFE</td>
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</tr>
<tr>
<td>ON GOING JOURNEY OF DISCOVERY</td>
<td>ACCEPTANCE OF OTHER WAYS OF THINKING</td>
<td>CONNOTATION TO THE NUMINOUS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TERRITORIAL PASSAGE FROM ONE SOCIAL POSITION TO ANOTHER</td>
<td>POSITIVE &amp; CONSTRUCTIVE</td>
<td>SOMETHING ESSENTIALLY FEMALE</td>
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<td></td>
</tr>
<tr>
<td>FORWARD LOOKING</td>
<td>INHERENT FEMININE WISDOM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALTERNATIONS IN THINKING PATTERNS</td>
<td>SECRET JOY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNUSED POTENTIAL</td>
<td>SPiritual GROWTH</td>
<td></td>
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</table>

These women’s conceptual meanings have the potential to contribute to forming the backbone of any more informed, more inclusive, women-centred model of women’s health or menopause.
THE VALUE OF POSTMENOPAUSAL WOMEN AND THEIR TEXTS - EMERGENT SIGNIFICANT REVELATIONS

“A feminist critique can alter the content and constructs of science and particularly the components of knowledge development in nursing if it transforms ways we perceive realities by creating new meaning”

(DeMarco, Campbell, & Wuest, 1993, p. 29)

I commence this section of this chapter with the above words regarding the value of a feminist critique and the importance of creating new meaning in the development of new knowledge. Although speaking about nursing in particular, De Marco, Campbell and Wuest’s (1993) comments are highly pertinent to the previous constructions of women’s experience of menopause.

My feminist critique through the discourse analysis of the biomedical model, together with the method of creating conceptual meaning, has highlighted the expansion, width and depth of the menopausal experience. The insertion of these new knowledges into the conceptual framework, designed and produced by Chinn & Kramer (1999), enables and presents the wider vision of the phenomenon of menopause. This expansion of knowledge, in addition to the biomedical knowledge, has emerged through the narratives of the postmenopausal women’s experiences, perspectives and theories as presented in their own texts and when juxtaposed with the biomedical texts we have a different picture.

In addition, these new knowledges (postmenopausal women’s) are not the final word or total truth of the phenomenon of menopause, as it is possible that more knowledge may emerge when more postmenopausal women’s narratives, perspectives and theories are published.

However, I have presented a case for the need to acknowledge women’s perspectives through the ageing life cycle, which moves beyond the scientific, technical, biomedical diagnosis of menopause. The negative pathological biomedical diagnosis of menopause is limiting and oppressive due to its underlying reductionist philosophy of Cartesian dualism, the body/mind separation, and where in the case of menopause, loss and decline are the privileged terms. Therefore the marginalized, ignored and deleted positive dynamic aspects of adult development and the normal body/mind/spirit wholistic menopausal life-cycle process are
Valuable, necessary and essential inclusions in the development of women’s health policy on menopause, women’s health educational programs for menopausal women, and good health practice for menopausal women. I now move to clarify further and on a deeper level, the value of the revelations that have emerged from the postmenopausal women’s texts.

This section presents a summary of revelations from the postmenopausal women’s texts. Four revelations are noted. In addition, upon juxtaposing the women’s stories with the biomedical texts, other revelations occur. Supported by cross-cultural evidence, it becomes evident that the value of menopausal and postmenopausal women has been ignored and omitted in our western culture. Therefore, postmenopausal women’s texts provide us with valuable revelations. Firstly, I address three revelations. The fourth is the revelation that emerges from the previous three revelations.

**Women’s Texts – Revelation 1. Wholistic Processes**

As presented in the postmenopausal women’s texts, menopause is a more wholistic process and experience rather than a reductionist one. Wholistic paradigms can be identified by connections and interconnections, where the whole person is implicated through biological, psychological, emotional, soul and spiritual connections. These connections are evident within these women’s texts. The degree of connection varies between individual women indicating different needs, as a result of her individual history and her immediate context. How easy or difficult it is for the woman to work constructively with these connections will also be affected by the other particular life stressors she maybe experiencing in her current life situation. However, the following is especially important to note.

The work of Christiane Northrup, MD, Professor of Obstetrics and Gynecology, makes an important contribution to the knowledge of menopausal and postmenopausal women. Northrup’s own experience of menopause, her expertise and her theory, taken from the context of her own life, gives us initial valuable insights into the phenomenon. In her text, *The Wisdom of Menopause* (2001) Northrup acknowledged the following:

1. “The brain and the reproductive organs are intimately connected by a complex series of feedback loops” (p. 50). She named this as the “Hypothalamus-Pituitary-Ovary Connection” (p. 50).
This body/mind connection is relevant. This was the connection that both Wilson and Utian omitted in their reductionist diagnosis.

2. "During perimenopause, GnRH levels begin to rise in the brain, causing FSH and LH to surge to their highest levels ever" (p. 49).

Both Wilson and Utian, in their diagnosis, ignored the increase in these hormones and focused only on the loss of estrogen.

3. "Those elevated FSH and LH levels stay elevated permanently" (p. 49).

In addition, the body/mind connection as penned in Northrup’s words in her chapter “The Brain Catches Fire at Menopause, indicates a powerful, dynamic process.

Our brains actually begin to change at perimenopause. Like the rising heat in our bodies, our brains also become fired up! Sparked by the hormonal changes that are typical during the menopausal transition, a switch goes on that signals changes in our temporal lobes, the brain region associated with enhanced intuition” (Northrup, 2001, p. 38).

She has dedicated one whole chapter to this phenomenon. It is also interesting to note that for many women, the hot flush experience, is the sensation of heat rising. Through Northrup’s own experience, she is highly aware of the significant ovaries/brain connection. This is the same connection that was minimized, marginalized and ignored in Wilson and Utian’s diagnosis of loss and lack. Rather than pathologising menopause Northrup brings our attention to the importance, and significance of this powerful dynamic connective impulse. Her text is very positive and most informative.

Christiane Northrup’s awareness moves beyond the area of thighs and belly button, and therefore is a more wholistic representation, where body/mind connections are acknowledged, and where a dynamic process is evident. The mentality of women as diseased, pathological and dysfunctional, has denied the powerful, dynamic and positive impulse and process of the phenomenon of menopause, not only to women, but also to our society at large.
Christine Downing (1987), Marian McCain (1991) and Judy Hall (1994) have also written on their experiences of the phenomenon of menopause. Their texts also indicate identical or similar themes as Christiane Northrup’s but each is a representation of what was important for them in the process of menopause. These women are professional women who work in the area of therapy/counselling and health education. Their knowledge of menopause includes revelations of their own menopausal experiences.

From all these postmenopausal women’s experiences, as revealed in each woman’s individual texts, it is evident that something more than a physical change of loss only is occurring. Within each of these women’s texts a more wholistic experience is revealed, body, mind, soul and spirit is occurring rather than a reductionist biomedical process of hormonal loss and body breakdown only. This is also evidenced in the measurement in the rising of other hormones in the brain. There is a complex dynamic shift, which is a body-mind transition, rather than a linear event of body breakdown only. A dynamic shift has also been noted as a transition that “moves from one kind of order to another kind of order” (Komesaroff, Rothfield, Daly, 1997, p. 5), and where “there is a border crossed by the menopausal woman” (Rogers, 1997, p. 232). Menopause has also been conceptualized as a “developmental transition” (Fishbein, 1992 cited in Schumacher & Meleis, 1994, p. 120).

In addition according to Schumacher & Meleis “transitions are processes that occur over time” (1994, p. 121). Further they (citing Chick & Meleis, 1986) state “the process involves development, flow, or movement from one state to another” (p. 121). The degree of this shift or move from one state to another varies with each woman. As indicated by Daly (1997) “a loss of balance, of feeling ‘out of kilter’” (p. 161) is experienced by some women. What I am suggesting here, is that as the woman moves from a reproductive system to a productive system, disturbance of previous functioning process is happening. A change is occurring as the balance in hormones is shifting. Estrogen is decreasing, whilst other hormones are increasing. In addition, Christiane Northrup has referred to the changing levels of other hormones, GnRH, FSH and LH, as well as the loss of estrogen, and the effects that these rising hormones can have on the woman. She states that changing levels of hormones can effect memory, which can in turn, effect emotions such as anger (Northrup, 2001). Significantly Christiane Northrup also informs us that “many women are disturbed or
frightened when they feel this anger arising” and even more significantly, she states that the anger “and its energy is always urging us towards self-actualisation” (p. 53).

As a reflection on self-actualisation, I now move to consider adult development, as the following discussion reveals the significance of biological changes within the normal adult ageing developmental process.

**Women’s Texts – Revelation 2 – Adult Developmental Process**

The women’s narratives revealed that the adult development process was one of transition, transformation and rebirth. According to Settlage, Curtis, Lozoff, Lozoff, Silvershatz, & Simburg (1988) a disturbance of previous functioning is implicated in the ageing life course process. They state that “[t]he biological changes of adulthood commonly result in decline and loss of functions. Such change is nevertheless instrumental in adult development … it can be a major stimulus for new development to compensate for loss (p. 352).

This process occurs for the menopausal woman as a transition from a reproductive body to a non-reproductive body. In this case, the loss of function of the woman’s (reproductive system) can also be the major stimulus for her new development. In addition, through the transition process, rises in other hormones are also occurring, resulting in brain changes. These raised hormones bring the women to a new awareness as energy is firing the brain, moving us into a new consciousness and often to new ways of thinking. The degree that the consciousness of the woman changes will vary between women, therefore each woman’s needs will vary.

In addition, a disturbance in previous functioning has been noted as the stimulus for an adult developmental process. They further comment that “[t]he stimulus for development is disturbance of the previously adequate self-regulatory and adaptive functioning …The disturbance of the previously satisfactory functioning creates an unsettled state of disequilibrium with varying degrees of mental and emotional stress” (Settlage, et al., 1988, pp. 355-356).

This disturbance then can be seen as the potential for new development. From disturbance to new development indicates a transitional state, which can also be unsettling for the woman,
causing stress as a result of her transitional state. This is especially so if she is unable to deal positively with her new developmental trajectory.

As women if we are not aware of the disturbance as being the stimulus for new growth it could be very difficult to come to terms easily with what is happening within one’s body and within one’s mind as the disturbance could be very unsettling. Importantly then, we as women need to know how to deal with, and be able to, define what the new stimulus is leading us to.

Through the transitional stage of hormonal change and imbalance, mental and emotional stress can occur, but in addition, it is not only the changing hormones that cause the stress. Other stresses too have also been referred to by Christiane Northrup (2001) in her text and her narrative. She referred to these stresses as resulting from “life situations, whether at work, or with children your husband, your parents, or whatever”. If these do not change, “they can exacerbate a perimenopausal hormone imbalance” (p. 38). Consequently, it is possible that extra external stresses upon the woman, whilst both her body and her mind are changing and functioning as stimulus for new adult development and new thinking, could cause varying degrees of mental or emotional stress.

Adult development, this shift to a more mature consciousness and thinking, may not only be new to the woman, but also new to those around her. For some women this may cause problems if she has not been given prior knowledge, and has therefore not been able to prepare for a successful menopausal transition. In addition, her family, social, cultural and economic situations may not allow for the development of her new consciousness and self-actualizing process, thereby limiting the developmental process of the fully-functioning mature woman and also exacerbating emotional and mental stress.

These aspects vary with each individual woman’s context. Also the strength of the shift varies between women, and can be experienced as adult development, transition, transformation, metamorphosis, rite of passage, initiation and even a complete change of life, or alternatively nothing much different at all. But what is most important is that women have prior knowledge of this wholistic phenomenon before it begins, so they can then be prepared for it. This necessity for prior knowledge about the phenomenon has also been asserted by
Meleis et.al. (2000) “Anticipatory preparation facilitates the transition experience, whereas lack of preparation is an inhibitor. Inherently related to preparation is knowledge about what to expect during a transition and what strategies may be helpful in managing it” (p. 21).

The utilization of the reductionist biomedical language of the dominant discourse has constructed menopause as disease. By utilizing reductionist methods, both Wilson (1966) and Utian (1978; 1987; 1990) named menopause pathologically as a disease thus providing the rationale for the application of HRT/HT as the recommended intervention. I would argue that the women’s experiences revealed in their texts highlight the need for a new discourse that is more comprehensive, wholistic, and inclusive of diversity and also one that names the phenomenon positively not negatively and acknowledges and addresses the new adult developmental process. Reference to the importance of naming and language now follows.

**Women’s Texts – Revelation 3 – New Naming and Terminology**

Naming is important. According to Marian McCain (1991):

> Language is so much more than a convenient way of communicating with others. It is a potent force which shapes the way we think. And in its turn, the way we think shapes our experience. The way we think and speak of menopause defines its meaning for us and defines the limits of what it may teach each of us in her own life (pp. 14-15).

The presentation of the medical discourse and language of the medical diagnosis of menopause as loss and lack only, is limiting for the menopausal woman as it may be difficult for her to make use of the positive mature adult developmental transition process that is part of her life-cycle process. She may not learn the wholistic picture of the transitional process. If the medical discourse defines and presents to women the biological losses only, without the gains, I believe the diagnosis of disease is restrictive, oppressive and limiting to the full potential and adult development of menopausal and postmenopausal women.

Further to this, Jill Astbury (2006, p. 389) stated that “terminology is always important and how a phenomenon is named reflects beliefs about its underlying causes, determines which etiologic factors are included in research and which are excluded, and underpins policies,
programs, and practices designed to ameliorate the phenomenon in question”. For example, according to Astbury:

> If what is currently named ‘depression’, treated as a psychiatric disorder, and believed to have a biological basis amenable to psychopharmacologic rectification were to be renamed ‘demoralization’ and believed to have a basis in rights violations, then the possibilities for treating and responding meaningfully to this new disorder would expand (2006, p. 389).

In addition, I believe that if the reductionist diagnosis of menopause as disease, having its roots in a pathological state, and believed to have a biological basis only, amenable to psychopharmacologic rectification were to be renamed as a **woman’s positive dynamic wholistic adult developmental process** (my emphasis) then the possibilities for supporting and responding meaningfully to the woman through the process would expand. In addition without a more positive construct, it is possible that a woman may think she is moving into a pathological state and her husband/partner, together with society/culture, may also view her as pathological also.

In addition, as mentioned before, what also emerges from the postmenopausal women’s text is an underlying wholistic paradigm. Connections and interconnections characterise the writing of these women. Their terminology is, I believe, inclusive, organic, dynamic, and vital. This terminology has been marginalized and omitted and therefore never included in the limited diagnosis of menopause as disease. It has never been, or is not on record so to speak, but is necessary and appropriate to disrupt and intersect with the scientific biomedical knowledge to create new knowledge. This would be in addition to the already existing knowledge. This omission can be seen as not only a failure of “egalitarian aspirations” (Grosz, 1990, p. 162), but I believe it is also an issue of equity failure.

A different paradigm of menopause and the menopausal woman is required to enable the consideration of her subjectivity that is, psychosocial factors as well as her spiritual impulses as it is only from postmenopausal women’s writings that we are able to obtain a sense of the lived experiences of women, which acknowledges the place of connections rather than separation, both internal connections (mind/body/spirit), and contextual connections. These
postmenopausal women also acknowledge the gains and the role of increased levels of hormones, not just the losses. In this sense, through their experiences, there are not binary opposites, but inclusive opposites.

Because postmenopausal women’s embodied experiences reveal additional knowledge regarding a body/mind connection, the necessity of a new paradigm beyond Cartesian body/mind separation is essential to support women’s needs beyond body functions only, as they transit this life cycle passage to a new developmental stage. This Cartesian separation has denied women and our culture at large, knowledge of a positive wholistic adult developmental process. What is essential is the integration of postmenopausal women’s experiences and perspectives, as wholistic perspectives, into policy development and educational programmes. The mentality of women as diseased, pathological and dysfunctional, the episteme of our time has denied the powerful, dynamic and positive impulse and process of the phenomenon of menopause, not only to women, but also to their families, and to our society at large.

**Women’s Texts - Revelation 4 - The Postmenopausal Woman as Liability or Valuable Asset**

The holistic definition of health “acknowledges culture as an essential component of health” (Clarke & McCann, 2004, p. 161). Health can be seen to depend on balance between the individual and the natural world, and also the socio/political context. The question is: how does our society/culture accommodate our adult developmental process to ageing postmenopausal women?

Our bodies change as we grow older, and the physical signs of ageing may be at odds with the internalized image we hold of ourselves. This may cause distress, especially as aging bodies are devalued in societies that emphasize the importance of having bodies that are taut, trim and terrific (Clarke & McCann, 2004, p. 161).

Looking good, youth, beauty and efficiency are the values of our society. Also in our society/culture, ageing human beings are undervalued as these values of looking good, the beauty image, youthfulness and efficiency are the dominant and ruling values. In our culture, ageing menopausal and postmenopausal women are given little status. In addition, the
wisdom and status of these women has not been formally acknowledged in policy design or educational program development. This is a culture where scientific processes and biomedical knowledge remain dominant and reign supreme. In turn, the structure of this hierarchy has been instrumental in preventing and omitting the value of the wisdom of the ageing adult developmental process.

In various other cultures, the ageing menopausal and postmenopausal women have value and are acknowledged with special status. These cultures acknowledge the wisdom of the elders and social status increases with age. This is the also the case in Japan. According to Lock (1993), the traditional Japanese culture gives high status to its ageing members, and Japanese women live the longest in the world. This could indicate that social status acts as a buffer and a preventative to ill health and also carries healing properties. They also have one of the best diets to support their physical health.

Equally important, is women’s mental health. Astbury (2006) has noted that “increasing women’s status as human beings” is a change that needs to be made for “women’s right to good mental health” (p. 389). Therefore it makes sense that a culture that respects and gives positive status to menopausal and postmenopausal women, rather than trying to focus on trying to keep them looking young and feminine forever would be supportive of women’s health. Accepting postmenopausal women for their ageing experience and wisdom, and delegating a formal status to them would also be a change that needs to be made for the good health of ageing women. In addition their experiential wisdom could be shared with other women who will be embarking on a menopausal transition journey. This will require a change at policy level, a change to include postmenopausal women and their narratives in defining policy. The need for change is highlighted through the juxtapositioning of the postmenopausal women’s narratives with the biomedical gaze.

**Important Contradictions between Wilson, Utian and the Women’s Narratives**

The following are the most important contradictions between Wilson/Utian and Northrup, Dowling, McCain and Hall is that Wilson and Utian claim that women should not change,
whereas the women’s embodied experiences and perspectives all indicate change as being a normal process.

Wilson and Utian’s main focus was the negative loss of estrogen only to enable them to promote medicalization as the cure for the disease of loss. To enable them to promote the negative loss aspect they ignored and deleted anything else that was relevant to the phenomenon of menopause, for example increase in other hormones. They lied when they related to women and the public that it was the loss of estrogen that was the main issue. They withheld the positive and dynamic aspects of the phenomenon in their pathological diagnosis, thereby presenting limited and untruthful information. This can be considered poor science as while being limited in perspective, it was also inadequate. To ensure that women would believe him, Wilson fabricated a truth that women should remain feminine forever and how women should continue to look attractive and good. Utian through his setting up of the medical clinic to prescribe the medication to women, supported and praised Wilson’s diagnosis although he acknowledged it had faults. To support their pathological diagnosis menopause was described as destroying womanhood, castration and decay. The menopausal women were also described in negative, metaphoric language, for example castrates, living decay, cow like passivity and the equivalent of a eunuch. Therefore, this served to scare women into believing that hormone treatments could save them from this so called living decay.

In contrast, Northrup and the other postmenopausal women acknowledged both the positive aspects (the increases in other hormones) together with the loss of hormones. Their language represented the dynamic interconnections between the losses and gains. They were also aware of, and discussed, the changes that were occurring for them on other levels beyond the biological such as body/mind/soul/spirit, which for them were positive experiences. Positive language was relevant to their phenomenon as they identified their changes in both cognition as well as the changes in their bodies. The processes of changes, both losses and gains experienced by these postmenopausal women have also been evidenced as adult developmental processes by other researchers (Settlage et.al., 1988). These women’s experiences of their adult developmental process, their wholistic changes being inclusive of both losses and gains and their language represents the most appropriate terminology, as it presents an wholistic portrayal of menopause and postmenopausal women. Rather than a...
pathological limited construction their narratives represent the more wholistic adult
developmental process that is occurring for them.

In summary Wilson and Utian were telling women they should not change but remain as
before, feminine forever; whereas the postmenopausal women’s embodied experiences and
perspectives all indicate change as the being the normal menopausal process. The
juxtapositioning is represented in the following Table 4.7.
Table 4.7 Medical Gaze Contradictions juxtaposed with the Postmenopausal Women’s Narratives

<table>
<thead>
<tr>
<th>Wholistic</th>
<th>Adult</th>
<th>Life</th>
<th>Transition</th>
<th>Journey</th>
<th>Biomedical</th>
<th>Gaze</th>
</tr>
</thead>
<tbody>
<tr>
<td>transition</td>
<td>transformation</td>
<td>life change/journey</td>
<td>rebirth</td>
<td>body/mind/spirit connections</td>
<td>physical</td>
<td>sociological</td>
</tr>
<tr>
<td>transition</td>
<td>life transforming transition</td>
<td>the change</td>
<td>a new definition of ourselves</td>
<td>wholistic processes involved in important transition</td>
<td>hormone deficiency disease: lack of oestrogen and progesterone;</td>
<td>un-feminine</td>
</tr>
<tr>
<td>own transition</td>
<td>threshold of total transformation</td>
<td>natural process with deep lessons</td>
<td>journey toward the true self</td>
<td>social psychological &amp; spiritual dimensions</td>
<td>loss of fertility</td>
<td>un-attractive women as an appliance</td>
</tr>
<tr>
<td>process</td>
<td>midlife transformation</td>
<td>centrally important life change</td>
<td>rebirth experience</td>
<td>positive psychological event</td>
<td>a soul experience</td>
<td>menopause as pathological: disease and endocrinopathy</td>
</tr>
<tr>
<td>transitional process</td>
<td>self transformation</td>
<td>major period of change</td>
<td>new way of being</td>
<td>coherent whole</td>
<td>menopause as castration and mutilation</td>
<td>menopausal women as ‘patient’</td>
</tr>
<tr>
<td>increase in hormones</td>
<td>transformation of deepest kind</td>
<td>rite of passage</td>
<td>new beginning</td>
<td>holistic approach</td>
<td>sexually dysfunctional: frigidity</td>
<td>males doctors and hormone therapy as hero</td>
</tr>
<tr>
<td>developmental stage</td>
<td>body mind spirit</td>
<td>journey</td>
<td>new knowledge of self</td>
<td>a blessing</td>
<td>physical deterioration: loss of hair, changes in the breasts and sex organs</td>
<td>poor self-image socially constructed</td>
</tr>
<tr>
<td>beginning another life-stage</td>
<td>positive change and infinite possibilities</td>
<td>regeneration and rebirth</td>
<td>body-event is soul-event</td>
<td>menopausal women as decaying property</td>
<td>medical confusion &amp; disar</td>
<td>non adaptable</td>
</tr>
<tr>
<td>female mid-life transition</td>
<td>journey</td>
<td>new creative energies</td>
<td>body, soul, spirit connection</td>
<td>decay, suffering &amp; incapacity</td>
<td>difficult to live with</td>
<td></td>
</tr>
<tr>
<td>confronting a transition with hope, dignity, and depth</td>
<td>natural staging post on the journey of life</td>
<td>unfoldment &amp; expansion</td>
<td>spiritual significance</td>
<td>ovaries as factories estrogen &amp; progesterone as</td>
<td>apprehension/irritable</td>
<td></td>
</tr>
<tr>
<td>Life Phase</td>
<td>Change</td>
<td>Pregnant with herself</td>
<td>Spiritual Adventure</td>
<td>Catastrophic change in whole organism</td>
<td>Insomnia</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Menopause: The Need for a Paradigm Shift from Disease to Women's Health</td>
<td>Margaret T.C. Harris</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural Unfolding Cycle of Life</td>
<td>Change of Life</td>
<td>Self Healing</td>
<td>Numinous Power</td>
<td>Lack of Youthfulness Airing Women as Deteriorating</td>
<td>Fritidity</td>
<td></td>
</tr>
<tr>
<td>New Phase of Life Journey</td>
<td>The Passage</td>
<td>Rebirth of Menopausal Self</td>
<td>Symbolic Significance</td>
<td></td>
<td>Women's Breasts Are Psychological Organs</td>
<td></td>
</tr>
<tr>
<td>Transition into New Phase</td>
<td>Women's Rite of Passage</td>
<td>Renaming Menopausal Self</td>
<td>Connection to the Numinous</td>
<td>Optimistic Change</td>
<td>New Perceptions</td>
<td>Mystery Connections</td>
</tr>
<tr>
<td></td>
<td>Rite of Passage</td>
<td>New Behaviour</td>
<td>Sacred and Mysterious Connections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Change of Life</td>
<td>New Insight</td>
<td>Feminine Gnosis</td>
<td>Self Awareness</td>
<td>Primal Knowing</td>
<td>Enhanced Intuition</td>
</tr>
<tr>
<td></td>
<td>Understanding &amp; Growth</td>
<td>New Ways of Thinking</td>
<td>Whole Stage in a Women's Life</td>
<td>On Going Journey of Discovery</td>
<td>Acceptance of Other Ways of Thinking</td>
<td>Holistic Experience</td>
</tr>
<tr>
<td></td>
<td>Territorial Passage from One Social Position to Another</td>
<td>Positive &amp; Constructive</td>
<td>Something Essentially Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Forward Looking</td>
<td>Inherent Feminine Wisdom</td>
<td>Alternations in Thinking Patterns</td>
<td>Secret Joy</td>
<td>Unused Potential</td>
<td>Spiritual Growth</td>
</tr>
</tbody>
</table>
THE WORLD HEALTH ORGANISATION GENDER POLICY

From the above it becomes obvious that the way menopause is culturally constructed in our western society, is a gender health issue. Positive constructions of menopause should be considered best practice in all policies and programmes. Of further particular relevance to my research project, is the recognition and acknowledgment by the World Health Organization (2002) (WHO) concerning “the social and cultural conditions of ill health/disease” and their will to promote equity and equality between women and men, throughout the life course, and to ensure that interventions do not promote inequitable gender role relations (p. 2).

Of further particular relevance is the recognition and acknowledgment of the immediate social contexts of women’s lives, and the environmental factors that contribute to their health or to their illness. All these factors could be addressed in a new construct, utilizing a feminist philosophy and a wholistic paradigm.

To address all these issues emerging from the postmenopausal women’s texts, a paradigm shift is essential as postmenopausal women’s knowledge will not fit the current episteme of our time as it would need (or include) a feminist intersection with the reductionist objective, positivist, dominant paradigm of science of our time regarding menopause. This would create new, broader and deeper expansive knowledge, rather than limited knowledge as it will be driven by a feminist philosophy similar to that offered by Grosz when she states:

Feminist philosophy could accept its position as historically grounded in patriarchal texts; yet its future involves a movement beyond this history…It would no longer accept concepts, terms, methods that have prevailed for millennia but would create new ones appropriate to women (1990, p. 169).

And of significance also, “[i]t would no longer be confined to women’s issues, issues concerning only or largely women, but be free to range over any issue. What makes it feminist is not its object buts its perspective” (Grosz, 1990, p. 169). This in turn, I believe, could provide an example to our culture of a new episteme of health care. Other appropriate interventions for the phenomenon at hand could then be applied. This completes the main theoretical and philosophical section of this thesis. What follows now are the political implications of the postmenopausal women’s texts and how they can intersect and interrupt
the traditional dominant paradigm. Also the need to bridge theory with practice will be addressed. Implicit within and directing this bridge will be feminist principles and feminist perspectives that have driven this feminist critique. But firstly, I offer the following summary.

**SUMMARY AND WHOLISTIC REVELATIONS FROM WOMEN’S TEXTS**

What emerges from the postmenopausal women’s text is an underlying wholistic paradigm rather than a reductionist one. Wholistic paradigms can be identified by connections and interconnections, where the whole person is implicated through biological, psychological, emotional, and spiritual connections. Connections and interconnections are evident and characterise the writing of these women, both inner connections as well as external connections. Their terminology is inclusive of other changes that also occur and it is inclusive, dynamic, positive, and vital. The degree of connection varies between individual women’s stories, indicating different needs, as a result of her individual history and her immediate context. How easy or difficult it is for the women to work constructively with these connections also will be affected by the other particular life stressors she also is experiencing.

The women’s terminology is expressive of a transitional experience and process. Specifically too, Christiane Northrup’s description indicates a powerful dynamic connection. Through her own experience she is highly aware of the significant ovaries/brain connection. This is the same connection that was minimized, marginalized, and ignored in Wilson (1966) and Utian’s (1978) diagnosis of deficiency, loss and lack. Rather than denying menopause, Christiane Northrup (2001) brings our attention of the importance and significance of this powerful dynamic connective impulse. Further, Christiane Northrup’s identification of the body/mind connections postulated within her text is very positive and most informative. Also the other women’s texts, in addition to Christiane Northrup’s, talk about transition and transformation indicating that an adult developmental process, within the ageing life course, is occurring. Settlage, et al. (1988) have described adult development indicating that changes in previous functioning are part of the life process of ageing and is fundamental to adult development. This adult developmental process could be seen as vital to the health of the ageing woman.
In addition, a post structural critique of biomedical texts, through a discourse analysis, prompted the exploration for differences and alternatives that had been marginalized, ignored and rejected within the technical pathological diagnosis. Echoing these thoughts Grosz (1990) has argued that “[f]eminist theory must exist as both critique and construct and it must be positive, creating alternatives, producing feminist, not simply anti-sexist theory” (p. 59).

A feminist exploration of postmenopausal women’s texts revealed not only an anti-sexist theory on menopause but more importantly an underlying perspective that constructs menopause, the menopausal and postmenopausal woman, not negatively, but positively through a wholistic philosophy. In addition, the postmenopausal women’s text not only provided the inclusion of the rejected and ignored differences and alternatives to the scientific, reductionist model, but at the same time revealed that the differences that emerged were also underpinned by a much healthier alternative philosophical paradigm.

The new paradigm seriously requires changes at many levels and is in accord with the WHO requirement for the inclusion of individuals and groups in order to strongly and effectively represent their needs and interests in the policy development. The necessity for the employment of this healthier paradigm requires the redistribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.

CONCLUSION

Our current, dominant cultural belief system and the mentality towards menopausal women as lacking and diseased, pathological and dysfunctional and requiring drugs, constructs women as patients, requiring cure. This can be confusing for some women. In addition, this episteme of our time has denied the powerful, positive and dynamic impulse and process of the phenomenon of menopausal not only to women, but also to their families and to our society at large.

In addition, the way menopause is constructed is a gender health issue. Positive constructions of menopause should be considered best practice in all policies and programs. The positive dynamic aspects and experiences of this normal life cycle noted and reported by these various postmenopausal women, have not been formally promoted in educational programs to other
women or to our society or included in policy design. Regarding the need for women’s constructions of menopause, Andrist & MacPherson (2001) refer to McBride, (1994), and they relate that:

She further noted a turning point in women’s health scholarship, moving from critique of the patriarchal paradigm to assertion, a positive statement of values. McBride stated, “…the move to assertion, by contrast, takes the stance that criticizing the extent to which women have been ‘constituted’ selves must now give way to their becoming ‘constituting’ selves, persons who define their own experience (p. 33).

In addition, the non-recognition of menopause as a positive dynamic transition as part of the normal ageing life-course process, and the construction of this transition as a scientific technical or biomedical process only, have the potential to adversely affect the long term health of older women. Women have been denied the knowledge of the positive adult developmental process as this wholistic process has been marginalized, ignored and omitted. What becomes evident is that a wholistic paradigm is required to enable inclusion of various discourses, including those that support women’s adult developmental processes and the integration of postmenopausal women’s experiences, perspectives and concepts. Further, the denial of, and invisibility of postmenopausal women’s knowledge regarding menopause is an issue of gender and an issue of equity, and more precisely, an issue of equity failure, and omission. This will be referred to in a further chapter. This concludes this chapter on the exploration of postmenopausal women’s texts and the method of creating conceptual meaning from the texts of these postmenopausal women. The following chapter explores in more detail the philosophical wholistic underpinning that has emerged from the meanings of these postmenopausal women’s experiences and perspectives and its connection to this women’s health issue.
CHAPTER FIVE – POLITICAL SIGNIFICANCE OF REVELATIONS FROM WOMEN’S TEXTS: WHOLISTIC, HEALTH, SYSTEMS THINKING & THEORY, COMPLEMENTARY & ALTERNATIVE MEDICINE, GENDER, EQUITY, WOMEN’S RIGHTS, SOCIAL JUSTICE, PARADIGM SHIFT AND SOCIAL MODEL OF HEALTH
“The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.”


Introduction

Postmenopausal women’s narratives are valuable contributions to the knowledge of the phenomenon of menopause. They are particularly valuable for women as they provide for women, vital, different, diverse and dynamic information not included in the limited, although dominant paradigm in our culture of the scientific biomedical model. In addition, I believe that although through these postmenopausal writings, women are sharing vital information with other women; they have also served to bring our attention to the insufficiency and obvious lack in the current dominant reductionist biomedical model. The women’s narratives have the effect of disrupting and intersecting the current biomedical knowledge and bring our notice to the limitations of the knowledge of our time, and the need for new inclusive knowledge thereby creating the need for a new model. This consideration is necessary and critical, for menopausal women. It may have implications for various other health issues also.

The disruption and intersection of the dominant pathological reductionist paradigm of menopause, for me, creates a reflective space and this in turn urges my work forward to consider a more appropriate wholistic philosophy, episteme, discourse, model and paradigm for this critical women’s health issue. This chapter explores the details of a more positive wholistic health model for women and its positive outcomes for menopause, the menopausal and postmenopausal woman. It does so by an exploration of the possibilities of a paradigm shift to a wholistic model. This is emerging as essential and critical. To do this, I recommend multidisciplinary perspectives to define a more wholistic philosophy and discourses for menopause and now draw on various disciplines, including physics, complementary and alternative medicine, nursing, gerontology, anthropology, psychiatry and also laywomen to provide the rationale for a shift to an expanded health model underpinned by a philosophy of wholeness.
Significance of Wholistic (Including ‘W’)

What I am proposing is a shift to a more wholistic paradigm. The need for this paradigm shift has arisen from the research so far, and has also included a feminist intersection with the reductionist objective, positivist, dominant paradigm of science of our time regarding menopause, to create new knowledge. Because this wholistic paradigm includes a feminist intersection I am choosing the word ‘wholistic’, which will be employed by me rather than the word holistic. I employ the term, ‘holistic’ proceeded by and including a ‘w’, as wholistic includes all, internal and external connections therefore signifying a model of inclusion.

‘Wholistic’ can also represent ‘w’omen’s perspectives and theories. The term wholistic also contains the term holistic, thereby making it the most comprehensive and inclusive term. This term also allows for and incorporates inclusive knowledge at every, or at least, many levels, and also includes context and environmental factors. Further, context and environment will be noted as central to and the underlying foundation the foundation for a ‘wholistic’ model of health.

Connections and interconnections have been revealed and highlighted as significant within the published texts of the postmenopausal women in the previous chapter. This revelation has been motivational and also instrumental for me, upon much reflection, to pursue and explore briefly the scientific model of systems views and thinking. However, because the history of philosophical thinking regarding the reductionist, objective and pathological model is important this will be addressed in more detail. To do this I draw rather heavily on the work of the physicist Fritjof Capra (1978; 1983; 1984; 1997) who has researched theoretical high-energy physics and lectured on the philosophical implications of modern science. His work is scientific and theoretical, has been published internationally in many languages and also has value or this woman’s health issue, as ultimately he steers us back to feminism and the feminist spirituality of the women’s movement as the place for an ecological vision (Capra, 1983). This is very much in line with the wholistic vision emerging from this research, the value and necessity of a feminist space in which to create new visions in philosophy, episteme, discourses and models, and finally the need for a paradigm shift.

Firstly, some definitions of health assist in identifying a wholistic women’s health model as more appropriate than a disease model for the phenomenon of menopause, menopausal and postmenopausal women. Because I see wholism and wholistic as containers for holism and
holistic, an exploration of holism and holistic will follow, together with a further explanation of reductionism. In addition, a systems model is briefly explored. Capra provides a brief historical journey, an insight as to how our Western scientific model and reductionist paradigm has come to dominate in our time. His work will be intersperses with that of Vincent Di Stefano who informs us more on holism and holistic views.

HEALTH
As stated prior, menopause is a body, mind, and emotional, spiritual phenomenon, and occurs within the context of a woman’s life. Reference to, and respect for the inclusion of these aspects is found in a model of ‘health’ rather than one of ‘disease’. It is therefore appropriate to reflect and explore the definition of health, as there are multiple meanings of health.

Multiple Meanings of Health
The World Health Organisation states, “[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1977, p. 1). Individuals and researchers from various disciplines have presented definitions of health from different disciplines. Capra has noted, “[h]ealth is really a multidimensional phenomenon involving interdependent, physical, psychological and social aspects” (Capra, 1983, p. 353). In addition Baum (2008) has presented other aspects and definitions of health taken from Blaxter’s Survey involving a sample of the British men and women.

1. **Health as not ill/diseased**: typical comments were *Health is when you don’t have a cold* or *Health is when you don’t feel tired or short of breath*. Some responses indicated a view that people could be healthy even if they did have a disease: *I am very healthy apart from this arthritis.*

2. **Health as a reserve**: some people saw health as a reserve - if someone becomes sick they are able to recover quickly.

3. **Health as behaviour, health as ‘the healthy life’**: primarily used when describing the health of other people as opposed to the respondent’s. *I call her healthy because she goes jogging and doesn’t eat fried food. She walks a lot and doesn’t drink alcohol.* There was some evidence that this attitude was expressed by people who stressed the role of ‘bad habits’ in disease causation.
4. **Health as physical fitness**: particularly popular with young men and less favoured by older people. Men tended to express health in terms of physical strength and fitness. Typical quotes were: *There’s tone to my body, I feel fit; I can do something strenuous and not feel tired after I’ve done it.* Women were more likely to define health in terms of outwards appearance, such as being a slim, a good complexion, bright eyes and shining hair.

5. **Health as energy, vitality**: seen in terms of both physical and psycho-social energy to do things, signified by being able to get up easily, not feeling tired and getting on with activities, having energy and enthusiasm for work and generally feeling good.

6. **Health as social relationships**: defining health in terms of relationships with other people, and more likely to be expressed by women. Younger people saw this as being able to have good relationships with their families: having more patience with them, and enjoying the family. Older people saw it as being able to help others and enjoy doing so: *You feel as though everyone is your friend, I enjoy life more, can work and help other people.*

7. **Health as function**: health is the ability to do things, which overlaps with the association between health and energy and vitality. More older people mentioned this, possibly because they no longer took doing things for granted: *She’s 81 and she has her work done quicker than me, and she does the garden.*

8. **Health as psycho-social well-being**: some people defined health solely in terms of their mental state: *I think health is when you feel happy, When I’m happy I feel quite well.* (Baum, 2008, p.7).

There are multiple definitions and conceptualisations of health which vary over time and within different disciplines. However, “the context in which health is understood must remain central in order for policy and programs to be meaningful to different individuals and populations” (Keleher, MacDougall, & Murphy, 2007, p. 6). I see this as pivotal to the phenomenon of menopause. It may also be pivotal for other topics of health. Very importantly, a health model, which includes context is very relevant because context plays the most influential part in the women’s experience.

The cultural context and situation is important as it is the holding space for individuals as well as for policy design and development and is therefore implicated in the health of individuals.
As Keleher et al. (2007) state the understanding about health and its meaning must be considered in relationship to the individuals and the population, therefore the policies about the positive policies for menopausal and postmenopausal women that are in place regarding the health issue rather than the disease issue of menopause. Therefore the following discussion expands on these concepts of health and are relevant for the menopausal woman.

**Optimal Health**

The inclusion of body, mind, emotional, soul and spiritual aspects occurring within a context have also been identified in a model of health by Keleher et. al (2007) who suggest that “[o]ptimal health is a balance of physical, emotional /mental, social, and spiritual well-being” (p.6). Each one of these aspects needs to be addressed in relationship to the menopausal woman and her context, because health is underpinned by a philosophy of wholeness and healing, and all the components of a ‘whole’ model. Therefore “[h]ealth is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities” (WHO 1986, cited in Keleher et.al., 2007, p. 6).

When seen this way health also draws on, and is therefore connected to positive, social and personal resources required for healthy everyday living. According to Health Canada (2002) “[h]ealth is a capacity or resource which corresponds more to the notion of being able to pursue one’s goals, to acquire skills and education and to grow – and to be able to respond to life’s challenges and changes” (as cited in Keleher et.al., 2007, p. 6).

Resources are positives we need for our everyday lives and health is seen as a capacity, which includes the impulse to pursue one’s needs and goals in life. These can include good food, housing, employment, involvement, skills, education, and continual growth rather than diminishment. This statement should apply to both menopausal and ageing postmenopausal women as well as to younger people. Health seen here as a capacity or resource makes it more than just a state of being, but a process of achieving what one needs in the way of skills, education and so forth which will in turn, facilitate a more appropriate response to life’s challenges and times of change. Very importantly this particular definition of health also acknowledges changes and challenges.
Health and Growth for Menopausal Women

Relevant to the menopausal woman are the words to grow and to change. This is in direct opposition to Wilson and Utian’s advice that women should stay in their previous state and remain feminine forever and their insistence and prescription that estrogen therapy will ensure this. It is now very obvious how Wilson’s clarion call and his promotion of estrogen replacement therapy as the magic bullet obscures the potential for woman’s adult developmental process emerging from the change and shift in hormones and may prevent the woman from pursuing her own developmental life-cycle process as she may also believe HRT/HT is the remedy.

Change is inevitable for women and is part of women’s nature. This is evident in women’s menstrual cycle, as for many years prior to menopause it is all about the changes that occur every month of every year. Woman’s body is therefore geared for changes. Therefore, when the menstrual cycle ceases, I would say her body could be out of sync with herself if a new development stage and change is not occurring at the same time. To not change, but to remain feminine forever maybe just what she does not want, or need. Of course, every woman’s need will vary with her own personal history and present circumstances. And the degree of change that occurs as a result of menopause will vary with each individual woman, thereby in turn defining her uniqueness. This uniqueness in turn alerts us to the fact that her new goals, relevant skills or education required for her new growth, in response to the changes from reproductive to productive woman, and in an effort to respond to this adult developmental stage, will also vary between women. In other words, the period of time involved with the reduction in some hormones, together with the increased quantity gains in other hormones also varies with each woman. However it is this process, which in turn creates the stimulus for new development that will also vary between women. The impulse to change and to define and pursue one’s goals, would be defined personally by each woman, rather than being defined as a universal staying ‘feminine forever’ as prescribed by Wilson.

According to Sandra Thomas (1997, p. 259), “[w]e cannot operationalize health with tools that list physical symptoms. Health is in fact a rather subjective phenomenon: attempts to assess it by objective ratings have not been entirely satisfactory … as … health involves a dynamic interplay of physical, psychological, and social factors” (p.261). She further states:
Health is conceptualised within a holistic philosophical perspective that differs from the disease-orientated medical model. Although some laypersons and health care providers continue to view health narrowly as absence of disease or ability to perform social roles, newer models have been introduced e.g. Newman’s (1986) conceptualization of health as expanding consciousness; Seeman’s (1989) systems model of positive health), and there is greater acceptance of broader concepts of health emphasizing vitality and actualization (Smith 1983). Investigators have begun to realize that we cannot study health by focusing on disease (Thomas, 1997, p. 259).

Most importantly Thomas emphasises vitality and actualization as concepts of health. In addition, “psychosocial variables are not only salient to health but also potentially modifiable by women themselves – if they receive accurate information or counselling from their health care providers” (Thomas, 1997, p. 257). The word ‘potentially’ is important as each woman’s context varies and her situations are diverse, therefore the potential for modification and actualization varies between individuals.

Health therefore in this case can be seen as a response to the challenge that change calls forth and requests of each of us, whatever that maybe, for each woman. It is this major change in the reproductive system that calls us to a new mission beyond the ability to create human beings. For some women, this is about a new creation of herself. This process is also a classic death/life phenomenon, death to the reproductive (the potential ability to birth the human race) and birth of the new productive (rebirthing of self). This women’s creative experience, which changes her thinking and raises her consciousness (See Northrup chapter 4) is contributing to her life experience and providing new knowledge.

Aboriginal Perspective: An Optimal Model of Health for Menopause

Further, to ensure that whatever a woman needs to pursue, to enable her growth, is not seen as selfish by family and friends, which very often happens, I believe that the Australian Indigenous definition of health highlights the value of each individual achieving their full potential, as each person’s wellbeing, in turn, contributes to the community also. The National Aboriginal Health Strategy (1989) sets out and promotes a wholistic view of health as follows:
Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life (NAHS 1989 cited in Keleher et.al., 2007, p. 6).

This National Aboriginal Health Strategy definition of health, I believe also holds the main central premise regarding context, situation and environment. It acknowledges the importance of community. However, it does this very systemically, by acknowledging that the wholistic well being of the community is dependent on each individual achieving their full potential, and in turn each individual’s health and well being also brings about the well being of the community. In addition, the health of the individual depends on the social and political policies. This indicates the importance and necessity of wholistic aspects for both the community and the individual. This is especially true of ageing women as ageing postmenopausal women can contribute to family and community bringing with them a raised level of consciousness. They are no longer a liability to community, society and culture, but can be valuable contributors, especially when they are encouraged and supported in this significant process and appropriate healthy policies for menopause. This is what we have lost in our patriarchal culture, the valuable contributions of postmenopausal women.

Furthermore this aboriginal health model acknowledges the cyclical concept of life-death-life. This life-death-life phenomenon is the actual menopausal experience. I believe this can be expressed as the ‘woman dying to her old self and birthing a new self’. Her female processes follow this trend throughout her life, firstly dying to her virgin self and birthing a powerful reproductive self, and this death and life scenario continues every twenty-eight days and is the life of her reproductive system. Then at menopause the death of this system to life again, that is the new life that the loss of the reproductive system is the stimulus for. The woman has inner knowledge of the natural experience of dying and rebirth, life/death/ life cycles. This cycle is also integrated in the aboriginal definition of health.

And in 2005, the WHO stated, “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination” (cited in Keleher et.al., 2007, p. 6). This would mean in the case of menopause that postmenopausal women
are not discriminated against in the policy design and education programs for menopause and menopausal women by not allowing them or their perspectives and theories to define policy. Wisdom shared within the community of women would continue to expand as each generation of ageing women share with the next generation of women therefore building a large resource of women’s knowledge. Therefore the question we may now ask is how well does our community, society, culture support menopausal and postmenopausal women through this adult developmental process to achieve their full potential as valuable contributors to the community as educators to our generations of women to follow?

Health as Health-Education

The following by Judith Smith also confirms the necessity of individual growth toward self-realisation as necessary to health. However, she expands this to include health as health education. As she relates:

*Paideia* is a Greek word recurring frequently in the literature of ancient Greek philosophy. No single English word can translate it and retain the full, profound meaning of the Greek word. Therefore, the Greek term closely following the usage in Werner Jaeger’s great work *Paideia: The Ideals of Greek Culture*, has been retained. The word means, to begin with, art of civilization. It is an art whose objective is the development of that character and qualities of life in which the individual can attain the fullest realization of his potential. Further paideia seeks the expression of ideas of human nature and conduct that are central to this growth toward self-realization. It is education in its broadest sense: education as the cultivation of and communication of the ideas of perfection in mind and body. If health is conceived as comprehensive well-being, as the fullest development of a person’s abilities, character, and quality of life, then it may be understood as health-education (Smith, 1983, p. 2).

Here health is conceived as health education, thereby stating that what one learns about health or disease can contribute to or on the other hand detract from the health and disease of the individual. So the question might be: Have women learnt about the comprehensive, dynamic, transitional, positive wholistic model of menopause with all its valuable connections and interconnections and the implications of these or the reductionist pathological disease model
and have postmenopausal women been nominated as most suitably equipped to pass on the knowledge of the positive body, mind, soul, spirit phenomenon?

Health as Wholeness

Health has also been defined as ‘wholeness’ and according to Polakoff and Gregory (2002) in their study, this challenges care providers to bring an appreciation of this view to their understanding of women’s health. Drawing on De Wolf et al. (1998) they state, “[t]he linguistic origins of ‘health’ and ‘wholeness’ were compared. Both words have ‘hal or ‘haelth’ as their Old English root, meaning ‘well’ or ‘whole’” (Polakoff and Gregory, 2002, p.842).

Polakoff and Gregory state that the lay women in their research study “would use these two words interchangeably, and that, for them, the touchstone of ‘health’ was the sense of ‘wholeness’ from within” (2002, p. 842). In addition, “phrases such as ‘in harmony’, ‘body and mind in tune’, and ‘spirit-soul connection’ typified the responses to the question about the meaning of health for them” (2002, p. 842). Also, the women in Polakoff and Gregory’s study spoke of “working to understand the past from their present perspectives, and moving into the future with a sense of a unified self” (2002, p. 842).

Further, regarding health and wholeness, according to Polokoff and Gregory (2002) the following nursing theorists all espouse the notion of ‘health as wholeness’: “Rogers 1970, Levine 1973, Paterson & Zderad 1976, Johnson 1980, Pender 1990, Newman 1986, Parse 1987, Watson 1985, Hall 1996” (p.842). Drawing on the work of Woods et.al. (1998), Polokoff and Gregory conclude that these theorists “do not advocate the separation of mind, body and spirit. Rather they point to the intimate and inextricable ‘connectedness’ of the various dimensions of being human” and “collectively, the theorists cited above view health as a process of becoming whole” (2002, p. 842). The following example indicates the moral significance and importance of connectedness for women as they journey to wholeness.

Gilligan (1988) discusses the moral disposition of women to view situations and decision-making in context and consider the interrelationships of the people, values, beliefs, and intent of the parties involved. This notion of ‘connectedness’ also would seem to pervade women’s sense of their own health and the well-being of the others
with whom these women shared their lives and their movement to wholeness 

In summary, the women in Polakoff and Gregory’s study articulated health as follows:

- Health is as a moving to or striving for; it was a process of becoming.
- Health is a dynamic experience of everyday life, a movement in the direction of wholeness.
- Health is process of becoming, an unfolding, and a movement forward.
- Health is a process of becoming, not a reserve, a store or a commodity of exchange. Rather, resources such as food, shelter, clothing, social networks, and personal supports were the requisites to the movement to health (2002, pp.842-843).

Women’s Health

It is important here to consider a description specifically of ‘women’s health’. Mulligan (1983), views women’s health as:

... the field of practice, education and research that focuses on the physical, social-emotional and political-economical well-being of women, and encompasses women’s internal and external words of reality. It is a field that includes acknowledgement that a woman’s definition or description of her state of well-being or ill-being is of equal worth to the professional’s definition and description of her state …. Practice, education and research in the field has as its emphasis the attaining, retaining and regaining of health which encompasses and gives equal weight to both the objective and subjective worlds of women (p. 2).

To enable the objective and subjective worlds of women in relationship to women’s health, Andrist (1988) states that women-centred practice is the employed approach:

Women’s health is committed to health promotion, maintenance, and restoration of the whole person through women-centred practice. Women-centred implies both identification with and concern for women, taking into account the patriarchal society that has influenced women’s development (p. 66).
A women-centred approach as preference allows the space for any variables that are impacting on the woman and her state of illness or health from the woman’s own perspective, rather than from the patriarchal perspective. Andrist (1988) also reiterates a wholistic approach:

Women’s health incorporates interrelation phenomena of the entire being. The biological processes are viewed in concert with psychosocial processes and life-cycle variables. Health and illness are viewed as extremes on a continuum, with health viewed as the dominant state. Health or the integrity of spirit, mind and body can be compromised through dysfunction of the bio-psycho-social processes as well as the impingement of environmental influences (p. 68).

Philosophy of Women’s Health

Women’s Health indicates the integrity of spirit, mind and body. In describing a philosophy of women’s health Andrist (1988) states “[w]omen are integrated beings, and as such are considered in the context of their wholeness” (p. 68). Further, in relationship to teaching, practice and research, she states that:

Therefore graduate curricula in women’s health must have several purposes: first, to focus the curriculum on the whole person-woman, not solely on issues of reproduction; and second, to socialize students towards feminist practice, in the profession, in clinical practice, and in research (Andrist, 1988, p. 66).

Also regarding context, women’s health is “concerned about the overall well-being of women as women, their dis-eases and not just their diseases” (Stevenson 1977 cited in McBride, 1993, p. 315). McBride (1993) alludes to wholism and women’s ecological relationships when she states:

This is a view that moves women’s health away from genecology, which is synonymous more or less with women’s plumbing, to GYN-ecology, meaning a concern for the positive fit between the woman and her environment (Rosser, 1991). Women’s health generally requires that both health promotion activities and considerations of dysfunction be conceptualised in terms of the fit between person and
environment. Such conceptualisation requires that practice and research be sensitive to the relationships between and among genetic, physiological, psychosocial, economic, political cultural, generational, developmental, and life-style issues. To what extent is the individual’s behavior facilitated or constrained by contextual factors?” Do larger social conditions exist in which a woman can perform the activities of daily living in a way that maximizes her sense of well-being? Does the total environment make healthy choices the easy choices? (pp. 315-316).

In this sense then Women’s Health is concerned with more than, but also including, the specific functions of woman. It is necessary from women’s health philosophy and perspective to consider the individual woman’s context in which she is embedded and to give it equal consideration. McBride contends that “women’s health is greatly affected by women’s roles in society (citing O’Rourke 1984 in McBride, 1993, p. 316), which required specific behaviours, and that women’s health can be either constrained or promoted by contextual factors” (McBride, 1993, p. 316). Further, Andrist and MacPherson (2001) relate that the health of women is connected with their status. Astbury (2006) has also stated that women’s status is implicated in women’s mental health.

**Impediments to Health and Wholeness**

Polakoff and Gregory (2002) draw on notions related to the social determinants of health referring to the forces of poverty as impediments to wholeness and health. Of critical importance also is social isolation as “[s]ocial isolation affects three times as many women as men, and the effects of it on the nutrition and general well-being or mental health of women warrants further investigation” (Polakoff and Gregory, 2002, p. 843). This indicates a lack of connectedness. Therefore, either poverty or social isolation can affect other aspects of their health as indicated above. What is important to note here is that a lack of connectedness can be an impediment to wholeness and health. However, what is even more important is a lack of quality connectedness.

As noted previously, the lack of status has also been identified by Astbury (2006) as a factor in mental health issues for women. The inclusion of status together with the above definitions of health in turn amounts to a very inclusive broad conceptualization of health. Finally Polakoff and Gregory (2002) with regard to health and the practice of health care state:
Health is about all of the person. The argument that such a broad conceptualization of health makes health unmanageable and, therefore, useless must be more fully explored. A person is an indivisible whole to be cared for in the context of their life, which must be known, acknowledged, and accepted as it is. What this means for care providers is that we must listen for the whole story, see behaviours in the context in which they were born and are being lived, and acknowledge the circumstances and relationships that clients bring with them to care in their hearts. We must work as partners in planning for health (p.844).

Western scientific biomedical practices and health care systems do not work this way. Having explored health and wholeness from various perspectives, including those of lay people such as the women in Polakoff and Gregory’s (2002) study, it is to Capra that I now turn again. Capra has explored the presence, or loss, of health and wholeness within our Western scientific culture. This has implications for the phenomenon of menopause. Capra’s work is very informative as it indicates, illustrates and highlights a cultural omission in philosophical thinking and perspectives when reductionist practices reign supreme and continue to dominate. This is especially relevant for menopause, menopausal and postmenopausal women. It is appropriate here to explore a wholistic model in more depth.

WHOLISTIC MODEL

Health and Wholeness – The Need for Balance

Both Capra (1983) and Pelletier (1979) have noted that both words that are spelt differently, holistic and wholistic, have a derivation from the Greek ‘Holos’, which refers to considering all aspect of something which cannot be reduced to smaller parts. There is also a close connection between the words ‘health’ and ‘whole.’ According to Capra (1983, p. 248), “Both these words, as well as ‘hale,’ ‘heal,’ and holy,’ derive from the Old English root word hai, which means sound, whole, and healthy”. He further states:

Indeed, our experience of feeling healthy involves the feeling of physical, psychological and spiritual integrity, of a sense of balance among the various components of the organism and between the organism and its environment. This sense of integrity and balance has been lost in our culture (Capra, 1983, p. 248).
Not only has the sense of integrity and balance been lost due to the Western scientific, reductionist, mechanical Cartesian view being dominant, but also the integrity of the older postmenopausal woman and her ability to contribute to the culture regarding this specifically women’s issue. This has not been present and has therefore been lost to us all within the Cartesian model. The views, ideas and perspectives of postmenopausal women do not fit the classical framework of science. Any that did not “fit into the framework of classical science were disdained, if not ridiculed” (Capra, 1983, p. 248). This also highlights the imbalance as the result of the “one-sided” and “yang-orientated” (Capra, 1983, p. 248), value system. Capra describes this regarding health as:

The fragmented mechanistic worldview that has become all-pervasive, and the one-sided, sensate and ‘yang-oriented’ value system that is the basis of this worked view, have led to a profound cultural imbalance and have generated numerous symptoms of ill health” (Capra, 1983. pp. 348-9).

Yang defines male energies. In the case of menopause, menopause has been diagnosed as disease by male thinking. Yang, together with yin is “two archetypal poles”, based on “continuous cyclical fluctuation”, “underlying the fundamental rhythm of the universe” (Capra, 1983, p. 17). Further regarding cyclical flow and change, he states:

The Chinese philosophers saw reality, whose ultimate essence they called Tao, as a process of continual flow and change. In their view all phenomena we observe participate in this cosmic process and are thus intrinsically dynamic. The principal characteristic of the Tao is the cyclical nature of its ceaseless motion; all developments in nature –those in the physical world as well as those in the psychological and social realms – show cyclical patterns. The Chinese gave this idea of cyclical patterns a definite structure by introducing the polar opposites yin and yang, the two poles that set the limits for the cycles of change (Capra, 1983, p. 17).

It is both yin and yang energies that are required to enable cosmic balance through flow and change and healthy processes. In this perspective nothing is fixed, rather it is fluid. The changes of menopause cannot be described as disease as this is a concrete reductionist analytical diagnosis portrayed in our culture as the truth. The changes of menopause are also
present as a dynamic holistic process that flows between body and mind, a synthesis, connections with soul, spirit and context.

Capra tells us further that “[r]eductionism and holism, analysis and synthesis, are complementary approaches that, used in proper balance, help us obtain a deeper knowledge of life” (Capra, 1983, p. 288). It is therefore important to have a model that includes holism and reductionism, analysis and synthesis. It becomes obvious then that holistic approach is complementary to the reductionist approach and both should be considered equally. Where relevant, treating certain symptoms of menopause with drugs may be an option that women could choose. However, within the approach offered by Capra, they can also consider other options, which can be implemented concurrently.

**Holistic & Holism**

It has been noted that “[t]o a large extent, all systems of medicine except those based on modern Western science are almost exclusively based on a holistic concept integrating the body, the mind, and the total environment” (Rene Dubos 1979 cited in Di Stefano, 2006, p.59). Di Stefano puts the case that historically there was an acknowledgement of the relationship between the environment, health and disease as part of medicine in a variety of cultures. He further argues that “[e]astern systems of medicine similarly view the person as being in dynamic and constant interaction with environmental influences” (Di Stefano, 2006, p.56). Expanding on this notion he explains that there is a lack of agreed approaches to explore contexts holistically and that this, by necessity, calls for an individualised approach (Di Stefano, 2006). In a holistic way, complementary medicine utilizes a range of different modalities drawing on the resources of both the patient and the practitioner in order to achieve the best possible health (Di Stefano, 2006). To explain this further, the following explanation is instructive on a philosophy orientated towards wholes. Holism has been defined by Di Stefano as:

Holism: A philosophical position directed towards an understanding of wholes. The term as used by its originator Jan Smuts in the early 1920’s, incorporates the notion that the phenomenal world represents a unified expression of matter, mind and life. In relation to medicine, holism refers to an approach to treatment that is directed more
towards the whole person than towards the disease or pathology with which they have been diagnosed (Di Stefano, 2006, p. 175).

In the case of the menopausal woman then, holism’s approach would be towards the whole woman rather than the disease, there is no disease or pathology is present within the normal life cycle process of menopause.

The New Holism

Further, Di Stefano refers to the new holism which “reaffirms the universal notion that we are embedded beings and are influenced by ‘a vast array of interlinked factors’ that determine our state of health and our proneness to disease” (2006, p. 67). Even more than acknowledging our situation as embedded beings, “a willingness to tease out the influence of these other factors represents the essence of the holistic mindset” (2006, p. 67). And teasing it out further:

Holism operates at a number of levels. The individual cell is a finely balance system in constant interaction with its surroundings. The human body is similarly endowed and responds as a totality to both interior and exterior changes. Our embodied nature also participates intimately in both mental and spiritual dimensions in ways that are poorly understood. Beyond the body, we are part of relational networks, beginning with the family and extending on to our various workplace, social and cultural groupings (Di Stefano, 2006, p. 66).

Di Stefano (2006) concludes by recognising the benefits of knowledge provided by reductionist approaches but also recognises the limitations in providing a greater understanding of the inter-related internal cyclic states and social and environmental contexts and the effect this has on health. Finally Di Stefano offers a statement by a traditional Chinese medicine teacher.

The biomedical model as we know it in the West has been based on the Cartesian, the mechanistic approach to understanding, which by its very nature required a smaller and smaller look at things, and a look at things in isolation. This was based on a scientific model that felt that if you looked small enough you’d eventually find the
building blocks of the universe and then you'd understand how everything worked. 
So therefore in looking small, the big picture – the relationships between phenomena, 
the holistic nature of the universe – was omitted, let’s say not recognised (2006, p. 62).

There are then also close connections between the terms wholistic and holistic. It becomes 
obvious the philosophy of holism and wholes is valuable in assisting us to obtain a deeper 
knowledge of life. Also valuable in assisting us to obtain a deeper knowledge of menopausal 
women, when the above are all implicated in the socio-political culture in which we are 
embedded. However, this causes a tension. Capra has notified us that “[t]he basic tension is 
one between the parts and the whole” (Capra, 1997, p. 17).

THE REDUCTIONIST VIEW, MECHANISM, SELF- ORGANIZATION 
AS OPPOSITION TO THE CARTESIAN PARADIGM

Capra elaborates on the scientific reductionist view in contrast to the whole. The scientific 
reductionist model also has its roots in a particular paradigm of mechanics. This developed 
during the second half of the nineteenth century, when the newly perfected microscope led to 
many advances in biology and where “physio-chemical explanations of life” (Capra, 1997, p. 23) 
were being sought. In addition, the “triumphs of nineteenth century biology – cell theory, 
embryology, and microbiology – established the mechanistic conception of life as a firm 
dogma among biologists” (Capra, 1997, p. 24).

The tension between reductionism (mechanism) and holism also has a historical record. 
Capra (1996, p.18) asserts that the “tension between mechanism and holism has been a 
recurring theme throughout the history of biology” as a result of “the ancient dichotomy 
between substance (matter, structure, quantity) and form (pattern, order, quality)”. The 
words substance (matter) loss of hormones, and form (pattern) quality of energy changes, are 
relevant for the phenomenon of menopause.

Further, there is a need for understanding biological form as it “is inextricably linked to the 
understanding of metabolic and developmental processes” (Capra, 1997, p. 18). Therefore, 
the whole cannot be understood by examining the parts. According to Capra “[a]s the 
systems theorists would put it several decades later the whole is more than the sum of its
parts” (1997, p. 25). Organismic biologists maintain that the additional ingredient is the understanding of “organization”, or “organizing relations” (Capra, 1997, p. 25). Therefore in the case of menopause, interactions back and forth between the losses and gains of hormones support the emergence of the new self. However, what is also absolutely necessary for this to occur, is a context that educates, supports and encourages this philosophy as being a valuable one, and not to be ignored, marginalized, denied and deleted.

Historically, much strong opposition to the mechanistic Cartesian paradigm has occurred. Some of the first critics in the late eighteenth and nineteenth centuries were William Blake, Goethe, and Emmanuel Kant (Capra, 1997). In addition to Goethe’s pattern of relationships within an organized whole, or understanding organic form, Emmanuel Kant believed that “science could offer only mechanical explanations, but he affirmed that in areas where such explanations were inadequate, scientific knowledge needed to be supplemented by considering nature as being purposeful” (Capra, 1997, p. 21). When discussing the nature of living organisms, he argued, “that organisms, in contrast with machines, are self-reproducing, self-organizing wholes” (Capra, 1997, p. 21). According to Capra, Kant wrote, “[w]e must think of each part as an organ that produces the other parts (so that each reciprocally reproduces the other)… Because of this, (the organism) will be both an organized and self-organizing being” (Capra, 1997, p. 22). Therefore Kant was the first to use the term ‘self-organization’ to define the nature of living organisms (Capra, 1997).

However, what has occurred is that Descartes added extra weight to the reductionist, mechanistic view of the human body by also incorporating mathematical laws and analysis to support the mechanistic practices, and extended his philosophy to living organisms as machines, and therefore also included human beings as mindless machines. Contrary to this view, Capra argues for understanding nature in the light of systems theory. He admits the importance of biological structure but contends that “a fuller understanding of life will be achieved only by developing … a biology that sees an organism as a living system rather than a machine” (Capra, 1983, p. 286).

**Machines and Organisms**

There are differences between organisms and machines, in other words between human beings and machines. As explained by Capra (1983): machines are constructed, organisms
grow indicating that organisms are process oriented and their activities are influenced by processes. Organisms are guided by cyclical patterns of information known as feedback loops. The flexibility of living organisms is controlled by dynamic relations, not rigid mechanical structures and are self-organizing. The “non-linear interconnectedness of living organisms indicates that the conventional attempts of biomedical science to associate disease with single causes are highly problematic” (Capra, 1983, pp. 288-290). Implications for evolution are:

The two principal dynamic phenomena of self-organization are self-renewal – the ability of living systems continuously to renew and recycle their components while maintaining the integrity of their overall structure – and self-transcendence – the ability to reach out creatively beyond physical and mental boundaries in the processes of learning, development, and evolution (pp. 288-290).

Organismic thinking is significant for the phenomenon of menopause. As described by the postmenopausal women, feedback loops are evident as there is a cyclical pattern of information flowing between ovaries and brain, a self-organising and renewing system rather than a machine. This self-organization can occur more easily and readily, with greater understanding of the discomforts or disruptions, if the woman is told previously that this is a positive adult development and evolutionary process.

Women have been deprived of knowledge regarding the body/mind/soul/spirit interconnections together with the education which encourages and supports the changes that occur on these levels. She needs the knowledge of the organismic thinking, and processes. It now becomes evident that another way of thinking beyond that of Descartes may be advantageous to the health and healing of bodies, minds, souls and spirit.

**Organismic Thinking and Systems Thinking**

The following provides clear insights into a different way of thinking, systems thinking.

The ideas set forth by organismic biologists during the first half of the century helped to give birth to a new way of thinking – ‘systems thinking’ – in terms of connectedness, relationships, context. According to the systems view, the essential
properties of an organism, or living system, are properties of the whole, which none of the parts have. They arise from the interactions and relationships between the parts. These properties are destroyed when the system is dissected, either physically or theoretically, into isolated elements. Although we can discern individual parts in any system, these parts are not isolated, and the nature of the whole is always different from the mere sum of its parts (Capra, 1997, p. 29).

It is also interesting to note that the organismic worldview is the basis of Chinese thought (Capra.1997. p. 28.). However, “[t]he emergence of systems thinking was a profound revolution in the history of Western scientific thought” (Capra, 1997, p. 29) and has been developed and expanded over many years by scholars and researchers in the areas of science, both physical and natural, engineering, management, education and the creative arts (Ackoff, 2010; Checkland 1981, Checkland and Scholes, 1990; Seddon, 2008; Wilson, 1990). Capra contends that:

The great shock of twentieth-century science has been that systems cannot be understood by analysis. The properties of the parts are not intrinsic properties, but can be understood only within the context of the larger whole. Thus the relationship between the parts and the whole has been reversed. In the systems approach, the properties of the parts can be understood only from the organization of the whole. Accordingly, systems’ thinking does not concentrate on basic building-blocks but rather on basic principles of organization. Systems thinking are ‘contextual’, which is the opposite of analytical thinking. Analysis means taking something apart in order to understand it; systems thinking means putting it into the context of a larger whole…For the systems thinker, the relationships are primary (1997, p. 37).

The importance of relationships as primary is where I see the term interdependent as the crucial link and in need of acceptance rather than independence, which is the term our society has promoted as priority.

**Systems Thinking, Interconnectedness and Evolution**

The menopause and the menopausal transition is to be located within this model of systems thinking as connections and interconnections have emerged from the postmenopausal
women’s experiences, perspectives and theories as a dynamic function of the phenomenon. Katie Love’s (2008) following exploration on interconnectedness is informative as she discusses the connection between holism and interconnectedness.

Interconnectedness is often paired with the word harmonious, especially in the studies grounded in precepts of holism (Goddard 1955; Hingelman & Kenkel-Rossi, 1985). Holism is a smaller model of interconnectedness in that it is primarily an interconnected embodiment of the mind-body-spirit (Goddard 1995; Pesut 2003). Smith (2006) acknowledges this duality in the differentiation of a horizontal spirituality (internal and between people) and vertical spirituality (connecting a person to a higher power) (p. 261).

Significantly, “the complexity of interconnectedness finds a place in the science of physics, quantum mechanics, and chemistry” (Love, 2008, p. 259) and also features in some religious contexts and Native Spirituality. “It is also seen in the writings of many nursing studies and the theoretical frameworks of Florence Nightingale, Margaret Newman, Martha Rogers, and Jean Watson” (Love, 2008, p. 259). Further Love states:

The primary connotation of this word, not reflected in the linguistic sources, is the element of the metaphysical or spiritual underpinnings. Many religions (such as Buddhism and Sufism, thinkers (such as Buber and Jung), and cultures (such as Native American) all reflect a spiritual concept of interconnectedness (2008, p. 256).

However:

The scientific conceptualization of individuality has been dominant for the past 50 years. The goal of empirics has always been objectivity and separateness. However, the view of true independence changed with the increased understanding of quantum physics (Hawking 1987; Richard & Thuan, 2001). It is well known that on the quantum level the energies that make up all things interact and move in and out of observable existence (Love, 2008, p. 259).

Further, regarding evolution, Love relates, “that evolution occurs under the influence of connections” (2008, p. 259). This new way of thinking about evolution and evolving leads
us away from individuality as the highest level of human development, to recognise and honour the fact that no person lives in a vacuum and everybody is dependent in some form or another, more or less, on their context, other human beings, in some cases animals, the air we breathe, and the vegetables and foods that are produced by the earth. Nobody is totally independent as we are all interdependent. The quantum realization of shifting energies is particularly relevant for the menopausal shift. The energies that have previously supported the reproductive system now interact differently within the women, they serve to support an evolutionary process; these energies now serve to fire her brain to a different level.

In the case of menopause, this interdependence, this relationship between the body hormonal losses together with hormonal gains in the brain are very evident in the women’s narratives, indicating a system at work. In addition, the body/ mind connections also have connections with the soul and spirit. Once again they are in relationship and not separate from each other. Love also refers to the connection with spirit, “[t]he concept of interconnectedness is strongly associated with spirituality, and therefore the Chinn/Kramer method will help support this level of meaning in the concept” (2008, p. 256).

Here, Love is referring to Chinn & Kramer’s (1999) method of creating conceptual meaning. This is the method I have also employed to present a more wholistic paradigm of menopause. Chinn & Kramer’s model allows for integrations, inclusions and connections as it allows a space in which to place all levels of the phenomenon of menopause. Whilst I am exploring the phenomenon of menopause, Love is exploring the concept of interconnectedness. I concur with her following statement of interconnectedness and recommend it worthy of reflection as it enables us to see the deeper value of inclusion, underpinned and characterised by compassion. Love states that “[o]verall, the concept of interconnectedness is intended to be one that unifies, rather than divides, and is a mutual relationship and responsibility among all things. The essential characteristics of the concept reflect an integrated family of being and compassion” (Love, 2008, p. 255).

I believe that separateness and division does not indicate compassion. Further I believe that connections and relationships, not divisions, are the rich ground of experiences that underpin and stimulate developmental processes. In this way connections and relationships are dynamic. Capra has also referred to this in his reference to a systems approach, which he
states is similar to that of the new physics, as it also “emphasizes relationships rather than isolated entities and, like the systems view, perceives these relationships as being inherently dynamic” (1983, p. 287).

Importantly he states that “[s]ystems thinking is process thinking; form becomes associated with process, interrelation with interaction and opposites are unified through oscillation” (Capra, 1983, p. 288.) This is exactly what occurs in the menopausal phenomenon as related within the women’s texts.

**Interdependence and Self-Organisation**

As indicated above, inherent in systems is the integration of organising patterns of relationships, and that structures arise “from the interactions and interdependence of their parts. The activity of systems involves a process known as transaction – the simultaneous and mutually interdependent interaction between multiple components” (1983, p. 287). Further to this the pulling apart of systems into smaller unrelated components parts causes a destruction of the system itself. It is therefore no longer possible to recognise the system as a whole (Capra, 1983).

For this reason, the word ‘wholeness’ that I utilize regarding the paradigm of menopause embraces both the words holistic and ecological, as an ecological view of phenomenon emphasizes the “interrelatedness and interdependence of all phenomena and the dynamic nature of living systems” (Capra, 1984, p. 140). Menopause can be seen as part of the integrated whole characterised by the natural living system of the woman, rather than a reductionist event.

The internal interconnections that occur between the ovaries and the brain, the body/mind interactions, their internal interdependence, together with the increase in other hormones as stated by Northrup are to be included, not omitted but integrated as part of the whole system and acknowledged as positive and important for the woman. This would acknowledge, confirm and substantiate the woman as a ‘living system’, a ‘living organism’ which is ‘self-organising’ as referred to by Capra (1984, p. 140).
In addition, Capra tells us that systems are not confined to just individual organisms and their parts, (for example, the woman and her ovaries), but that the same systemic aspects can be found in any social system. He suggests that “[t]he same aspects of wholeness are exhibited by social systems such as a family or a community and by ecosystems that consist of a variety of organisms and inanimate matter in mutual interaction” (Capra 1984, p. 139).

What becomes evident here is that the culture, society, family, and therefore the community can be affected by a changing menopausal woman, and in turn, the changed postmenopausal woman can have an effect on the culture, society, family and community as a result of her raised level of consciousness. “Living systems, then, exhibit a stratified order, and there are interconnections and interdependencies between all systems levels, each level interacting and communicating with its total environment” (Capra, 1984, p. 140).

Within the woman too, the fluctuating hormones, some decreasing, some increasing, are changing the internal principles of organisation of the individual living organism.

In addition, as the woman changes, the context and social systems in which she is embedded may need to change to support her change, rather than to prevent her from changing. This can also include a wider social and cultural environment. Capra encapsulates this predicament well:

A living organism is a self-organizing system; that is, its order in structure and function is not imposed by the environment but is established by the system itself. Self-organizing systems exhibit a certain degree of autonomy; for example, independent of environmental influences they tend to establish their size according to internal principles of organization. But living systems are not isolated from their environment; on the contrary, they interact with it continually, although this interaction does not determine their organization (Capra, 1984, p. 140).

So it is the social and cultural systems which can either support or inhibit the dynamic adult developmental process of menopause that has the potential to occur within the woman. In the case of the menopausal woman, her social and cultural environment can indicate to her the need for HRT/HT, indicating a pathological state, which leaves many women confused and questioning what is really going on within her body/mind. Or alternatively her social
cultural environment can educate her in systems phenomenon where body/mind/soul/spirit are all involved in the phenomenon of menopause, occurring within her living social/cultural context. This knowledge has been omitted in the reductionist scientific diagnosis. However, postmenopausal women themselves have this knowledge but this knowledge has not been formally allowed to influence the design or development of policy for menopause, or educational programs and health promotion for women based on the wholistic knowledge that has emerged from these postmenopausal women’s narratives.

Very often, the woman’s new thinking, this change in consciousness will be different from the patriarchal thinking she has inherited from her social and cultural conditioning and socialization and education within a patriarchal system. This new thinking comes from a totally female place of being, from a place of being female.

**Linkages**

More importantly, what is also occurring for the woman in their narratives is the interrelation and interaction between the opposites, the losses and gains. What is most important here is not quantity measurements as such but the quality of the interconnectivity between the opposites and the qualities and strengths that are emerging and can emerge as a result of the positive changes, in this case, the gains in hormones. To put this in another way, it is focus on the linkages that are important.

Psychiatrist, Koeske, (1982) states the need for interdisciplinary research. She uses the term linkages as she states “[g]reater attention needs to be paid to the complexity of linkages that are possible between the various sets of oppositional categories (p.14). Koeske (1982) goes on to emphasise that “[m]ore explicit acknowledgment needs to be made of the uncertainties inherent in any linkage between systems of concepts and their operational translations” (p.14).

It is also this research focus on linkages that I believe is the most ethical stance, as one power does not stand over the other; there are no hierarchical levels, just interactions back and forth. I believe that this process is what occurs in menopause, and this organizational process supports the emergence of the new self. However, what is also absolutely necessary for this
to occur is a context, which educates, supports and encourages this philosophy as being a valuable one, and one that is not ignored, marginalized, denied and deleted.

**Summary and the Value of Systems Thinking and Theory**

Capra’s words regarding systems are indicative of what I believe actually occurs in the women herself. “Systems are intrinsically dynamic. Their forms are not rigid structures but are flexible yet stable manifestations of underlying processes. Systems thinking is process thinking; form becomes associated with process, interrelation with interaction, and opposites are unified through oscillation” (Capra 1984, p. 140). It is therefore the systems view as the appropriate paradigm in which to place menopause and the menopausal woman. A paradigm shift from a scientific reductionist view to the systems view is most appropriate here. The systems view is also a wholistic view. It also supports the significance of the role of the opposites in the hormones, both the losses and the gains, and the interconnections between body/mind. A systems view acknowledges “basic principles of organization” (Capra, 1984, 139). Organizing patterns of relationships and the integration of wholes are irreducible.

What is critical here regarding menopause and the menopausal woman is to ask what environment, what cultural policy, what educational program, what health care strategy and health promotion process based on a systems view will be most conducive to assist the woman in her new adult developmental process and support her new thinking? In other words, assist her evolutionary development. Or where in the curriculum is health taught from a systems perspective? Where can women learn the alternative to the reductionist model of disease and HRT/HT? This model continues to rule as the dominant paradigm and episteme of our time, thereby bringing equity and therefore balance back to the limited pathological diagnosis.

It is here that attention to alternatives to HRT/HT is appropriate to consider as systems theory also provides a suitable framework in which to include unconventional therapies, complementary and alternative medicine (CAM) and patient centred rather than disease orientation interventions.

Systems theory provides a rational conceptual framework within which to evaluate CAM systems, integrative medicine, and patient - rather than disease-orientated
clinical research. … Systems theory and systems science involve the study of the whole as a whole. … That is, a complex system such as a human being is one whose properties are not fully explained by an understanding of its components parts, (organs, cells, molecules) … a person is also a dynamic system in that he or she evolves over time … (Bell, Caspi, et al., 2002, p. 136).

Consideration of various unconventional and CAM therapies can provide more wholistic support therapies upon which the menopausal and postmenopausal woman may wish to draw. Historically unconventional therapies have been ignored or marginalised within the biomedical system. Further considerations have been proposed by Gray in an attempt to classify and give unconventional therapies a place from which he considers they can be viewed. These are the Biomedical, the Alternative, the Progressive and the Postmodern.

**CONTRARY VIEWPOINTS - COMPLEMENTARY & ALTERNATIVE MEDICINES (CAM) AND UNCONVENTIONAL THERAPIES**

“Science has always been – and should be – a battleground for contending views on what is true. Because of the close connection between knowledge and power, however the risk is always present that those who command the dominant theories or ideologies will rely on their positions of influence to overcome those who oppose them. It is important that those who treasure tolerance and the value of open, unfettered discourse remain sensitive to these risks and – even when they personally disagree – to protect and foster the expression of contrary viewpoints” (Komesaroff, Moore & Kerridge, 2012, p.82).

Contrary viewpoints follow as two authors Gray and Tataryn attempt to classify perspectives and paradigms of health, CAM and unconventional therapies. Firstly, I refer to Gray’s article.

**Four Perspectives on Unconventional Therapies**

Gray (1998) in his article ‘Four perspectives on unconventional therapies’, defines unconventional therapies as “specific therapies which are not standard within mainstream medicine” (Gray 1998, p.56). As HRT/HT has been the standard intervention for menopause, it could be said that any other therapy when applied to menopausal women would be unconventional.

According to Gray (1998), unconventional therapies are no longer ignored and marginalized, as consumers increasingly turn to them to complement or replace traditional biomedical
practices. Research findings “have shown that better educated, more privileged people are most likely to investigate and use unconventional therapies” (Eisenberg et. al., 1993; Cassileth et. al., 1984 cited in Gray, 1998, pp. 58-59). Acknowledging that unconventional therapies is a broad definition, Gray (1998) identifies and characterizes four perspectives relevant to consideration of unconventional therapies.

Gray names these as the ‘biomedical’ first and the ‘alternative’ as the second. He also identifies these two as “contrasting world views on the nature of health and illness” (1998, p. 57). Thirdly the ‘progressive’ is the one that attempts to bridge the historic rift between first and second. The final perspective is ‘postmodernism’. Postmodernism too “is a world view, although one which has been rarely applied directly to a consideration of health practices. It provides a broad context for considering the tensions between the first three perspectives as they relate to unconventional therapies” (Gray 1998, p. 57). Gray (1998) also gives an extensive explanation of each perspective. I refer briefly to these perspectives.

**Gray’s Biomedical Perspective**

According to Gray, biomedicine is a product of western culture and draws on some dominant western philosophical traditions only, firmly rooted in a scientific tradition which sees a particular kind of research, that of empiricism, where “the randomized clinical trial has become the ‘gold standard’ of biomedical research …” and “eclipsing the importance of clinical observation in charting medical progress” (Gray, 1998, p. 58). Biomedicine is a “modernist project, characterized by the defining features of grand narrative, belief in progress, and valuing of reason, science and technology” (p. 57). The following are assumptions which permeate biomedicine:

1. That the natural order is autonomous from human consciousness, culture, morality, psychology and the supernatural;
2. That truth or reality resides in the accurate explanation of material (as opposed to spiritual, psychological or political) reality;
3. That the individual is the social unit of primary importance (as opposed to society);
4. That a dualistic framework (e.g. mind/body) is most appropriate for describing reality (Gordon, 1988a; Kirmayer, 1988 cited in Gray 1998, p. 57).

The fourth point of the biomedicine assumptions confirms Descarte’s method of body/mind split as the ruling Western scientific philosophical theory as noted previously in this thesis. It
is the method that underpins the biomedical process providing biomedicine with its power by providing one metanarrative of universal truth by deleting any other reality. The biomedicine perspective based on scientific methods, does not consider a social model as relevant, does not support a biopsychosocial model as the focus is a disease focus.

In addition, “[p]roponents of biomedicine have historically been antagonistic towards unconventional therapies, characteristically dismissing them as variations of quackery” (Gray, 1998, p. 58).

Gray’s Alternative Perspective

The alternative perspective can extend discussion of treatments to include a range of other possibilities beyond those prescribed by biomedicine only and “many unconventional therapies are rooted in either oriental philosophies or models of health and illness …” (Gray 1998, p.60). This perspective also includes “[a] variety of systemic physical approaches, such as diet modification and use of herbs, maybe seen as complementing, or for a few, replacing disease-focused interventions” (p. 60). Significantly:

Interventions at the social, psychological and spiritual level are often also thought to have importance. In total, this describes the biopsychosocial model, which sees healing as well as curing as an appropriate focus for intervention. Biopsychosocial medicine is concerned with the physiological processes of curing but also with the human experience of whatever is physically, mentally, emotionally, and spiritually possible in the face of illness, which is healing (Lerner 1994 as cited in Gray, 1998, p. 60).

Also with the alternative perspective another common assumption is that “disease processes are symptomatic of underlying systemic issues” (Cassileth et.al., 1984, as cited in Gray 1998, p.61) and the “associated belief that that there are strong, natural healing mechanisms within the body, and that healing has as much to do with activating these as it does with specific attacks on disease processes” (Gray, 1998, p.61).
In addition, the alternative perspective claims that empiric testing is not appropriate for unconventional therapies as the individual’s differences need to be accounted for and this cannot be done empirically.

Another feature of the alternative perspective is a strong critique of biomedicine. One aspect of this critique applies to the domain of research. There is often discomfort among proponents of the alternative approach with biomedical researchers’ attempts to isolate the impact of individual factors from all other factors. This practice violates the belief of many unconventional practitioners that combine health care interventions provides optimal effect (Gray, 1998, p. 61).

In addition:

They typically believe that healing is an individual matter with unique as well as common aspects. Thus, a randomized controlled study can only provide information about a place to start in treatment, which will often need to be modified to match individual circumstances (Gray, 1998, p. 61).

Gray defines the difference between the biomedical and alternative views. As he states “[t]he essence of these difference is that biomedicine sees the role of physician-scientist as that of technician applying skills to physiological problems, while the biopsychosocial approach explicitly includes the psychological, social, and (sometimes) spiritual context in its understanding and treatment of physiological problems” (Lerner, 1994, as cited in Gray 1998, p. 57).

**Gray’s Progressive Perspective**

Progressive proponents believe in an even handedness approach to both the above perspectives and advocate for extending (as opposed to blocking) the application of research methods, and even research funding, to the alternative domain. However they suggest that “both biomedical and alternative perspectives are also strongly characterized by assumptions about the nature of health and illness, while proponents of the progressive perspective deliberately subjugate such beliefs to the crucible of empirical testing”… therefore, “biomedical forces continue to control health research and practice” (Gray, 1998, p. 64).
Therefore “relevant to the viability of the progressive approach at a more fundamental level is its exclusive reliance on scientific data” (Gray, 1998, p. 65). “[B]y virtue of this focus, other possible value bases for decisions, such as principled beliefs, emotions, or intuitions – get ignored, dismissed, or at the very least minimized … [because] … empiricists (progressive or otherwise) tend to ignore the ways in which values inevitably come into play … [and] … questions about how findings get interpreted and about what gets left out when truth is conceived in quantifiable, experimental terms” (Gray, 1998, p. 65).

Furthermore, “the current popularity of models which attempt to integrate numerically various values into mathematical formulae to guide decision-making are evidence of how empiricism shapes and controls values through methodology” (Cassidy 1995 cited in Gray, 1998, p. 65). The progressive perspective, as Gray (1998) argues, “with its reliance on empiricism”, is value laden. There is a fundamental belief in objectivity and “how its methods come to define reality” (p.65). Finally, “[r]eliance on empiricism can also lead to loss of hope for seriously ill persons, when evidence fails to support any particular course of action to make a positive difference” (Gray, 1998, p. 66).

**Gray’s Postmodern Perspective**

Gray commences this perspective by stating its relationship to modernism. Where:

modernism has been characterized by a belief in ongoing progress by virtue of continued refinement of all aspect of society under the guidance of reason, science and technology, … postmodernism includes a historical shifting away from absolute faith in science, reason and technology, an unravelling of the unifying assumptions of meta-narratives and a ‘deconstructing’ of linear models of progress (Gray 1998, pp. 66-67).

Postmodernism has been covered previously in this thesis so I will not refer to Gray’s presentation. However, his following points are very relevant once again to menopause.

Postmodern means multiple perspectives, and “proponents have been particularly concerned with encouraging voices often silenced by dominant discourses” (Gray, 1998, p. 68). These proponents are affirmative postmodernists. Gray’s words reinforce my stance previously stated in this thesis that the affirmative postmodern stance is to encourage “the postmodern
individual (and society) to take positions and make decisions, while acknowledging that these will ultimately be value-based” (1998, p. 69). Therefore “with an understanding of the different perspective, individuals may feel less overwhelmed by any one version of reality, and may be better able to proceed to match their own values to the decisions they must make about unconventional therapies” (Gray 1998, p. 70).

Further, Gray (1998) argues that:

Postmodernists argue that all perspectives are value-based and socially constructed, and that no one perspective will have all the truth about health practices, or anything else. They encourage the articulation of multiple perspectives as a basis for fully informed decision-making, with the individual person as final arbitrator … For patients to acknowledge that illness has many faces, and that the biomedical perspective is only one of these, provides them with a creative space from which they may more fully participate in the task of healing (p.70-71).

Gray’s above statement makes it essential to explore further the unconventional therapies within the scope of healing rather than curing, as healing has relevance to menopause whereas curing has none, as there is no disease to be cured. It is within the individual client’s creative space where she can identify her individual need and explore possibilities to enable her to match her therapeutic interventions with her need.

**Tataryn’s Paradigms of Health and Disease**

Tataryn in his article *Paradigms of Health and Disease: A Framework for Classifying and Understanding Complementary and Alternative Medicine* (2002) categorizes complementary and alternative medicines (CAM) and the many modalities to be considered as well as biomedical, (allopathic) medicine. Gray (1998) in his article refers to unconventional therapies. Tataryn believes that whilst Gray’s (1998) system organised under the four perspectives discussed above, provides an insightful means of classifying the beliefs of people toward health and illness and the treatment of disease, “this system does not transfer readily as a framework for classifying CAM modalities per se” (2002, p. 879). Whilst this is so, Gray’s article is valuable as it does alert us to what Komesaroff et.al (2012) refers to at the beginning of this section.
Tataryn (2002) designed a framework that encompasses what he calls the four paradigms; they are the body paradigm, the mind-body, the body-energy and the body-spirit paradigm. His Table 2, *Four Paradigms of Heath and Disease: Classifying Common Therapies*, (2002, p.881) refers to his classification of modalities under these headings. I refer very briefly to his description under each heading and then follow on very briefly with a recommendation in relationship to these categories and also in relationship to a postmodern feminist perspective on therapies for menopause and postmenopausal women.

**Tataryn’s Body-Based Paradigm**

According to Tataryn, “body paradigm therapies are materially reductionist or exclusionist” (Engel 1977 cited in Tataryn, 2002, p. 881). In this paradigm there is a direct linear, “relationship between cause and effect that is … limited to physical mechanisms and principles … [and] … the interventions simply attempt to intervene with or manipulate the biochemistry in different ways” (p.882).

**Tataryn’s Mind-Body Paradigm**

This paradigm acknowledges the role that mind plays in health and illness. In his text Tataryn (2002) refers to a further two typed classification within this paradigm although he does not define these two on his table. The two classifications are the philosophical mind-body dualism assumption, and the mind-body unity assumption.

*Mind-Body Dualism Assumption:* In Tataryn’s opinion, the dualism or weak assumption of mind in the mind-body paradigm, is that the mind is indirectly causative, with mind as an interpretative organ, that pays attention to how the person will experience the pain and how much it will limit him or her, or how a person might react to the news of a potentially terminal disease; depression or fighting spirit. In addition, it is obvious that the mind can decided in choice of diet and lifestyle choices. “This position however, is not based on the inherent unity of mind and, thus, rests within the dualist position” (Tataryn, 2002, p.884).

*Mind-Body Unity Assumption:* Tataryn (2002) explains: “This assumption falls from the notion that the mind and body are not two separate entities but rather that each exists as a separate facet of an underlying entity, intimately and ultimately connected in their core” (p.884). Support for this explanation comes from a “recent amalgam of biologic and psychologic
Meditation is also listed under Body-mind paradigm. Considering meditation, Berliner and Salmon (1980) have noted that regarding holistic practices:

Most assume they are totalistic by stressing the unity of the body, mind, and spirit. However this ignores the larger social world outside the body from which much of disease originates. Meditation, for instance, can relieve the effects of stress on an individual, but it does not remove the stress source. When one stops meditating, the social stress is still there (p.144).

I believe for the menopausal woman temporary relief through meditation may be helpful, but any external social stress situations could continue to add to both her internal body and mind changes.

**Tataryn’s Body-Energy Paradigm**

According to Tataryn (2002):
CAM that share the assumptions of the energy paradigm toward health and illness presuppose that all life, indeed, the entire universe, exists via the balance, flow and interplay of subtle energies. These energies are known by different names in different traditions (e.g., qi, chi, prana, and life force) and refer to several different energies that are often not differentiated each other, although, within their respective traditions, the energies are quite distinct (p.884-5).

Within the body, any disruptions of chi or life-force energy, either in terms of flow or in terms of over-abundance or under-abundance will create an imbalance in the body and eventually lead to physical illness … Interventions are directed at re-establishing the energetic balance which facilitates the body’s ability to heal itself (Saucier, 1996 cited in Tataryn, 2002, p. 885).

Whilst Tataryn (2002) continues to describe some of the body-energy interventions, it is homeopathy that he describes as being initially dismissed by biomedicine (p.885)….however, “accumulation of outcome research regarding efficacy and effectiveness” (p. 885) is indicating its attraction of larger numbers of patients. Also according to Tataryn “[n]ew research and writing by theorists from a number of different disciplines (Malmivuo and Plonsey, 1995; Peterson, 1996; Syldona and Rein, 1999; Wirth and Cram, 1997) represent innovative and scientifically informed attempts to translate and understand the construct of ‘energy’ and its biologic concomitants within the body” (Tataryn 2002, p. 886). I believe this is particularly relevant for the phenomenon of menopause as the energy that originates in the brain is no longer required for the creation of new life. Therefore this unused energy moves from the ovaries, back again to the brain. Interestingly the hot flush is often experienced as heat rising to the upper part of the body, neck and head. In this respect Homeopathy is important.

**Tataryn’s Body-Spirit Paradigm**

Included within this paradigm, Tataryn (2002) lists some modalities that can be termed as new age therapies and also some religious ones. Both are important to people’s beliefs. Whilst all have a place within a postmodern sensibility, it is also possible to see spirit operating within a material universe, where the classification of spirit is beyond one definition. I believe it is the creative life-giving spirit that needs to be embraced here. For the menopausal
postmenopausal woman it may be the recreation of herself or some other transitional
development of self.

**RELEVANCE OF TATARYN’S PARADIGM FOR MENOPAUSE:
BODY-ENERGY AND HOMEOPATHY**

In consideration of Tataryn’s (2002) paradigms, I believe it is a suitable framework in which
to reflect upon. It is also possible with certain changes to make it initially relevant to
menopause and postmenopausal women. Importantly, I would suggest the word perspectives
rather than paradigms. In brief I would also recommend the following as the most appropriate
for menopause.

It is the Body-Energy paradigm that I believe is crucial for the menopausal woman,
particularly the inclusion of homeopathy as a supportive intervention to assist the woman with
the shifts that are occurring for her. The shifting hormonal energy system within the woman
is significant in the phenomenon of menopause, and homeopathic interventions address the
emotions and feeling states.

In addition, external positive social support, which will enable her to readdress the balance in
a form that meets her needs, thereby, reducing the stresses on her immune or endocrine
systems, which can occur if imbalances are left for too long. Homeopathy, within the body-
energy paradigm is a practice that acknowledges all levels of the environment, including the
levels of the social context and system, which can impact on one’s personhood. Homeopathy
considers these various levels when prescribing a particular form of individual homeopathic
intervention, particularly in relationship to the emotional reactions of the person to the
stresses of the external environmental levels. Vithoulkas in *The Science of Homeopathy*
(2005) refers to the various levels of environmental influences that can have an impact on
individuals and that people vary in their sensitivity to these environmental influences.
Vithoulkas (2005) goes into more detail regarding these environmental influences which is
helpful in highlighting the importance of the environment and therefore the context, including
the social and also family within which we are embedded and being influenced. In addition to
the internal stresses that can arise if energy balances are not brought in to play, any of these
external influences can cause additional stress to the woman, and increase her symptoms.
The homeopathic practitioner, unlike the biomedical practitioner, considers these influences when prescribing a remedy. It is for this reason I consider a homeopathic therapy as most appropriate for menopause. In considering these aspects, the homeopathic practitioner comes closest to the Social Model of Health in addressing the internal impact on the client, in relationship to the external social aspect. Whilst the homeopathic practitioner addresses the emotions and feeling states that arise as a result of the social situation it does not attempt to change the social. Therefore it does not directly address or act upon the external social problems that may be present for the woman.

Therefore, I believe that the homeopathic practitioner is a most useful initial consideration for menopause and menopausal women as according to Lockie 2006, homeopaths believe in a vital force that is instrumental in maintaining equilibrium and regulating self-healing capabilities of the body. Further, “[t]he vitalistic concept of science had existed for many years by the time Hahnemann was developing his theories. It claims that all living things possess a subtle energy beyond their physical and chemical states …” (Lockie, 2006, p. 18).

Whilst advocating homeopathy from my own experience, in other women’s situations homeopathy may not be the preferred therapy. The choice would need to come from the woman herself.

Acupuncture as a body-energy practice may also be very relevant and a choice for the menopausal and postmenopausal woman as it can assist in balancing energies. There is a “growing body of research on the efficacy of acupuncture (Peterson, 1996 cited in Tataryn, 2002, p. 886).

As noted by Komesaroff et.al (2012) it:

… is not to seek to suppress all approaches to health care which we cannot understand or with which we do not agree. Rather, it should be to establish a system of safeguards that minimise risk, while continuing to protect the rights of consumers to choose their own health care practices (p.82).

Finally I believe there is not enough knowledge available to women to know the strengths and weaknesses of each philosophy and practice to enable them to make informed choices. What
is required is the sharing of knowledge from a range of philosophical theories and various practitioners through the processes I have identified in Chapter Six. Postmenopausal women can be influential in sharing what is needed to enable women to gain more knowledge regarding complementary and alternative (CAM) and unconventional therapies.
CONCLUSION

Whilst Tataryn’s (2002) framework is comprehensive, it omits anthroposophical medicine, osteopathy and kinesiology. Also whilst comprehensive, I see this framework would need to be restructured to address the women’s health issue of menopause. As an initial critique, I would see the following placement changes of perspectives as more appropriate in relationship to the results from the postmenopausal women’s narratives in Chapter Four of this thesis.


The body, that is consideration of body interventions or biomedical interventions, is addressed first.

The body-energy should be addressed next. The therapies that are appropriate to the body/energy should be considered to enable the woman to identify and choose a practice and therapy that can assist with her energy shift. This will vary with each individual woman and therefore her individual choice of alternative practitioner may vary.

The body-mind therapies to be considered third as they will assist the woman to identify the changes in consciousness that are occurring for her.

The body-spirit is the result of what has emerged for the woman as a result of her new and raised consciousness due to the increase in hormones. This can be expressed creatively in various ways including new interests, endeavours, writings and artistic expression. These are some ways she can engage her re-creative energies in a new creativity, not someone else’s creativity, but her own. Christiane Northrup has also referred to her creative energy (2001) in Chapter Four of the thesis. Significantly, the words of Cavanaugh & Whitbourne are very much in line with my thinking regarding creativity for menopausal and postmenopausal women. “Creativity is the ability to innovate, to change the environment rather than merely adjust to it in a more passive sense” (Cavanaugh & Whitbourne, 1999, p. 228).
Re-creative now, no longer pro-creative. If these energies no longer required for pro-creation are not engaged in some new meaningful way the woman may continue to experience increased unpleasant symptoms.

Therefore, the body-energy paradigm appears as second between the body paradigm and the body-mind paradigm which is third. Also body-mind dualism is less relevant to menopause than body-mind unity. The following figure 5.1. is my representation of unconventional therapies and CAM in relationship to menopause.
Figure 5.1 My Perspective of CAM and Unconventional Therapies in Relationship to Menopause.

Also, regarding Gray’s perspectives, the third would be exchanged for an energy perspective, as this is the one that I have identified to sit between body (biomedical) and alternative (body/mind). I see Gray’s actual third perspective as not really useful or relevant to the phenomenon of menopause.

Even more relevant is the acknowledgement of the external forces that either support or ignore and deny the impact of the increase in hormones to the woman’s brain and the new energies emerging from this body/mind exchange and therefore, change.
Whilst acknowledging Tataryn’s (2002) paradigm and Gray’s (1998) unconventional therapies as very necessary and useful, I concur with Berliner and Salmon (1980) that “most holistic practices continue to exclude the external social world from their attempts at healing, failing to provide strategies for changing economic and social relations” (p. 143). Additionally, the most obvious reason why biologically determinist arguments have been so prevalent is “that they justify existing social organization” (Birke, 1992, p. 75). Further to this Bell et.al. (2002, p. 135) have argued that:

Valuing scientific evidence as a method to augment societal understanding of human life and health, integrative medicine recognizes that good medicine must always be based in good science that is inquiry driven and open to new paradigms … Yet evidence suggests that the medical establishment does not necessarily reciprocate an openness to new paradigms.

Bell et.al also suggest “that by adopting a world-view derived from complex systems theory in which the whole equals more than the sum of its parts, a new perspective for medicine and health care research emerges” (2002, p. 133).

It is my recommendation that a paradigm shift to a wholistic paradigm and a social model of health will be more valuable for the phenomenon of menopause. This wholistic framework including the biomedical, CAM and unconventional therapies, would enable a transformative model of health care for perimenopausal, menopausal and postmenopausal women.

PARADIGM SHIFT

I believe the most appropriate shift from a reductionist paradigm to a wholistic paradigm is the one required. Further, psychiatrist, Koeske, has recommended a paradigm shift also. She proposes that the new paradigm should be comprehensive, focus on the whole including biological, cultural and social systems and include “lay concepts as they provide additional and/or alternative perspectives on function and dysfunction which also need to be give consideration” (1982, p. 16).

A paradigm shift has also been proposed earlier by Edward E. Sampson. Sampson in his article published in 1978, Scientific Paradigms and Social Values: Wanted – A Scientific
Revolution refers to the need for “developing an equal-status partnership for an alternative conception of what is proper science (Sampson 1978, p. 1332). In this early publication, accordingly he states, “[w]e must change the existing model of our science”, so that “we may represent a wider choice of human values” (1978, p. 1332). This is because the approach to science affirms a “partial value perspective” (p. 1332) only. From a sociological and social anthropological perspective, he too is indicating the necessity of a paradigm shift. Sampson’s recommendation is a shift from Paradigm I to Paradigm II to enable a change in the existing model of our science. This too, I argue for. However, I employ different terms, those being reductionist paradigm to wholistic paradigm, as my concern is with the shift in medical and health paradigms specifically.

The Emerging Paradigm in Health-Related Research

Ratcliffe and Gonzalez-del-Valle (1988) in their article, discuss rigor in health-related research and they also refer to paradigms, and shed further light on the emergence of the new systems paradigm. They refer to “a new paradigm emerging from the work of Einstein and others that is beginning to vie with the Newtonian Paradigm” (1988, p. 363). The Newtonian Paradigm favours analysis, resulting in universal laws obtained through objective methods. The new emerging paradigm is called “the Systems Paradigm” (1988, p. 363). In applying this paradigm to health they identify the necessity for integration as discussed earlier, and go on to include expansionism and relativity. By expansionism Ratcliffe and Gonzalez-del-Valle (1988, p. 363) mean “that all problems are subsets of larger wholes”. While acknowledging that structurally “subproblems” are parts of a problem, the doctrine emphasises functionality that is the whole integrated system which is non-divisible. They further suggest that:

The integrative approach is thus involved in synthesis as well as analysis; instead of conceptualizing that which is to be explained (e.g., the practice of science) as an independent problem, it is conceived as an interdependent part of a larger system of problems, and is at least partially explained in terms of its functional role in that larger system. The integrative mode of thinking is thus complementary to the analytic mode, yet it is usually ignored in the research process because the conventional approach to conceptualization is based on the analytic mode of thinking (Ratcliffe and Gonzalez-del-Valle, 1988, pp. 363 - 364).
Chapter Five – Political Significance of Revelations from Women’s Texts

Drawing on Einstein and Heisenberg, Relativity is perceived by Ratcliffe and Gonzalez-del-Valle (1988) as a doctrine in which the laws and truths of science are determined contextually. Ratcliffe and Gonzalez-del-Valle (1988, p. 370), refer also to the WHO definition of health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity” They state further regarding this definition that:

This definition is a positive one in that its focus is health rather than its negative counterparts, disease and illness. Operationalizing this definition (to use it as a guide to action) requires first differentiating those social conditions that promote mental and physical health and longevity from those social conditions that generate disease, illness and premature death, and second, working at the level of society to maximize those conditions that promote health and minimize those that promote illness and disease. Those research scientists whose work is informed by this definition see health problems primarily as social problems, as consequences of the social-organizational structure within which populations groups are affected in similar ways … and which must be addressed through broad changes in social policy if health is to be improved. The health of society is emphasized; and disease and illnesses in individuals are deemphasized because they are seen as symptomatic of an unhealthy society, and hence potentially preventable. Research is therefore focussed on interrelationships between disease or illness in populations and their social contexts, which are the result of particular patterns of social policy (Ratcliffe and Gonzalez-del-Valle, 1988, p. 370).

The acknowledgment of social policy here as the control point of populations and their social contexts is not only important but critical as it indicates that the issuing health problem is not always only to be found within the individual, but also within the policy controlling that particular health issue. There is a relationship between the two.

**Relationships as Primary**

The need for relationships to be primary is also evidenced in the writing of Di Stefano, (2006) who suggests that work in the area of psychoneuroimmunology rejects “Cartesian dualism” (p. 56) and supports the integration of mind and body which can be experienced in unforeseen ways. Further quantum theory has alerted us to be able to think differently about matter
(things) in a more flexible way indicating a need to “accept the fact that the solid material objects of classical physics dissolve at the subatomic level into wavelike pattern of probabilities … of interconnections … [which] … are interconnections among other things” (Capra, 1997, p. 30).

Connections within the body (interconnections) have also been identified by other researchers. Capra reports Candace Pert and her colleagues have found that “molecular messengers interconnect three distinct systems – the nervous system, the immune system, and the endocrine system – into one single network” (1997, p. 274). Further “in the traditional view, these three systems are separate and serve different functions” (Capra, 1997, p. 275). Recent research on peptides refutes the traditional perspectives of systems separation and support the need to conceptualise systems as “forming a single psychosomatic network” (Capra, 1997, p. 275).

Therefore Utian’s statement that for gynaecologists their expertise is in the area between the belly button and the thighs confirms the limitations of one area of expertise as split off from other disciplines and therefore their diagnosis of disease is made from a very limited place of expertise which deprives women of a more wholistic description of the phenomenon. In addition, none of the other systems, the nervous system and the immune system are included but are indeed significant to the process. They are also neglected, marginalized and omitted in our dominant Western scientific paradigm of menopause. Traditionally these interrelationships are ignored.

Regarding ageing, the following from the frontiers in Neuroscience as a worthy reflection and caution for future research. Smith and Casadesus (2009), suggest that the sheer complexity of the brain as part of the nervous system means that a reductionist approach will limit the understanding of normal functioning. They present a case for a synergetic model, which is in line and in step with a systems model. In particular it is their following reference to menopause that is also most relevant.

To date, aging neurosciences research is divided across disciplines. The study of age-related molecular switches driving cellular processes from stem cells to mature neurons is, to some extent, studied separately from how the switches are genetically
determined, or the process in which environmental factors such as stress, sex-specific events such as menopause, nutrition or even climate affect the blueprints. In addition, the functional manifestations of aging encompassing cognitive, motor, and emotional age-related changes are often studied as separate entities. The challenge, therefore, is to unite the fields into closer approximation to allow a constructive input and open synergetic dialogue between these closely related research entities (Smith & Casadesus, 2009, p. 1).

What is of most importance here is their reference to the sex-specific event of menopause as affecting the blueprint and has influence beyond the physical body only. This confirms the need for research into gender equity issues, such as menopause.

**RELATIONSHIPS - SOCIAL MODEL OF HEALTH**

**Social Policy and the Need for a Social Model**

In addition to a paradigm shift from a reductionist paradigm to a wholistic paradigm, I am also recommending an alternative model of health for menopausal women to the biomedical model. I refer now to Broom (1991) as she directs us to the social model of health which has been reflected in Women’s health policy at both a state and national level and embedded in the new public health. This has been affirmed by the Australian Women’s Health Network and is “rooted in the same soil as the new public health” (Broom, 1991, p. 52). This is the most appropriate for this women’s health issue because it is also underpinned by the social determinants of health. Important determinants are implicated in this women’s health issue of menopause. These particular determinants of health will be addressed in following chapters.

Broom contrasts the social model of health with “technical medicine” (Broom, 1991, p. 52). With reference to the women’s health movement Broome states that the focus is on:

> the whole woman and her social environment and material circumstances, and adopts a more ‘holistic’ approach to health than the fragmentation fostered by contemporary specialist technical medicine …. [and] … recognises the relevance of social and economic factors to the cause and prevention of ill health, disability and premature mortality (Broom, 1991, p. 52).
The social organisation of the physical environment is recognised and illness is seen as an interactive process between individual and their environmental contexts. It stresses the fundamentally social character of the distribution of illness and injury, and the contribution of improved living conditions to the historical increase in longevity. Increasing health standards for all people involves an emphasis on resource allocation to prevention as well as treatment (Broom, 1991). Expanding further on the social model of health she suggests that it:

fits well with the notion that women’s illnesses are frequently either caused or made worse by the material, social and psychic circumstances of women’s lives. It opens the possibility of considering the cultural foundations of women’s bodily experiences, and hence the possibility of non-medical approaches to the management to and prevention of illness and the development of health. Within a social model of health, bodily experiences maybe understood as structured and organised not by the blind forces of brute ‘nature’ (e.g. germs) but by the social and political environments … within which people live. A social model does not claim that there are not infectious or injurious agents or physical defects. However it draws attention to the fact that such agents and defects are not shared equally or distributed randomly in the population (Broom, 1991, p. 52).

The social model of health and illness recognises that social and economic factors can be instrumental in causing and preventing ill health, disability and premature mortality. In other words, the context and its structure, including also the social and political environments, can be instrumental in defining who gets sick and when one gets sick. Depending on an unsupported environment, one may become ill, whereas another person when supported by the environment (social and political) may not succumb to the same illnesses. An example of this is referred to by Astbury (2006) when she notifies us that women’s status, or lack of women’s status, is implicated in women’s mental health issues (see page 286 of this thesis). Finally Broome draws attention to the fact that this conceptualisation is not new and proposes that “[t]he social model of health recognises that health problems and other social and economic inequities are interrelated, and that health cannot be restored, protected, or promoted if it is defined and approached as if it were simply biological” (1991, p.53).
Writing about women’s health, Broome (1991, p. 49) contends that “the social tends to be deflected by a kind of mind/body dichotomy that splits real bodily illness from psychosocial factors that are only ‘illness behaviour’, or conditions that are psychosomatic and hence imaginary”. And a final word from Broom who says “[a]ll illnesses (with the possible exception of outright malingering) are simultaneously both psychic/social and bodily. Hence, the dichotomy between the categories obscures rather than enlightens understanding” (1991, pp. 49-50). To ensure a more enlightened understanding occur for this women’s health issue of menopause, menopausal women and postmenopausal women, a social model of health is recommended urgently rather than a biomedical model.

Women’s Health and Feminist Spirituality

Regarding the field of women’s health, Mulligan’s wholistic picture of the field can inform us, as it connects and includes aspects, rather than splitting and dividing.

Women’s health is the field of practice, education and research that focuses on the physical, social-emotional and political-economical well-being of women, and encompasses women’s internal and external words of reality. It is a field that includes acknowledgment that a women’s definition or description of her state of well-being or ill-being is of equal worth to the professional’s definition and description of her state … Practice, education and research in the field has as its emphasis the attaining, retaining, and regaining of health which encompasses and give equal weight to both the objective and subjective worlds of women … (Mulligan, 1983, p. 2).

Giving equal weight to the subjective worlds of postmenopausal women’s narratives will enable ageing postmenopausal women to take their rightful place in policy design and development, educational programs and health promotion thereby adding to the limited reductionist knowledge. Only then can women’s spirituality be integrated into the design and development of policy for women. This is critical as “[f]eminist spirituality is based on awareness of the oneness of all living forms and of their cyclical rhythms of birth and death, thus reflecting an attitude toward life that is profoundly ecological” (Capra, 1983, p. 462).

Drawing on, Spretnak ‘s work regarding the contribution of the feminist movement Capra suggests that the movement “is also creating a new self-image for women, along with new
modes of thinking and a new system of values. Thus feminist spirituality will have a profound influence not only on religion, and philosophy but also on our social and political life” (1983, p.463). The cultural change brought about by the feminist movement is aimed at “a thorough redefinition of human nature, which will have the most profound effect on the further evolution our culture” (Capra, 1983, p. 463).

Of particular relevance to the phenomenon of menopause, is the necessity of postmenopausal women themselves and their experiences through their narratives, perspectives, experiences and theories, to be the designers and developers of health policies for menopausal women. This not only will assist, but also is essential to women’s evolutionary and adult developmental process. Their sense of wholistic processes through the interconnectedness of body and mind equip postmenopausal women more appropriately for this task. Under the culturally dominant paradigm of our time, the knowledge of this developmental process is what women have been deprived of, thereby stalling our evolutionary spiritual ageing process, and thereby depriving us and our society of our cultural status and the contribution of our wholistic wisdom. Interestingly, Capra has noted the following.

What we do know is that for the past three thousand years Western civilization and its precursors, as well as most other culture have been based on philosophical, social, and political systems “in which men – by force, direct pressure, or through ritual, tradition, law and language, customs, etiquette, education, and the division of labour – determine what part women shall or shall not play, and in which the female is everywhere, subsumed under the male” (Rich, 1977 cited in Capra, 1983, p.10-11).

When the woman with her own embodied knowledge is subsumed under dominant male biomedical knowledge, it deprives her and the society/ culture of a balanced impulse, evolutionary thinking, and an adult developmental process.

When discussing the adult developmental process of human beings, Capra offers a valuable contribution regarding this development. He states that the women’s movement, have questioned patriarchal authority. In addition, civil rights leaders have also done so. When questioning patriarchal authority, “others have proposed shifting the definition of ‘development’ from the development of industrial production and the distribution of material
goods to the development of human beings” (Henderson, 1980 cited in Capra, 1983, p. 464). This is a significant statement in line with my proposal. The process of development for the menopausal woman would come from individual postmenopausal women who have wholistic knowledge of movement through the life cycle developmental process which is occurring to enable the new balance from the hormonal changes affecting in the brain, thereby moving them to a new consciousness. This new consciousness very often requires new activities in the world for postmenopausal women.

**Ethical Consideration**

Capra elaborates on the dynamic biology of evolution within a new paradigm. He speaks about “a system in homeostasis – a state of dynamic balance characterized by multiple, interdependent fluctuations” (1983, p, 110). In situations of disturbance negative feedback loops maintain balance in the system by reducing the equilibrium deviation. He also speaks about the role of positive feedback loops in maintaining the deviation as a response to factors in the environment. New structural change is said to occur through fluctuations in the stability of systems.

Capra (1983, p. 110) argues that “the stability of living systems is never absolute … [and that] any system is always ready to transform itself, always ready to evolve”. He draws on the work of Prigogine and his collaborators, stating that this model of evolution has been “applied successfully to describe the evolution of various biological, social, and ecological systems” (1983, p. 111). In addition, the following foundational scholars may be of interest also, as they could present in more detail further discussion on the following perspectives beyond what I have considered as relevant to the phenomenon of menopause only: Prigogine (1997), Hayles (1991), Bateson (1979,2000) on complexity theory in science; Rapoport (1986), Ackoff’ (1963), Ackoff (1994), Checkland (1981), Churchman (1968) on systems theory; and Lovelock (1995, 2009), Maturana & Varela (1992), Bohm & Peat (2000) on wholism in science and health.

Differentiating between the new systems theory of evolution and the classical neo-Darwinian theory, Capra contends that for the classical theorists, evolution is viewed as an equilibrium state aimed at achieving environmental adaptation. However, in a systems approach, evolution occurs not by maintaining equilibrium but through the interaction of creative and
adaptive forces. The environment is evolving as well, and co-evolution of the organism occurs together with the environment. Finally Capra (1983) states “consideration of such mutual adaptation and co-evolution was neglected in the classical view, which has tended to concentrate on linear, sequential processes and to ignore translational phenomena that are mutually conditioning and going on simultaneously” (p. 311).

The Ethical issue I see here is the co-evolution of organism plus environment that is required to enable the evolution and adult development of the menopausal and postmenopausal individual woman. In this particular case the evolutionary development of the menopausal and postmenopausal ageing woman and a supportive context. A diagnosis of disease and medicalization as intervention, aimed at adaptation to remain at a previous physical state, does not support and educate for the evolutionary developmental impulse in the woman. A paradigm shift is required to include a new positive, wholistic model including a social and cultural environment (context), which supports the woman’s evolutionary development and is therefore co-evolutionary.

**SUMMARY**

What has emerged so far from this research is the adult developmental process involved for the woman, which has been overshadowed, rejected, marginalized, ignored and deleted in the biomedical model, and which requires more emphasis on wholistic processes. As an ageing postmenopausal women myself, I have knowledge, through my own acute experience of this menopausal transitional process together with my academic studies of what has been omitted and deleted in the biomedical model. This developmental process is important for the woman. I believe that the adult developmental process should be the focus for the next research project for menopausal and ageing postmenopausal woman. In addition, I believe we need to look to women themselves, to explore what the effect of brain changes and the increased hormones are for the woman as part of the menopausal transition and transformational process. The focus on the loss of hormones only and the risks and benefits of HRT/HT as defined by the biomedical model has been the focus of much research funding to date. Equal funding is required to enable more wholistic knowledge, and the implications of increasing hormones for women themselves, to emerge and enable an ethical balance to occur.
I now turn to the social model of health as I am proposing a paradigm shift from the scientific biomedical model to a social model as this is more congruent with the paradigm shift from a reductionist paradigm to a wholistic paradigm. In addition, I argue that the reductionist, pathological and limited disease diagnosis of the biomedical model is a gender equity issue. I further believe that it is within this social model of health that the rejected, marginalized, ignored and omitted wholistic process can be rescued, acknowledged and addressed more appropriately. I also believe that this women’s adult developmental process of body/mind/soul/spirit and the change in the women’s consciousness and her new adult developmental process can have a place within this model and can be addressed within this space more constructively, adequately and positively for the menopausal and the ageing postmenopausal woman. This is a gender, equity, human rights and social justice issue.

Figure 5.2 illustrates the paradigm shift from a reductionist to a wholistic paradigm.
Figure 5.2 Summary of the Paradigm Shift.

POLITICAL SIGNIFICANCE OF REVELATIONS FROM WOMEN’S TEXTS: WOMEN’S RIGHTS, SOCIAL JUSTICE AND THE NEED FOR A PARADIGM SHIFT

The research presented so far indicates, through my discourse analysis on biomedical texts, that this gender health issue is also an equity issue. The position is not only one of equity, but more specifically one of inequity, that is, of equity omission, as the dominant paradigm, has been birthed and instigated by scientific reductionist practices and has ignored or denied other paradigms or discourses, especially postmenopausal women’s voices. Therefore this calls for social and cultural change.

A different voice emerges from women’s narratives, one that is positive, dynamic and wholistic. A paradigm shift from a reductionist model to a wholistic model is necessary and
essential to enable the inclusion of postmenopausal women’s voices in policy design, health education and health promotion. This is a gender health issue.

I believe the paradigm shift will involve a move from a model of power-over to one of equity, inclusiveness, integration and power-with. Authors from various disciplines have also acknowledged the need for a similar shift to a multidisciplinary approach to the phenomenon of menopause. This paradigm shift requires the inclusion of postmenopausal women’s texts, their perspectives, theories, knowledge and philosophies to be acknowledged formally, and equally, together with the reductionist diagnosis of menopause as disease. The shift should be evident in all health policies, education programs and health promotion and all health disciplines. This paradigm underpinned by a wholistic philosophy, will therefore also be inclusive of the biomedical reductionist philosophy.

Inclusion and voice are essential to the phenomenon of menopause. The following World Health Organization (WHO Commission on social determinants of health, 2008) statement on Political Empowerment-Inclusion and Voice is relevant as it confirms the importance of other voices in decision-making and equitably distributed health. The document states:

A society concerned with better and more equitably distributed health is one that challenges unequal power relations through participation, ensuring all voices are heard and respected in decision-making that affects health equity. Being more inclusive requires social policies, laws, institutions, and programmes to protect human rights. It requires inclusion of individuals and groups to represent strongly and effectively their needs and interests in the development of policy. And it requires active civil society and social movements. It is clear that community or civil society action on health inequities cannot be separated from the responsibility of the state to guarantee a comprehensive set of rights and ensure the fair distribution of essential material and social goods among population groups (p. 165).

The inclusion of individual and groups of postmenopausal women’s perspectives, theories and voices, in decision-making and design of policy development at Government levels is necessary. In addition, there is a need for the inclusion in health educational programs on menopause, as well as the design and implementation of health promotion for menopause,
menopausal and postmenopausal women. This is necessary to ensure the fair distribution of essential material and social goods among population group, in particular midlife and ageing women.

Most importantly, it is a social model of health that I believe is the most appropriate for the phenomenon of menopause as it allows women’s contexts to be addressed, and it has connections with wholistic aspects. Consequently, a new more sustainable health model will emerge which has the potential to empower menopausal and postmenopausal women when menopause is addressed within the social determinants of health framework, focusing initially on the socials determinants of gender and equity. This is more likely to propose recommendations for a more positive, ethically sound and sustainable practice and policy.

According to the World Health Organization’s (WHO) Commission on Social Determinants of Health, Final Report:

> [T]here is the need to look at women’s issues in a holistic manner and to address them as part of overall societal and development concerns. It will not be possible to attain sustainable development without cementing the partnership of women and men in all aspects of life (2008, pp. 110-165).

Through scientific reductionist practices menopause has been diagnosed as a disease, an estrogen deficiency disease (Wilson, 1966), and an endocrinopathy (Utian, 1987) based on biomedical processes that in turn are underpinned by Descartes’ body/mind dualistic philosophy. These processes have all been designed by men.

If the cementation of the partnership of women and men is to be realized it will be necessary for postmenopausal women to define and develop policy, programs and health promotion as their experiences, perspectives, theories and philosophies present additional knowledge to the episteme of our time. The philosophies emerging from both men’s and women’s theories can enable a more appropriate balance of feminine and masculine principles to enable an equitable partnership of women and men.
Menopause as Gender Issue

Catherine MacKenzie (2007) notes that regarding gender, “policy-makers, researchers, and promoters commonly treat the terms sex and gender as though they are the same” (p. 107). When contrasting the two, sex defines male and females whereas gender, by contrast is a social construction and is therefore defined by social norms (p. 109). MacKenzie draws on Eveline & Bacchi (2005) when referring to the production of public policy as a site where gender roles and responsibilities are presumed as the norm stating:

Production of public policy is one of the sites where gender roles and responsibilities are allocated and reproduced as ‘the norm’. Health promotion workers and policy-makers need to be alert to ways in which they may be unintentionally contributing to the gendering process. For example, physical activity policies and programs that aim to address women’s role as unpaid carers by child care provision could instead (or in addition) advocate for the redistribution of caring responsibilities between women and men. Thus it is useful to attend to gender relations within sites such as policy production where gendering processes occur (pp. 107-108).

With regards to the above I believe the following example is relevant regarding menopause. The International Menopause Society’s Summary of the First IMS Global Summit on Menopause-Related Issues, March 29-30, 2008 (Pines, et al., 2008) held in Zurich was supported by unrestricted educational grants received from three pharmaceutical companies. Although the title of the IMS global summit refers to menopause-related issues, this publicly released report stresses the promotion of HRT/HT as the appropriate intervention. Their summit summary, and knowledge distribution, once again, is primarily and predominantly the result of a reductionist model. This Summit was supported by “unrestricted educational grants received from three pharmaceutical companies, Wyeth Pharmaceuticals, Bayer Schering Pharma and Novo Nordisk Femcare” (Pines et al., 2008, p. 4). This summit presents as a case of gender blindness. Further, the following points are made by MacKenzie (2007) “[i]n research and program planning use sex to mean biological distinctions (for example statistical differences) and gender to discuss social constructions and resultant power imbalances” (p. 108). Health promoters, researchers, and policy-makers, “be mindful of the ways in which you may be gendering the people who will be affected by the policies you produce” (p. 108). In other words, it would be fundamental and wise that health promoters,
health educators, researchers and policy makers be mindful and aware of gender blindness and to attend to gender equity within sites such as policy production, where gendering processes are occurring or may occur.

To correct this blindness it would be important that government funding be directed to women’s conferences and summits, organized, narrated and presented by postmenopausal women to enable more balanced wholistic models of health to emerge and develop, in addition to, and be inclusive of, the reductionist pharmaceutical models.

This research has indicated that the way menopause is constructed is a gender health issue. The wholistic, positive dynamic aspects and experiences of this normal life cycle noted and reported by these various postmenopausal women have been deleted in the biomedical reductionist model and have not been professionally and formally promoted to other women or to our society/culture. This is a matter of gender omission. This gender omission, menopause as a positive dynamic adult development process, together with the positive aspects, experiences and perspectives of this normal life cycle as noted and reported by women have been ignored and have not been formally promoted to other women, or to our society/culture.

Importantly, positive constructions of menopause should be considered best practice in all policies and programs. The non-recognition of menopause as a wholistic positive dynamic transition as part of the normal ageing life-course process and the construction of this transition as a scientific technical, reductionist biomedical process only, have the potential to adversely affect the long term health of older women. It is therefore not only a woman’s right, but also essential in the development of policy on this women’s issue, to have the perspectives of postmenopausal women included and integrated in policy design and development and educational programs. Consequently then, there is a need for integration of gender differences and perspectives, especially in the case of menopause and the menopausal woman. This is essential. It is important in relation to gender equity and as a matter of policy and good public health practice. This is also a gender health issue.

Very importantly, the need for an integration of gender differences and perspectives has been promoted by the World Health Organisation, together with the commitment to allocation of appropriate funding. The necessary commitment has been emphasized as the integration of a
gendered perspective in work plans, and budgeting, as well as technical aspects (WHO, 2002). In addition gender is a determinant of health.

According to Keleher (2004b):

Gender is a relational determinant of health because it alters the way we consider any of the social determinants of health, but the effectiveness of gender as a framework is dependent on how we understand it. Rather than seeing gender used as a political code for maintaining a focus on women, gender can be seen as being used selectively or comprehensively. A selective understanding of gendered health sees that it is a concept that represents analysis of men’s and women’s health, and of the differences between women’s and men’s health, in the patterns of use of general practitioners, in the uptake of health messages and personal health practices. The more comprehensive understanding of gendered health incorporates analysis of discrimination and its impact and of the embodiment of inequities of health whereby differences are largely social determined (p. 277).

The World Health Organization (2002) also states their will to “promote equity and equality between women and men, throughout the life course, and ensure that interventions do not promote inequitable gender role relations” (p. 2). This is particularly relevant for menopausal and postmenopausal women as menopause is a women’s reality within the life course.

Also what is omitted in a biomedical diagnosis, because this model focuses on internal reductionist procedures only, is the impact of the social determinants of a women’s context. According to the World Health Organization, gender is a social determinant of health. To address this gender issue, then the World Health Organization’s determinants of health are relevant, as they have described gender as a determinant of health within a social model of health. In addition the WHO contends that sustainable development depends on women and men working together on all levels in order to examine women’s issues in a wholistic way (WHO, 2008).

It makes good sense to integrate women’s theories, concerns, personal positive experiences as well as their negative experiences of the menopausal transition, as integral in the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres as described by the WHO. Women should be equally
responsible in defining their policies, especially when this is a women’s experience only. As asserted by Grosz (1990), “patriarchal philosophies are forced to accept their limits, to recognize that their specific methods and orientations cannot be universal” (p. 170). Women’s own knowledge is different, and in its disruption, can intersect and contribute to new knowledge of menopause, the menopausal and postmenopausal woman.

This gender health issue then is also an issue about inequity and equity. Importantly, we must also ensure that organisations develop the capacity to address gender. I refer now to the work of Helen Keleher as she has placed gender, equity and inequity together to be dealt with within a social model of health. It is her work that I draw on rather extensively as her writing on the social model of health, including the determinants of health, together with health promotion, is very appropriate to deal with the gender issue of menopause. This gender health issue is now explored within the realm of equity and inequity.

**Gender, Equity and Inequity**

Equity has been named as a determinant of health (Keleher, 2007a, 2007b). Importantly, Keleher in her work clearly defines equity and inequity as distinct from equality and inequality by drawing on the work of Kawachi, Subramanian & Almeida-Filho (2002) and states that “[i]nequality and equality are dimensional concepts that refer simply to measurable quantities” (2007b, p. 35). On the other hand, “[i]nequity and equity are political concepts because they express a moral commitment to social justice and human rights” (Keleher 2007b, p. 35). Regarding inequity in relationship to gender Keleher suggests that “[w]hen inequities and social and economic inequalities are beyond the control of individuals and communities, or are the result of inadequate distribution of material factors, discrimination, and gender or racial disparity, they are considered unfair and unjust” (Victoria et.al, 2003 cited in Keleher 2007a, p. 51).

Also specifically regarding gender equity and equality MacKenzie (2007) states that:

Gender equality denotes women having the same opportunities in life as men, including the ability to participate in the public sphere…[whereas]…Gender equity denotes the equivalence in life outcomes for women and men, recognising their different needs and interests, and requiring a redistribution of power and resources (p. 108).
Equally relevant and most important regarding gender is that inequitable gender role relations and the connection between gender and inequity are intimately chained. Regarding the conceptualisation of inequity Keleher (2004b) contends that it is “about unfairness and forms of injustice, and gender is a concept that embodies inequity. Therefore, gender is a concept that should be used visibly, responsibly and comprehensively, to recognize and actively tackle gendered health and social inequities” (p. 278).

Gender frameworks could enable a response that is more appropriated for women. Also according to Keleher, “gender as a determinant of health, refers to the inter-related dimensions of biological difference, psychological difference and social experience” (2004b, p. 277). This is especially true in the case of menopause as it is a phenomenon inclusive of all these inter-related dimensions that health promotion programs should address.

Therefore, in addition to referring only to biological or psychological differences between men and women, the responsibility for decision makers or advocates when talking about gender is to talk about it comprehensively. Account should be taken of the power position, the dominant biomedical paradigm of menopause that has shaped the experience of menopause in our social, cultural, and economic environment and deprived women of their opportunities in defining and developing policy, education programs and health promotion on this wholistic embodied experience that only women experience. The implication of this is that a more comprehensive understanding of menopause as a gendered health issue that should “incorporate analysis of discrimination” (Keleher 2004b, p. 277). Keleher further states:

There is a responsibility for anyone, whether decision-makers or advocates, when talking about gender, not to use it selectively, i.e. to only mean biological or psychological difference, but to use it comprehensively – to recognize and take responsibility for the stereotypes, societal expectations, discriminations, power relationships and social and sexual norms that shape so much of women’s experience, and the social, cultural and economic environment that shape women’s opportunities” (Keleher, 2004b, pp. 277-278).
In our culture, postmenopausal women have been discriminated against through power relations in development of policy design and educational programs for menopause and menopausal women, as formally postmenopausal women’s own theories, experiences and philosophies have not been included. They are not only invisible in formal professional education, policy design and health promotion, but they do not exist at all.

**Discrimination and Disempowerment**

In addition, the inequities discussed above regarding menopause, need addressing as these omissions have not only formally deprived us of postmenopausal women’s knowledge, but have also disempowered ageing women themselves. According to Keleher (2004b) “[a]pproaches that are directed at social change and policy are needed to ensure gender is not rendered an invisible determinant”. Inequities and “subordinate positions of power and lower levels of decision-making, whether in political arena, workplaces or within families’ are addressed” (p. 278).

This social, cultural and economic environment of the dominant paradigm together with discriminations and power relationships are responsible for the inequities regarding menopause and the menopausal woman. It has also deprived and robbed postmenopausal women of their opportunities, this being an obstacle that prevents postmenopausal women from reaching their full potential, by restricting their participation and consequently, disempowering women.

Further it prevents postmenopausal women, women who hold the embodied experience of the body/mind connection and the accompanying wisdom of the phenomenon of menopause, from contributing to the discourse of, and as ageing women. This renders them, together with this gendered knowledge formally invisible and ignored. This contributes to the lack of status for postmenopausal women and a situation where they are undervalued. In various other cultures, the ageing postmenopausal woman has value and is acknowledged with special status and empowerment. In our culture, it is a situation of disempowerment. Regarding Empowerment – Inclusion & Voice the WHO (2008) states that “[u]nderpinning the realization of right and fair participation and inclusion in decision-making and action that affects health and health equity are transparent accountable and participative political and legal systems that build on and reinforce authentic participation” (p.158).
This strongly indicates the need for empowerment for menopausal and postmenopausal women. To address all these issues, the following message to health professionals is necessary:

In order to tackle inequities, health professionals need to take an active role in shaping actions to mitigate the adverse effects of the determinants of health. This means that all health professionals should have the capacity to integrate actions for health into their practice. It means that all health professionals should understand health equity and develop competencies of how to enable, advocate, and mediate to ensure that their clients are receiving not just the best health care but are also being given the best health choices. These are issues of justice, equity, and empowerment (Keleher & Murphy, 2004, p. 6).

Further, Keleher, MacDougall & Murphy (2007) assert, regarding the social determinants of health, and with regards to health promotion, that health promotion is limited by a biomedical or behaviourist orientation only. They emphasise the value of a social determinants approach in contributing to a greater understanding, therefore augmenting biomedical and behaviourist perspectives. In this particular case of menopause, and for menopausal and postmenopausal women, the relevant social determinants are gender and equity. However, Smith (2009) refers to the health promotion situation in Australia saying it "is often identified as a central goal in the mission statements of departments of health in Australia, yet funding for this area remains only a fraction of that directed towards the treatment of disease and injury (biomedical model of health)” (p. 109).

THE OTTAWA CHARTER, HOLISTIC PERSPECTIVE AND SYSTEMS THINKING
Importantly, Smith (2009) links health promotion to the Ottawa Charter, and advocates for a reorientation of the total health care systems from ill health “services to population health improvement, or from a total focus on biomedical approaches to a more integrated approach taking up social and preventative models” (p. 119). Smith goes onto to identify the imbalance in funding for “health promotion and prevention, relative to treatment” (p. 111). According to Smith (2009), “empowerment of individuals and communities was positioned as central to the purpose of health promotion” (p. 108).
The Ottawa Charter for Health Promotion ("Ottawa Charter for Health Promotion," 1986) also articulated values that continue to guide health promotion priorities and practice as follows.

1. A holistic perspective was adopted that recognised the physical, mental and social dimensions of health, determined by diverse factors – (behavioural, social, cultural, environmental, economic, and political).

2. The goal of social justice was evident in the emphasis given to reducing differences in health status related to unequal access to societal resources and opportunities (Smith, 2009, p. 108).

The Ottawa Charter for Health Promotion taken from the First International Conference on Health Promotion 1986 draws attention to the importance of both individuals and groups to realize aspirations, meet needs and manage in an ever changing social, political and physical environment. In this context health becomes a resource focussed on well-being rather than a healthy life-style.

### Systems Thinking and Health Promotion

Keleher (2007b) goes on to recommend capacity-building as the work of health promotion and cites “‘the capacity for systems-thinking’ as a necessary attribute of competent practitioners” (p. 36). On this point she contends that other important elements of competent practitioners be skilful in evidence based practice and have knowledge on capacity-building in health promotion.

Systems’ thinking is implicit in a wholistic paradigm as connections and interconnections are fundamental to systems thinking. Wholistic connections have also emerged and been revealed in the postmenopausal women’s narratives, perspectives and theories of their experiences of menopause. Therefore systems’ thinking is appropriate for menopause as postmenopausal women’s experiences indicate that interconnections and connections are involved in the phenomenon. This confirms a social model of health, including systems thinking as more relevant and more appropriate for menopause, menopausal and postmenopausal women. Further according to Keleher (2007b) capacity-building and
empowerment are closely connected to community development approaches to health promotion, I will return to these again in the following chapter.

**Systems, Enabling Environments and Community Development**

The case for gender equity would be required to be included in policy development to highlight social and personal resources as significant. Social resources can affect health for better or worse. Consequently, it is therefore one’s social context that can either inhibit or enable better health. Context then is an enabling or inhibiting factor in health outcomes. Contexts can also be described as environments within the system.

Empowerment is an approach that helps people to understand and identify their own health or social issues and concerns, and gain the skills and confidence to take action to deal with them. Community empowerment works through the skills of community development and advocacy (Keleher, 2007b, p. 38).

Keleher (2007b) has suggested that two WHO charters, the Alma Ata Declaration of Primary Health Care (1978) and the Ottawa Charter of Health Promotion (1986) drew on Freire’s (1970) seminal work on community participation and empowerment to “provide the foundations for community development in health, drawing on seminal work on empowerment and participatory approaches to education and health development “ (p. 38).

And further:

Community development means there is an active involvement of people sharing in the issues that affect their lives, by drawing on existing human and material resources to enhance self-help and social support (WHO 1986). For many communities, social well-being needs to occur before health outcomes can be improved. This is because powerlessness, lack of opportunity, low income, and stress are key determinants of illness and disease. Empowerment, a sense of control, and hope are linked to better health, while loss of meaning or value in life underpins much self-destructive behaviour (Keleher, 2007b, p. 38).
Empowerment, health promotion, enabling environments and community development will all be addressed further in the next chapter as these concepts I believe, can empower and enable more fairness and equity in the process of achieving social justice for menopausal and postmenopausal women. When discussing health promotion MacKenzie (2007) argues that policy-makers must be aware that policy can be gendered and points out that, in this context social justice means “[f]airness and equity as a right for all in the outcomes of development, through processes of social transformation” (p. 109).

It is the words ‘social transformation’ that I think are very relevant and necessary for menopause, menopausal and postmenopausal women. It is essential that laws support the necessity for postmenopausal women to develop and define menopausal policies, professional formal educational programs and health promotion. I would suggest initially by professional postmenopausal women who, whilst having published their own experience of menopause, are over the age of fifty-five and are also aware of the diversity of women’s experiences.

**Health Promotion and Health Equity**

Keleher (2007b) has brought the concepts of equity and inequity to the fore and recommends that they “require some careful unpacking” (p. 35). The reframing of health promotion to one that is based on a determinants approach is preferable. According to Keleher “[h]ealth promotion from a determinants approach is based on ‘the values of social justice and equity’” (2007b, p. 35). She also draws out the political relevance of inequity and equity linking the concepts to social justice and human rights. The need for inclusion of social justice ethics and principles and also the principles of equity can be seen here as a need to tackle health inequities in policy design. Further, inequity can be related “to access to economic resources, race, gender, and health. The work of equity-focused health promotion is towards achieving social justice and equity through strong commitment to the prerequisites and determinants of health. Health equity is key concept for health promotion” (2007b, p. 35).

Whilst achieving social justice is possible through a strong commitment to the prerequisites and determinants of health, equally important to note and remember is that equity is a key concept for health promotion. In addition, and according to Keleher, equity approaches are required in health policy, health actions and research as this can enable the inequities to be brought forth therefore directing policy decisions, health education and health promotion to
eliminate inequities. In terms of equity therefore, “approaches in policy, health actions, and research are about making visible the sources and characteristics of inequity and actively taking policy decisions and programmatic actions directed at improving equity in health or in reducing or eliminating inequities in health “ (ISEqH 2005 cited in Keleher, 2007b, pp. 35-36).

In addition, Keleher states regarding the last point that “[t]hese are steps that any organization can take to ensure it is addressing inequities but surprisingly few actually do incorporate specific health equity steps into health promotion planning” (2007b, p. 36). For menopausal and postmenopausal women this needs to be addressed and changed.

This is especially relevant in the case of menopause, menopausal and postmenopausal women. It is of critical importance because “health promotion’s agenda is so much more than merely the ‘absence of disease’, because it is about opportunities and capacities” (Keleher, 2004b, p. 278). More importantly Keleher states “[b]ut in developing the capacity to tackle inequities, work must be targeted more if it is to be effective” (2004b, p. 278).

Social Justice – Reform Required

From all of the above it is very evident that it is women’s rights and also an issue of social justice that it is essential in the development of policy on this women’s issue, to have the perspectives of postmenopausal women included and integrated in policy design. According to the WHO Commission on the Social Determinants of Health, Final Report (2008), “[u]nderlying the structural drives of inequity in daily living…is the unequal distribution of power” (p. 155). In addition, this Final Report also states that “[o]ne of the most equitable and inclusive political reforms is that which addresses the marked global gender inequities. This requires the participation of women in policy and decision-making processes and will increase the probability of gender-sensitive planning and delivery” (p. 159).

The need for an integration of gender differences and perspectives has also been promoted strongly by the World Health Organization in their Gender Policy (2002), together with the commitment to allocation of appropriate funding. The necessary commitment has been emphasized as the integration of a gendered perspective in work plans, and budgeting, as well as technical aspects. And according to the WHO Commission on Social Determinants of Health, Final Report, “[g]ender inequities are socially governed and can be changed to
improve the health of millions of girls and women worldwide. Action includes ensuring that laws protect and promote gender equity and addressing gender biases in organisational structures and policies” (2008, p. 154).

In the case of menopause it is essential that laws support the necessity for postmenopausal women through their own menopausal experiences to develop and define menopausal policies. In addition educational programs and health promotion programs should be developed and designed by postmenopausal women. I would suggest initially by professional postmenopausal women who, whilst having published their own experiences of menopause, are also aware of the diversity of women’s experiences. The inclusion of women’s perspectives, through their own texts is important in relation to gender equity and as a matter of policy and good public health practice.

**Determinants Approach**

Therefore, the need for inclusion of social justice ethics and principles and therefore the principles of gender and equity, can be instrumental in challenging health inequities in policy design. To address this challenge, a reframing of health promotion is necessary. Whilst bringing the concepts of equity and inequity to the fore to deal with the inequities, Keleher recommends the reframing of health promotion to one that is based on a determinants approach. Drawing on the Health Promotion Forum of New Zealand (2004), Keleher (2007b) argues that:

> Health promotion from a determinants approach is founded on a values base of social justice and equity, and the need, therefore, for health promotion to tackle health and social inequities. Social justice is ‘a vision of society where rules are just and fair and resources are shared equitably among the members of the community, in the interests of the common good (p. 35).

Drawing on Reidpath (2004), Keleher & Murphy (2004) suggest the any factor that alters health in either a positive or negative way is a health determinant. Further, focusing on health determinants enhances the understanding of both individual and population health issues. It is therefore to the agenda of health promotion that I now turn as I believe it is most appropriate to address the phenomenon of menopause, the menopausal and postmenopausal women.
However it is to a proposal of health promotion from a determinants approach that I believe is critical to address menopause, the menopausal and postmenopausal woman.

Returning to the health determinant and political concepts of equity and inequity, the following points from Keleher (2007b, pp. 35-36) regarding equity and inequity are important:

Inequity can occur in relation to access to economic resources, race, gender and health… Health equity is a key concept for health promotion… Equity approaches in policy, health actions and research are about making visible the sources and characteristics of inequity and actively taking policy decisions and programmatic actions directed at improving equity in health or in reducing or eliminating inequities in health.

Reform in Action

Keleher’s (2004a) ideas regarding upstream empowering health promotion work, health care delivery and gender, include the contribution this approach has to participation and advocacy, direct social and policy change that is sustainable. These notions of empowerment indicate how changes can be made to enable postmenopausal women to have equal opportunity to develop policies, especially as menopause is a women’s experience. Postmenopausal women’s own knowledge is different; its disruption can intersect and contribute new knowledge, through women creating their meaning of menopause. Also regarding political empowerment:

Political empowerment for health and health equity require strengthening the fairness by which all groups in a society are included or represented in decision-making about how society operates, particularly in relation to its effect on health and health equity. Such fairness voice and inclusion depends on social structures, supported by the government, that mandate and ensure the rights of groups to be heard and to represent themselves – through, for example, legislation and institutional capacity – and on those structures, through which active participation can be realized. Beyond these, fairness depends on the growth of civil society organizations, networks, and movements and their progressive ability to challenge inequity and push for the
installation of equity – in general and in relation to health – in the centre of all existing and emerging political debates (WHO, 2008, p. 158).

In summary, the employment of postmenopausal women in policy design, health education and health promotion in all women’s health projects regarding menopause is a gender health equity issue. In addition, it is a path to equity, by correcting and deleting inequity regarding menopause, menopausal and postmenopausal women. I believe it is also a path to healthier postmenopausal, that is, ageing women.

Finally, both gender and equity are social determinants of health. Regarding social determinants of health, the Commission (10.3) recommends that “[t]he monitoring of social determinants and health equity indicators be institutionalised and health equity impact assessment of all government policies, including finance, be used” (2008, p. 114).

CONCLUSION

Postmenopausal women’s narratives are valuable contributions to the knowledge of the phenomenon of menopause. They are particularly valuable for women readers as they provide for women, vital, diverse and different information not included in the limited scientific biomedical discourse, although the dominant paradigm in our culture. In addition, although these writings, I believe, are written to share vital information with other women, they also serve to bring our attention to the insufficiency and obvious lack in the current dominant biomedical model. This has the effect of disrupting and intersecting the current knowledge and bringing our attention to the limitations of the knowledge of our time, and the need for new inclusive knowledge. It also highlights the necessity for postmenopausal women to define and develop menopausal policies, educational programs and also health promotion.

The inclusion of new knowledge, in the case of menopause necessitates a paradigm shift to a wholistic model. A shift to a wholistic model would acknowledge connections, both internal and external. Internal connections involve body, mind and spirit. The external connections are the woman’s context and the social-political and social-economic aspects of the woman’s situation. This need for a paradigm shift has emerged as central to the women’s
texts. These postmenopausal women’s texts have also highlighted menopause as a gender inequity issue.

The social determinant of equity can support change for the women’s health issue of menopause and for menopausal women. However, to strengthen sustainability as a pillar of health promotion, planning and action, regarding what has been highlighted in this particular case, is the need and necessity for a paradigm shift from a negative reductionist pathological model to a wholistic model. This is necessary to allow the wider and deeper circumstances that also contribute to a person’s ill health or well being to emerge. I believe the wholistic model emerging from this research can have implications for various other health issues. In chapter six, I will propose a model of health care delivery specifically for menopause, menopausal and postmenopausal women. This model brings forth feminist principles and perspectives and the political platform for change necessary to bring the needs of menopausal women to the centre rather than the periphery.
CHAPTER SIX - FEMINIST PRINCIPLES AND PERSPECTIVES - POLITICAL ACTION FOR AGEING WOMEN
"Menopause is a process unique to the lives of women, touching on multilayered aspects of women’s lives, aspects that range from individual women’s physiology and intrapsychic experiences to sociological structure and norms. The experience of an individual woman is nested within the larger framework of sociohistorical context and process that is continuously subjected to the overarching umbrellas of the socially constructed meaning of aging and the sociocultural organization of the oppression of women" (Carolan, 1994, p. 193).

**Introduction**

It is important and relevant here, to consider how postmenopausal and menopausal women can fulfill their potential, by putting into action their unique contributions. How can women’s embodied knowledge, experience, theoretical concepts, and contribution to a wholistic paradigm of menopause, situated within a social model of health, contribute new knowledge to all women and to our society? Importantly, this validated contribution would also be instrumental in lifting the status of ageing woman. Part one of this chapter addresses this. Part two addresses the process for lifting the status of ageing women and part three is action to support this. Part four stresses the need for collaboration.

**PART ONE: FEMINIST PRINCIPLES**

It is my intention now to present my directions for initiating this move. However, firstly I think it is appropriate here, to consider an evaluation of my research so far to determine if I have addressed and met the three basic feminist principles listed in the first chapter of this thesis. This is also important for me as a check and balance, and evaluation of the research so far. The three basic feminist principles as listed in the first chapter were as follows:

- a valuing of women’s experiences,
- increasing the awareness of factors that oppress women
- creating social change through critique and political action.

So far, I have presented a case for the valuing of postmenopausal women’s experiences by presenting their perspectives through their own experiences, and by letting their own words stand rather than interpreting their words. Secondly, through the use of a postmodern feminist discourse analysis, I have increased the awareness of the limitations of the biomedical model
of menopause as disease, and how Cartesian dualism and separation rather than connectedness is the philosophy that underpins this scientific pathological biomedical paradigm. This has revealed that the dominant biomedical paradigm has limiting and oppressive factors for women as it does not support and encourage wholistic life cycle development. Thirdly my task as a feminist researcher is to create social change through critique and political action. As Spender argues:

There is a growing body of evidence that the very substance of women’s lives, including language and communication, is socially and ideologically constructed...men deny equal status to women as conversational partners with respect to rights to full utilisation of their turns and support for the development of their topics. This is another example of male dominance, as men exercise control over the talk of women. Just as they have more rights to the formulation of the meaning in the language as a system, so it seems that men have more rights when it comes to using that system. Males have greater control over meaning and more control over talk (Clare, 2003, p. 132).

My critique to date indicates that regarding menopause, menopausal and postmenopausal women, a change needs to occur, not only regarding the language of disease but also the meaning of the phenomenon as described by postmenopausal women. And the very meaning of the phenomenon needs to be reclaimed by women themselves. This task I see as the responsibility of postmenopausal women as they have experienced the embodied transitional and transformational process themselves. However, this responsibility needs to be supported by the society/culture, through policy changes. It is essential that these changes occur as this is, as noted previously, a matter of social justice.

This cultural change will require a paradigm shift from a reductionist model to a wholistic model. In turn it will require postmenopausal women’s input into policy design and educational programs and health promotion, as they are the human beings that have experienced the embodied wholistic experience and can provide additional knowledge regarding the phenomenon and therefore contribute to the episteme of our time. Creating conceptual meaning is the method that I recommend as the tool to enable an ethical
representation of menopause. Finally a social model of health is highly recommended as it can accommodate all these aspects.

My third feminist principle is yet to be completed. Therefore as a postmenopausal woman myself, and in an effort to instigate political action and to enable a social change that is required as a result of the research so far, and to meet the criteria of my intended political action, my proposals and actions now follow. These will be addressed during the body of this chapter. But firstly I refer to a few more words from Keleher.

**Devoid of Recognition**

“*Health is sensitive to social environments*”.  
*(Keleher et.al., 2007, p. 4)*.

As previously indicated in this thesis, programs designed on biomedical principles only can be very limited and narrow. In addition:

Despite the best intentions of health promoters, the narrowly cast versions of health promotion that are focused on expert-led health education and exhortations for behaviour change are frequently culturally inept, lacking in skills to address the causes of poor health, and lacking in capacity to enhance people’s agency. People are too often the passive participants in programs that have little, (if any), relevance for them. So much health promotion effort has been invested in risk factors and behaviour-change propaganda and so little on the causes of health and social problems from which risk behaviours arise (Keleher et.al., 2007, pp. 4-5).

Keleher et.al. (2007) give the following example of how “[a]boriginal people’s knowledge and wisdom’ has been ignored in the ‘repeated attempts to deliver health education and behaviour-change programs that have been developed through middle Australia white man’s {sic} eyes’ (p. 5.), and how health promotion is ‘devoid of this recognition” (p. 5). So too, has health promotion been devoid of recognition of postmenopausal women’s knowledge and wisdom, including their perspectives and theories regarding the phenomenon of menopause, as it has also been defined and diagnosed through white man’s eyes, and in addition, scientific biomedical processes predominantly. In this scenario women are in a passive position. To correct this gender blindness, gender inequity and gender discrimination, it is therefore
Chapter Six - Feminist Principles And Perspectives

appropriate that postmenopausal women themselves present this embodied process of menopause. Women’s extended knowledge should be included in the development of policy design, health education and health promotion in addition to scientific biomedical knowledge, as postmenopausal women are the original carriers and agents of the knowledge of menopause. According to Keleher (2007a):

As a social construct, gender discrimination is classified along with racism, ethnocentrism, and discrimination based on sexuality (Kreiger, 2001). In the taxonomy of prevalent types of discrimination, gender inequity occurs where the dominant social groups are male, the subordinate groups are women and girls, and the dominant ideology is sexism (p. 57).

In this case, a more accurate wholistic depiction of menopause, the menopausal and postmenopausal woman is required to address the limited reductionist biomedical scientific diagnosis of disease. This is the task of postmenopausal women.

Women’s Human Rights

The process of adult development and the terminology of transition and transformation, as noted through the voice of postmenopausal women’s texts have been marginalized and omitted and therefore never included in the limited diagnosis of menopause as disease. They have never been, or are not on record so to speak in the biomedical discourse on disease, but are necessary and appropriate to disrupt and intersect with the scientific biomedical knowledge to create new knowledge. This would be in addition to the already existing knowledge. This omission can be seen as not only a failure of “egalitarian aspirations” (Grosz, 1990, p. 162), but also an issue of equity failure. Postmenopausal women’s experiences and perspectives have not been included in the system, as there is no space at all, for postmenopausal women’s theories and perspectives within the reductionist, objective and positivist scientific paradigm. Unfortunately the paradigm of the reductionist model is still dominant in our time.

A different model to that of the reductionist model of menopause and the menopausal woman is required to enable the consideration of her subjectivity that is, psychosocial factors as well as her spiritual impulses. This would be based on the philosophy that emerged from postmenopausal women’s wholistic embodied experience of the phenomenon. It is only from
postmenopausal women’s voices through their writings that we are able to obtain a sense of the lived experiences of women, whose experiences acknowledge the place of connection rather than separation, that is internal connections (body, mind, soul, spirit), together with contextual connections. Importantly, these women’s voices acknowledge the gains in increased levels of other hormones, in addition to just the decrease and loss of estrogen.

This separation (the body/mind dualism philosophy) has denied women and our culture at large, knowledge of a positive wholistic adult developmental process. The mentality of women as diseased, pathological and dysfunctional, the episteme of our time has denied the powerful, dynamic and positive impulse and process of the phenomenon of menopause, not only to women, but also to their families, and to our society at large.

Therefore, what is essential is the integration of postmenopausal women’s experiences and perspectives, as they indicate a need for wholistic and postmenopausal women’s perspectives into policy development, educational programs and health promotion. This has emerged as a result of my research utilizing feminist methodology and method. This in turn has enabled an awareness of how different philosophies and different models result in different outcomes and therefore different interventions. MacKenzie (2007) citing Travis & Crompton (2001) refers to this, stating “[a]pplying feminist principles and research methods can enable health promoters and policy-makers to reveal otherwise hidden mechanisms of power and privilege that maintain the oppression of particular groups of people based on sex, class, ethnicity, age, and disability” (p. 107).

Because postmenopausal women’s embodied experiences reveal additional knowledge regarding a body/mind connection, the necessity of a new paradigm beyond Cartesian body/mind separation is essential to support women’s needs beyond body functions, as they transit this age life cycle passage to a new developmental stage. This is a woman’s right and women’s rights are human rights. What is essential here is the integration of postmenopausal women’s experiences and perspectives, as these theories indicate a need for wholistic and postmenopausal women’s perspectives and theories into policy development and programmes. This is a gender issue, in particular, one of gender omission.
Utilizing postmenopausal women, women elders, to guide our education in menopause, and also the education of the menopausal women would seem timely now. Ultimately, this could set an example to our society/culture that the ageing postmenopausal woman would not be considered just a chronic patient and liability in need of medication, but a potentially valuable asset to our society. The development of her new consciousness, her wisdom and knowledge gained through her experience, could be passed down to future generations of women. This would mean postmenopausal women taking responsibility for menopause education and health promotion. The employment of this strategy is a gender equity issue and a human rights and social justice issue. This move would require an appropriate level of funding and support. Accordingly, the World Health Organization has issued a directive for, and has recommended appropriate funding and support for gender equity. I now move to address the political significance of this gender equity issue.

PART TWO: THE PROCESS FOR LIFTING THE STATUS OF AGEING ADULT WOMEN

"Whether understood as fortunate or unfortunate, gender identity is clearly a happening of life. One inextricably is bound to assumptions about one’s gender category until they can be deconstructed and revised" (Young-Eisendrath & Wiedemann, 1987, p. 218).

The above words of Young-Eisendrath & Wiedemann (1987) refer not only to deconstruction and revision at the level of disciplines or intellectual knowledge, but also personally at the level of each individual woman. I think it becomes evident that each of us are born and gendered into our culture, dominated and controlled by a male patriarchal system, which has shaped our thinking. Young-Eisendrath & Wiedemann assert the importance of both levels, the disciplinary level, together with the personal level, stating that “[a]s long as we restrict personal agency both in characteristics for ‘ideal women’ and in social institutions in which girls grow up, we can expect serious problems in the motivational capacity of adult females” (1987, p. 218).

In addition and just as importantly then, they state that, “as psychotherapists, it is imperative to oppose psychological models that undermine women’s beliefs in their abilities to engage actively with their own lives” (Young-Eisendrath & Wiedemann, 1987, p. 218). They also refer to Lipman-Blumen (1984) (cited in Young-Eisendrath & Wiedemann, 1987) who points out that “[w]hite males dominate other groups largely through belief systems” (p. 218)
addition, they refer to “two prominent beliefs frequently taken as implicit assumptions” related to patriarchy within these belief systems. Firstly, “[t]hat men have the necessary knowledge to master our social and cultural systems, knowledge which women do not have and secondly, “[t]hat men control the major cultural resources on which women depend” (Lipman-Blumen 1984. p. 9, cited in Young-Eisendrath and Wiedemann, 1987, p. 218).

Upon reflection and in consideration of these words, it seems obvious that strategies are needed for new knowledge of menopausal woman and postmenopausal woman, and the phenomenon of menopause. Firstly that postmenopausal women contribute to the cultural knowledge, not to master our social and cultural systems, but to bring balance and correct the episteme of our time regarding menopause and the postmenopausal woman. This is also an equity gender issue as the above current beliefs have been instrumental in promoting inequitable gender role relations. Secondly, that the cultural resources for women moving into the second half of life be controlled and distributed by women, I would say postmenopausal women because of their experience, and in a way that addresses all levels of the phenomenon of menopause and also allows for diversity of experience from other women.

Feminist Principles and Perspectives – Political Action

When considering the restrictions on personal agency of ageing postmenopausal women and how this can be instrumental in creating serious problems in the motivational capacity of adult females, it is important and relevant here, to consider the personal agency needed for both postmenopausal and menopausal women to fulfill their potential, as this could also be instrumental in lifting the motivational capacity, and also the status, of the ageing woman. This means it is necessary for postmenopausal women to formally contribute their experiences, perspectives and theories in additional to the scientific biomedical knowledge.

With the inclusion of their knowledge, this more accurate depiction, whilst not being the total truth for every woman, will in turn, ensure that health promotion practitioners, uphold the ethical principle guiding health, “to do no harm”, by not “ignoring people’s realities or their need for agency in their own lives” (Keleher et.al., 2007, p .5). The main points to note here, are to ensure that the woman’s social reality is not ignored, and that the individual need for agency in both the menopausal and postmenopausal women’s lives is not ignored, but that it is actively encouraged and supported on multiple social and political levels. This is gender equity and social justice issue. In agreement with this Keleher et. al. (2007) state that
“[h]ealth promotion must therefore turn its gaze to enabling people and communities to take control over those factors (or determinants) that affect their health and well-being or decisions that have health and well-being consequences” (p. 5).

It is therefore essential that policies and resources are forthcoming to enable ageing women together with the appropriate relevant multi-level communities, to provide the resources for the extended knowledge held by postmenopausal women to be formally made known, and formally presented, to all women who will undertake, or be undertaking the process of the menopausal transition. The requirement here is to ensure a strategy so the embodied theories and knowledge be made known, initially by postmenopausal women over fifty-five years of age, who have already moved through the menopausal transition, and have possession of the embodied experiences, the internal knowledge, the external knowledge, and who have also published texts on their experience, perspectives and theories. Their texts, their perspectives and theories would guide the programs. Ultimately this would be a strategy for change. As noted before in this thesis, the omission of this knowledge is a gender equity and social justice issue that needs to be addressed, recognised and changed, rather than being devoid of recognition. As a result of this research so far, my own vision and directions for this strategy for change follows. However, firstly, I briefly refer to other researchers who also recommend the need for communities of people and specific populations to contribute their particular ways of knowing, thereby implementing a more comprehensive and integrated model of health promotion.

Ways of Knowing: Lay People and Communities of Knowing

A more comprehensive model of health promotion has also been referred to as integrated health promotion. Keleher (2007b) draws on Nutbeam when she refers to integration in terms of integrating resources, programs, and expertise that could be called “ways of knowing” (p. 33). It is the most embodied unique ways of knowing that postmenopausal women can bring to policy, education programs and health promotion. In these ways of knowing what her experience is, the menopausal and postmenopausal woman can also then identify what it is that will assist or inhibit her transitional process on more than just the level of HRT/HT. Supporting this proposition, Keleher, states:
Many communities and populations have their own ‘ways of knowing’ about health, and what creates it or destroys it, which is a critical foundation for developing programs that will be both effective and sustainable. To understand those ways of knowing, health promotion practitioners need to a few essentials in the toolbox: values about respect, rights, and reconciliation, and partnerships with expertise to guide everyone into those ways of knowing and doing (p. 33).

It is the ways of knowing from postmenopausal women, in addition to, ways of knowing from various other disciplines that are also necessary for a more comprehensive and integrated model. The need for these other perspectives has been also addressed in this thesis. Some referred to are anthropological perspectives, psychological perspectives, social cultural perspectives, and feminist approaches, all indicating the need for change. These are disciplines that can also contribute to health processes. Therefore it is this integrated approach for change that offers the greatest potential for impacting on the population of menopausal and postmenopausal ageing women, who still have unmet needs. This would also address health inequities and create a sustainable model.

In accord with Keleher (2007a), regarding communities and populations having their own way of knowing, it has become evident through this research that communities and populations of postmenopausal women will also have their own ways of knowing. This in turn will have an impact on the health of the ageing women population as a whole. It would address inequities, and would contribute to more sustainable change over the long term as the integrated knowledge, including ageing women’s knowledge can be passed down through the generations of women (Dillaway, 2007). Most importantly, it would cover and include extensive knowledge far beyond that of biomedical reductionist knowledge which has been studied only between the ‘belly button and thighs’ of the menopausal woman and ageing postmenopausal women.

Interestingly, Popay and MacDougall (2007) highlight the shift that has occurred between lay beliefs and lay knowledge saying that this shift has occurred in both research and within the public sector. In defining lay knowledge they state, it “comprises the ideas and perspectives that people use to interpret their experience – it’s experiential, it’s drawn out of the experience of everyday life in the context of today’s presentation, their experience of health and illness”
(2007, p. 70). In other words, it is the way people make meaning and their interpretations of their life and their experiences. Consequently, the utilizing of Chinn & Kramer’s method of “creating conceptual meaning” becomes essential as useful in the transitional developmental process for menopause, menopausal and postmenopausal women. Further to this Popay and MacDougall, state:

The shift from talking about lay beliefs to lay knowledge is a sign of the increasing status of experiential wisdom, no longer a primitive leftover, but now a key part of what it is to be a human being in society. Lay knowledge reflects how we make sense of our world at any particular time and in an any particular place. And I think the shifting language reflects an increasing understanding of the sophistication of this experiential wisdom and a growing recognition that this wisdom, this knowledge, has important implications for the way policy and practice get done (2007, p. 71).

Not only is the increasing status of experiential wisdom referred to by Popay and MacDougall very important, but the source of the experiential wisdom is even more critically important, and therefore should also have, and be due, increasing status. In the case of menopausal, it is the ageing postmenopausal women who deserve increasing status, as they themselves are the ones who have transitioned the experiential process. They hold and carry within, extended knowledge and wisdom of the phenomenon. Well and truly beyond the limits of between the belly button and thighs only!!!

In addition, Popay and MacDougall go on to explain about “crucial ways in which the content and form of lay knowledge differs from professional, codified knowledge” (2007, p. 71). Drawing further on their work:

This knowledge does seek to identify causes in everyday life that lead to experiences of positive health or negative health, so there are causal explanations – lay theories – embedded in this knowledge. But the key issue is that lay knowledge is also about attributing meaning to experience. When we talk about our experiences we are trying to make sense of that experience in terms of morality, politics, and what we call cosmologies – a kind of who am I? question. This subjectivity can be the problem for professionals because we’ve all been trained to be wary of the subjective, adding to the
problematic nature of the interface between lay knowledge, policy, and practice (Popay & MacDougall, 2007, p. 71).

It becomes critical then that we realize the importance of individual women’s meanings of their experiences, and also that Chinn & Kramer’s (1995) method of creating conceptual meaning can become a significant tool in this process.

COLLABORATION & PARTNERSHIPS

Visions and Directions

Whilst I have found that researching women’s texts is extremely important as their texts have been instrumental in highlighting the aspects of the biomedical model that have been ignored, marginalized and omitted, I also believe, as a feminist researcher, that whilst I have been doing research on these women’s texts, it is now more important to collaborate with these wise women authors. Inviting these wise women authors to collaborate with other postmenopausal women and with us, in order to direct women’s health policy, would be of great value. More importantly, their knowledge is essential and desperately required in the design of policy, educational programs and health promotion.

As a reflective task, I firstly present the following as my visions and directions as a strategy for formally bringing the new knowledge of menopause to all women, firstly through collaboration with these postmenopausal women themselves, or alternatively through the use and sharing of the published texts of these postmenopausal women.

The vision is partially based on the synthesis of professional women’s texts and is limited by the type of postmenopausal women’s texts analysed, in that they were well educated and often in health-related professions.

Visions

As I am proposing a more wholistic model and paradigm of menopause and menopausal women, the following provides initial suggestions for inclusion of postmenopausal perspectives, theories and experiences in the development of women’s health policy. I also propose that a women’s health strategy that supports women’s value and status will include the following:
1. Collaboration with women elders
2. Education by women elders
3. Wholistic education for women
4. Developing a wholistic model, including the biomedical model, within a social model of health.

1. Collaboration with Women Elders

Researching women’s texts is important. However, I also believe that working with these wise women authors and inviting them to collaborate with us in order to direct women’s health policy will be of great value. Bringing their ‘elder’ wisdom and the gifts of their knowledge through their experiences, to the generations of women who will be following on this adult developmental life-cycle journey will be a valuable health strategy. Through these women elder’s experiences they are indicating that the ageing journey into postmenopausal status is a positive, empowering and valuable one. It is essential that their theories are not marginalized in policy design and development.

In addition, it has been noted by Clarke and McCann (2004) that “health professionals must also lead the way in challenging the negative stereotypes associated with ageing. To do this, they themselves will need to value ageing, rather than fear it” (p. 168). The value of menopausal women’s transitional and transformational developmental process needs to be honoured, valued and signified through the development of rites of passage ceremonies. By doing this we are also forging a status pathway and honouring for other postmenopausal women, who can also be our valuable resources for women from generation to generation. These are the connections we as women need to renew. We then, as a society of women and men, can give status to postmenopausal women for their life experiences by honouring them as our elders and mentors. As previously noted by Astbury (2006) women’s increased status is linked to good mental health. Accordingly increased status can assist menopausal and postmenopausal women as it would also provide an opportunity to positively support their developmental journey. In return younger women can learn from older women. We as women can invite these women to be our guides, to include them in our new models of menopause and to guide other women through both the positive as well as negative aspects. This in turn can also strengthen the threads between generations of women through the ages, as we will truly have “herstory”.

Menopause: The Need for a Paradigm Shift from Disease to Women’s Health

Margaret T.C. Harris
2. Education for Menopause by Women Elders

The employment of women elders to guide our educational programs would be beneficial. Women who have already experienced the phenomenon, and have been able to articulate both the negative and the positive dynamic life giving aspects through their experiences have much to offer. They can prepare women, not only for a decline in estrogen, but also for a process of adult development and the possibility of a change in consciousness.

Various stories of menopause as told by postmenopausal women can prepare us and act as possible guides for other women’s journeys. Whilst their texts represent their own personal journeys and theories, each of us will have our own variance on the journey. However, their stories and theories can reassure us that the process is normal and not dysfunctional, and also that similarities and differences can occur for each of us. Also we know we are not alone if we experience our journey differently. A variety of stories would enable a resonance for many women. They may also assist other women to hold and design a positive path for themselves, which they in turn can pass down to generations of women. Their language of menopause as transition, transformation, metamorphosis is valuable for us as women. Importantly, knowledge and preparation have been identified as necessary to assist a healthy transition. Meleis, Sawyer, Im, Hilfinger, DeAnne, Schumacher (2000) have stated that “[a]nticipatory preparation facilitates the transition experience, whereas lack of preparation is an inhibitor. Inherently related to preparation is knowledge about what to expect during a transition and what strategies maybe helpful in managing it” (p. 21).

Therefore funding to support more women to publish their experiences, perspectives and theories of menopause would be most appropriate, significant and valuable, together with comprehensive education for women, through conferences, workshops, and groups.

3. Wholistic Education for Women: Essential Aspects

In order to educate women comprehensively concerning preparation for menopause, life-cycle transitions and supportive strategies, education related to both the biomedical model and HRT/HT, and in addition, more wholistic models which focus on connections of body, the mind and the spirit are essential.
Looking after the body:
Through menopause we are called to ourselves in a new way. We are also called to care for our bodies in a new way. Good nutrition is very important, as is regular exercise and appropriate relaxation. Stress reduction is also vital. Temporary and regular time out for the menopausal woman is essential. Continual stress at any time is a threat to health but is even more so to the menopausal woman whose body and mind are in transition. In addition, natural and complementary therapies maybe just as important and useful, or even more important to women, as HRT/HT. This is especially those who are warned that HRT/HT would be risky for them.

Looking after the mind:
Addressing our new consciousness rather than denying it is also a helpful strategy. The degree of new consciousness will vary between women. It is also important to engage the brain in something meaningful. Exercising the brain as we age is advised, just as it is with the body.
In addition, art processes to assist with grounding the experience of change and also the new consciousness would be recommended as useful and very beneficial.

Looking after the spirit:
This will be connected to looking after our bodies, our minds, our connections to our community, society and culture, the environment and the cosmos, and will vary for each woman, therefore the wisdom and spiritual gifts that can be brought to fruition to share with future generations will vary for each woman.

4. Wholistic Models – Developing a Wholistic Model
It is important to consider the interconnections of body, mind and spirit together with the external connections, environmental conditions and the context that can facilitate or impede progress through a healthy menopausal transition process. Personal, community, or societal conditions have been identified by Meleis et al. (2000) as factors that facilitate or hinder the process of transitions. In addition they reported that low socioeconomic status can also be an inhibitor to healthy menopausal transitions and that other studies have shown that women who have “low socioeconomic status are more likely to suffer psychological symptoms” (Meleis et.al., 2000, p. 21). In addition, Meleis et.al. state “[c]lients daily lives, environments, and
interactions are shaped by the nature, conditions, meanings, and processes of transition experiences. Transitions are both a result of, and result in change in lives, health, relationships, and environments” (2000, p. 13).

The above words are very indicative of a wholistic perspective. Pizzorno and Snider (2006) echo the above thoughts noting the complexity of physiological, mental, emotional, spiritual and environmental interactions. They acknowledge the interrelationship of all things suggesting that changing one aspect will reverberate through the whole system.

Through menopause, we may be called to change ourselves in a more positive way. Integrating into the whole could also mean an exploration of the community and the biosphere and how our sociocultural, socioeonomic and sociopolitical contexts can support or inhibit our adult development process into more positive ageing. All these contexts can be addressed in the social model of health and have been covered in chapters five and six. In addition, all the above factors are implicated in the experience of menopause.

I have briefly highlighted the sociocultural and sociopolitical aspects that are inhibitors for the transition in our society. In addition, the importance of educating women in preparation and knowledge of the phenomenon of menopause cannot be understated. Women’s language of transition, transformation, metamorphosis, initiation, or rite of passage as expressed in the women’s narratives can be explored in relationship to the meaning for each woman as part of her adult development. Additionally the socioeconomic factors are also implicated within the contexts of each woman’s experience.

**Directions**

Initially, conferences to educate women regarding both the biomedical and wholistic models, including body, mind, soul and spiritual aspects would be not only advantageous, but essential. Facilitating workshops to educate and assist women in defining the possibilities of their future journey into their postmenopausal years could prove to be a helpful strategy and to assist women to identify sociocultural, sociopolitical and socio-economic factors that may be relevant to them, and assist their change.
Additional to workshops, group processes, to assist the above processes and also as a follow on from the above educational directions, could also assist women to define their situations and context, and also assist in the development of their own special gifts or their chosen contribution as elders. Very importantly, education for partners and husbands regarding the change would be highly recommended.

Workshops and forums will be inclusive of all women participants both academic and non academic, professional and non professional women, and will be based on the process utilized in the New Women’s Health Policy State and Territory Consultation Forum (2009) in Melbourne. This would be a very practical and suitable process of women’s circles to support inclusiveness of all women where many women-centered visions and needs can be defined by women themselves. These would be learning experiences for non academic and non professional women, who then, through their participation in workshops and forums could define their own narratives, experiences and needs. Also in this chapter, I have made reference to Keleher (2009) who has stressed the importance of the role and knowledge of lay people and communities of lay people relationship to experts. Therefore the role of communities of lay menopausal and postmenopausal women and their knowledge would be a significant inclusion in all activities. This also confirms the urgency to take this work forward of conferences, seminars, workshops and forums to enable a strong backbone to emerge for a more inclusive woman-centered model of the women’s health issue of menopause as a feminist principle.

Encouraging women’s narratives could assist in all of the above, as it could contribute to a process which would be useful for identifying and developing each of the women’s own spiritual gifts. Other artistic processes would also be useful and recommended where necessary, including drawing, painting, writing and drama. In effect, this enables the grounding of the change process and can in turn be a contribution to community.

I believe the above can be instrumental in promoting, empowering and facilitating women as agents of change. Facilitation of change is necessary and preferable to overcome barriers to self realization through self recreation thus supporting postmenopausal women to become producers and distributors of extended knowledge beyond biomedicine thereby making them
valuable contributors of knowledge to society. Figure 6.1 illustrates this within the paradigm shift.

**Figure 6.1 Components of the Paradigm Shift**

**PART THREE PRAXIS – ACTION TO SUPPORT AGEING POSTMENOPAUSAL WOMEN**

**From Interventions to Levels of Action – First Action – Submission**

In this section, I have my actions to date to fulfill the third feminist principle of taking political and social action to address this gender equity issue of menopause and to support sustainable change for ageing women on several levels. The following is my action on the political and social level to address the upstream factor of equity.

At an Australian national level, a submission to the New National Women’s Health Policy (NWHP), *(New national women’s health policy (NWHP), 2009)*. This submission is a result of my thinking regarding the women’s health issue of menopause as a gender equity issue, and also the first step towards fulfilling the third basic feminist principle of creating social change through critique and political action. This submission regarding menopause, the menopausal and postmenopausal women can be found in Appendix 1.
Other Practical Actions for Change: Advocacy, Enabling & Mediating

As a feminist researcher and a women’s health promoter, I have considered and acknowledge the necessity for changes in policy regarding menopause, the menopausal and postmenopausal women. As stated by Keleher (2007c) “[a] core skill for the all health promotion practitioners is to turn concepts and strategies into practical actions that are effective in creating change and tackling inequity” (p. 23). She recommends the Ottawa Charter’s following three foundation practices of advocacy, enabling, and mediating. I am presenting these three important practices in Keleher’s own words, as I believe these three foundation practices can form the basis for achieving a paradigm shift from a reductionist to a wholistic paradigm for menopause, menopausal and postmenopausal women.

**Advocacy in health promotion** is the process of defending or promoting a cause. It involves active participation in public debate and activity to gain political commitment, social acceptance, and policy support for a particular issue or change (Health Promotion Forum of New Zealand, 2000). Advocacy is also a combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems support for a particular health goal or program (WHO 1998). In other words, health promotion advocacy aims at making conditions favourable for health, which is a core responsibility of all health professionals.

**Enabling in health promotion:** Enabling means that health promotion practitioners take action in partnership with individuals or groups with the intention of empowerment. This will require the mobilization of human and material resources (WHO 1998) and, very often, encompasses facilitation skills such as the facilitation of learning or skill development in others. Health promotion practitioners are catalysts for the development of appropriate health resources in the community, and assisting people to increase their health knowledge and skills. Practitioners enable access to political processes that shape public policies affecting people’s health; they assist people to identify the determinants of their own health; and to identify actions through partnerships to increase health, and improve the conditions for health.

**Mediating in health promotion** is the process through which competing interests are reconciled in ways that promote and protect health (WHO 1998). Competing interests
include personal, social, political, and economic interests, in the pursuit of better health outcomes for individuals, communities and populations (Keleher, 2007c, p. 24).

These three foundation practices are all very relevant for menopause, menopausal and postmenopausal women. In particular and regarding the last practice, how does a reconciliation of interests occur?

I have presented a case for a paradigm shift and the inclusion and integration of postmenopausal women’s perspectives and theories into policy development, education programs and health promotion for menopausal and postmenopausal women. As noted before, menopause as gender equity issue is also an inequity issue as menopausal and postmenopausal women have been disadvantaged through this neglect and omission. This inequity is therefore also a social justice issue as postmenopausal women have been disadvantaged. Consequently then policies driven by social justice are appropriate for the issue of menopause.

In addition, the dominant paradigm and episteme of our time, of menopause as disease, is gender blind, which is a particular issue of gender inequity. To enable a correction of this inequity of blindness, a shift in health services is also required. The two areas where I see this shift needs to occur in order to address the phenomenon of menopause, menopausal and postmenopausal women is from the old public health model to the new public health model and also a shift from primary care to primary health care. Initially, primary health care itself is more indicative of a wholistic approach as it includes the word ‘health’ emerging from the same root as ‘whole’, whereas primary care omits a wholistic and health representation therefore presenting a reductionist medical approach.

**Creating Political and Social Change for Women: Where Shifts can occur**

Keleher (2009) discusses where shifts need to occur in areas of health in order to address issues of inequity and equity. She goes on to discuss a shift in emphasis of public health and health promotion as necessary and appropriate to the new public health system, and a shift from primary care to primary health care. It is to the new public health interventions and primary health care that I now turn as I believe these are appropriate to address and incorporate a paradigm shift. According to Keleher (2009) who cites Labonte et.al. (2007):...
Universal services are one strategy for overcoming inequities of health care access, based on evidence ‘that publicly funded and universal systems which integrate strong primary health care with public health interventions are associated with better health outcomes and fewer inequities (p. 32).

In addition, both the new public health and primary health care, attempt to address social justice and inequity and equity issues. In addition, within the area of primary health care, there is an attempt to shift the emphasis to address inequities at an even very more fundamental level. This becomes obvious in the broad vision that comprehensive primary health care, as distinct from selective health care, adopts a “[c]omprehensive PHC has a broad vision through which practitioners work to change the social, political, environmental, and economic determinants of illness, in order to create better health communities, regions, or cities” (Keleher, 2009, p. 36). Keleher recommends comprehensive primary health care as appropriate in contrast to selective health care.

The distinction between primary care (PC) and primary health care (PHC) is also important to note as, in the case of menopause and the menopausal and postmenopausal woman, primary health care (PHC) is the preferred framework. As noted a previous chapter of this thesis it is primary health care (PHC) that is preferred and required for the phenomenon of menopause as it includes and incorporates a (w)holistic health paradigm. I now draw once again on Keleher as she defines very clearly the key principles of PHC.

Primary health care (PHC) was first recognised through the Alma-Ata Charter for Primary Health Care (WHO 1978). Its key principles were:

- **Equity:** essential health care, universally accessible, and affordable
- **Social justice:** achievement of health as a resource and human right
- **Reorienting health systems** towards raising the health status of individuals, families, and communities
- **Enabling** people to lead socially and economically productive lives.

Primary health care (PHC), at one level, is a health development model. More fundamentally, PHC is a key strategy of public health derived from the social model of
health designed specifically to deal with the determinants of health. Primary health care is more than a philosophy. It is also a system response to reducing health inequities and ameliorating the effects of disadvantage, to guide the delivery of primary health services (Keleher, 2009, p. 35).

Keleher (2009) goes on to suggest that:

Primary health care practice requires the participation of those most affected by the problem and health worker accountability for that participation. Practitioner focus is on the most urgent needs of communities, the priorities set by communities themselves, and the equalisation of relationships between ‘experts’ and communities. This focus is intended to address health disadvantage and tackle health inequities by building empowerment of people that is, building skills in individual clients and in communities to develop their capacity for self-determination (p. 37).

I see the postmenopausal women as the community, who together with the community of both menopausal and perimenopausal women help these women to address the obstacles to their transition together with those of their life-cycle developmental process. I see them also as the equalising factor in relationships between ‘expert’s and communities.

Further Keleher states that “[c]omprehensive PHC has a broad vision through which practitioners work to change the social, political, environmental, and economic determinants of illness, in order to create better health in communities, regions, or cities” (Keleher, 2009, p. 36). In addition, Anne McMurray has also defined the value of, and preference for (PHC) primary health care, and its inclusions and its alignment with the social model of health.

Primary Health Care

According to McMurray (1999) primary health care is internationally recognised as a way of structuring community health activities. McMurray goes on to state that in some cases the terms ‘primary care’ and ‘primary health care’ are used interchangeably, and this occasionally causes confusion. She notes the distinction between primary care and primary health care as follows:

When people require health care because of injury or illness, the first line of care is primary. But primary care is more than just the initial decision as to what must be
done. It extends to the primary management of a person’s condition. Primary care may involve only one intervention, or treatment over an extended period of time, but it is still primary because it is aimed at helping people with whatever problem required care in the first place. Physicians, nurses, dentists, physiotherapists and a range of other health professionals provide primary care – that is, depending on the circumstances, they may be responsible for managing a health problem (McMurray, 1999, p. 23).

So, for example, if an athlete suffers an injury on the sports field, the trainer will often provide first aid and then refer the athlete to a physician, who will assume the role of primary care provider. Similarly, a nurse in a hospital emergency department or in a community clinic may provide initial treatment for an emergency, and then either refer the person to the local GP to manage the condition, or manage it her/himself, depending on the situation. In the latter case, the nurse would be acting as a primary care provider, and this often happens in remote locations where there is no medical doctor (McMurray, 1999, p. 24).

In the case of menopause, the intervention of HRT/HT only would be the primary care approach, as this is the recommended intervention to addresses the problem in the first place. However, in contrast, the primary health care model encompasses a more wholistic philosophy, and Primary Health Care according to McMurray (1999):

*Primary health care* includes primary or initial care, to address a problem, but it also encompasses the broader activities of government and other sectors of society. The goal of primary health care is to help communities and the people in them to achieve lasting improvement in the quality of their lives… [E]mbedded within the philosophy of primary health care are several principles that guide community health promotion activities (McMurray, 1999, p. 24).

The major principles of primary health care are also in line with the social model of health. According to McMurray (1999), “[t]he major principles of primary health care are *equity, access, empowerment, community self-determination and intersectoral collaboration*” (p. 24). Hence a shift from primary care to primary health care is essential for menopause and menopausal women.
Primary Health Care and Sustainability

Further with regards to the value of primary health care, McMurray (1999) indicates the relationship of primary health care to sustainability, as sustainability is also a determinant of health, she states:

Primary health care is an equal opportunity concept, and this is embodied in the principle of equity. Health for all people means equal opportunities for all people, whether they differ by geography, race, age, gender, language or functional capacity. An ecological view of community health extends beyond these familiar aspects of equity to consider sustainability as an equity issue. Sustainable health means that any present measures taken to improve our environment must not compromise the ability of future generations to meet their needs (Lowe 1994). So in a socioecological framework, the principle of equity has broadened beyond the needs of the present generation to consider those of future inhabitants of our communities when planning community health programs (p. 24-25).

In the case of menopause regarding sustainability, the status and value of the ageing postmenopausal woman would also be bestowed upon the younger generations of women as they moved through their menopausal process to postmenopausal status assisted with the value of the extended knowledge of other postmenopausal women. This knowledge would be passed down through the generations of women to become ‘herstory’ over many generations thereby creating and sustaining vibrant and vital communities of ageing women through the generations. This will guarantee a more sustainable model than a limited reductionist pathological scientific model.

This process is also indicative of a comprehensive health care model. In Australia and elsewhere, according to Keleher, comprehensive PHC has not been well supported by governments. Describing primary health (PHC) at a more fundamental level, Keleher (2009) states:

Primary health care practice requires the participation of those most affected by the problem and health worker accountability for that participation. Practitioner focus is on the most urgent needs of the communities, the priorities set by communities.
themselves, and the equalisation of relationships between ‘experts’ and communities (p. 37).

Within primary health care (PHC) and in the case of menopause, I believe, it is obvious that postmenopausal women would have a central role to play, as in PHC they themselves are the community of ageing women. Primary health care could include and integrate the participation of postmenopausal women as they have the experience of having being most affected by the embodied phenomenon. In addition, they have worked through and with the phenomenon. Therefore it makes sense that their perspectives and participation would be of value to the ongoing and continuing community of menopausal women. Therefore sustainability would rely on postmenopausal women’s continual input.

The postmenopausal women would be familiar with some of the most urgent needs of the community of menopausal and postmenopausal women, and they would act as guides only, not experts. In effect, these ageing postmenopausal women would fill the gap between experts and the local community (areas and regions), and be instrumental in equalising the relationships between the ‘experts’ and the communities of menopausal women themselves. Ultimately postmenopausal women talking about their own particular body, mind, soul, spirit needs and also helping menopausal women to define their needs wholistically would ensure contribute to a system that responded and supported women with more than just the one recommended intervention that of HRT/HT.

In addition, “to engage in primary health care activities therefore requires political and social consciousness, that is, deliberate consideration of the needs and agendas of all people” (McMurray, 1999, p. 25). Further to this, “to engagement in primary health care, it requires deliberate consideration of the wholistic needs and agendas of all people” (p. 25). This is also a social justice issue as the wholistic perspective should apply to all. McMurray explains that:

A commitment to primary health care dictates that we remain aware of the health needs of our local community, and how they relate to those of others. It is also to meet health needs across the spectrum of advantage and disadvantage. By approaching health planning in terms of the ‘big picture’, we can ‘think global and act local’ (1999, p. 25).
Distinguishing Points and Advantages of Primary Health Care (PHC)

Having explored systems thinking and the social model of health as more conducive to the health of menopausal women rather than the reductionist model, it is to primary health care (PHC) rather than primary care that I now turn as a potentially more appropriate strategy to address menopause. Primary health care is a strategy of public health. Primary health care is also derived from the social model of health, which, in turn, I have also recommended as the most appropriate model for this health issue.

As Helen Keleher notifies us that:

Primary health care is a strategy of public health, derived from the social model of health and sustained by the Declaration of Alma Ata, which was jointly sponsored by the World Health Organization and UNICEF (WHO, 1978, 1986). These Charters demonstrate the co-dependency of primary health care and health Promotion (Keleher, 2001, p. 58).

The following addresses firstly the main points of PHC that are relevant for the phenomenon of menopause, then Health Promotion, and secondly the strategy that I recommend for optimal health for menopause, and ageing menopausal and postmenopausal women beyond PHC. Thirdly, health promotion as the co-dependent of the new primary health care strategy for menopause will be included.

It is appropriate and advantageous to note the distinguishing points and advantages of a primary health care approach. These points address the issues that have emerged from the research, as critical.

- Primary health care demonstrates a commitment to ongoing action or advocacy to deal with the causal circumstances of the presenting problem. It is very important to recognise that primary health care requires the participation of those most affected by the problem and health worker accountability for that participation (Werner, Sanders, Weston, Babb & Rodriquez 1997 cited in Keleher, 2001, p. 59).
A comprehensive primary health care approach addresses a whole range of social and environmental factors that cause ill health as well as those that sustain and create good health. The World Health Organization’s blueprint for Primary Health Care (WHO, 1978) recognises that only a comprehensive primary health care approach will actually improve the quality of life and health outcomes of people in capacity for self-determination (WHO, 1986). It is these principles which distinguish any society and that PHC must be modified to suit the differing needs of population groups (Keleher, 2001, p. 59).

The principles of PHC include equity on the basis of need, affordable access to needed services the sustainability of PHC services, empowerment of people alongside efforts to help them be more self-determining. In other words, a PHC service operates on social justice principles (my emphasis) (Keleher, 2001, p. 59).

A systems approach is paramount to PHC whose practitioners are committed to the building of skills in individual clients and in communities in order to develop their comprehensive primary health care from primary care (Keleher, 2001, p. 59).

The first point above indicates the need for the responsibility and participation of ageing women themselves in primary health care action. Action at the top level means being responsible for policy design and development. The second point recommends a comprehensive approach because this is more congruent with a wholistic paradigm. A comprehensive approach sustains good health as it also improves the quality of life, including the capacity for self-determination. In addition, it indicates the inclusion of social and environment factors (context), and would also emphasise the needs of population groups, in this case, ageing women including both menopausal and postmenopausal. The third point recognizes the concept of equity as based on need, and recognises this as a social justice issue. It emphasises the importance of the inclusion of equity as a principle, supporting self-determination, and therefore operates on social justice principles for ageing women. The last point identifies the systems approach to acknowledge the value of PHC as the path to strengthening communities of ageing women, therefore extending the action of self-determination to communities also. The recommendation of a systems approach has also been my recommendation.
Intentions and Orientation of Primary Health Care Practitioners

Most importantly it is relevant to note the intentions, aims and orientation of primary health care practitioners:

Characteristically, primary health care practitioners work to change the social, political, environmental and economic determinants of illness in order to create better health in communities, regions or cities. The range of social determinants of health incorporates inter-related circumstances of poverty, wealth and income distribution, psychosocial deprivation discrimination such as sexism and racism, powerlessness, factors related to gender, age, race and ethnicity, socio-ecological environments, literacy, and health service utilisation (Keleher, 2001, p. 59).

All of the above approaches and principles of primary health care are relevant and have emerged as necessary for menopause, menopausal and postmenopausal women. Any of the above social determinants of health maybe relevant to individual women, however, it is gender and equity as the social determinants that are definitely relevant for menopausal women to address this gender issue. It is the communities of postmenopausal women who can be the primary health care practitioners to make these, perspectives and theories have not been equitable in the defining and promotion of menopause as disease with HRT/HT as recommended intervention. This needs to be remedied and continually monitored in all recommendations and actions, and more appropriate interventions delivered. This omission can be remedied by the inclusion of postmenopausal women, their perspectives and theories and design and development of policy by these women. PHC could allow this to occur.

However, having explored PHC as more comprehensive primary health care model rather than selective primary care, which is more congruent with a wholistic paradigm, my recommendation extends beyond this care model to an even more comprehensive multidisciplinary health care model to address menopausal women’s issues. It is an Enhanced Primary Health Care (EPHC) approach that I believe would be the most and even more appropriate for the phenomenon of menopause. This would allow and include multidisciplinary practitioners beyond medical practitioners to be included also in the package of practitioners and therapists available as requested by women. I believe this is essential also to enable artistic therapists to be included also in the health care model.
PART FOUR: HEALTH PROMOTION, PARTNERSHIPS & COLLABORATION - A SOCIAL MODEL OF HEALTH, AND DETERMINANTS OF HEALTH

Comprehensive and Sustainable

I now refer back to Keleher’s (2007b, p. 30) work as her definition of a comprehensive, rather than a selective approach to health promotion and her frameworks clearly define the difference between interventions and levels of action as a means for change.

A more comprehensive approach to integrated health promotion is to understand interventions in relation to levels of action that are designed to influence the determinants of health. Levels of action are upstream-downstream, and move away from the concept of ‘intervention’ with its connotations of doing something to people. Delivering interventions to people is a term more consistent with a medical/primary care approach than with the empowerment intentions of equity and determinants-focused health promotion, while the term ‘action area’ is consistent with the WHO Charter for Health Promotion. Thinking in upstream-downstream terms enables planning to develop multiple levels of action (Keleher, 2007b, p. 30).

Keleher provides a Determinants Framework of Health Promotion actions diagram. It provides examples of “actions that can be taken at upstream-downstream levels, to influence change in the social determinants of health” (Keleher, 2007b, p. 32). This expanded Framework provides examples of actions that can be taken at upstream-downstream levels, to influence change in the social determinants of health. The landscape of health promotion is moving upstream because downstream approaches have done little to change the health status of the poorest and most vulnerable people (Keleher, 2007b, p. 31).

All of these levels are important for menopause, the menopausal and ageing postmenopausal women. However, it is the upstream level that is the most critical for this phenomenon as it...
includes inequities reduction, gender equity, social exclusion, discrimination, long life learning, strengthening community action, and healthy public policy, all very relevant to the phenomenon of menopause.

Upstreaming also calls for healthy public policy. I have already indicated this as necessary throughout this thesis. In addition, whilst Keleher’s list does not refer to menopause only, it lists many other important aspects that impact on this phenomenon. In addition, more importantly the upstream factors work towards a more sustainable women’s health care model of menopause. A more sustainable model is recommended. Importantly, together with the upstream factors, the midstream and downstream are also still very relevant for menopausal and postmenopausal women.

It is Keleher’s frameworks and the social model of health that I believe are useful to employ to instigate the beginning of the necessary shift from the reductionist scientific biomedical model to the social model for menopause, menopausal and postmenopausal women. Within these frameworks, my visions and directions in addition to my proposals within the submission to the new NWHP can all be incorporated and put into action. What remains also is the issue of further partnerships and collaboration to help to further and enable the shift.

**From Interventions to Levels of Action – My Second Action**

To enable the contribution of postmenopausal women’s experiences into educational programs and health promotion for women, collaboration with other organizations is also necessary. As noted in chapter six, social resources as well as physical capabilities are also necessary for health issues. To instigate this social political action of collaboration and to focus on the social resources available for menopausal women in a much more local area, I conducted an interview at a women’s health agency. The interview explored the service needs of women in a regional area of NSW Australia. This was to address and identify the service’s capacity for addressing and supporting ageing menopausal and postmenopausal women and their issues of menopause and to ascertain any possibilities of collaboration to support my suggested ‘directions’. Whilst the first interview with the manager of a Women’s Health agency indicated that the service did not discriminate against ageing women, ageing women and their issues were not a priority for this women’s agency. The priority was stated to be: to accommodate young women’s issues and also indigenous women’s issues. It was
their practice to refer women with menopausal issues to another women’s health service/agency within the same geographical area which focused on menopausal issues. The first interview highlighted a gap in the service of this Women’s Health agency as ageing women’s health had not been included as a priority in their operational plan. This was disappointing as this Women’s Health agency operate from feminist theories and perspectives. However the WH agency was willing to correct gaps, and most importantly was willing to work in collaboration with the other women’s health agency in the area. The women’s health agency was prepared to be involved with workshops, conferences, groups and counselling. There was recognition of the fact that ageing women were not celebrated or honoured in Australian society.

Health Promotion Initiatives

I now turn to Keleher’s (2004a) chapter ‘Health Promotion Planning and the Social Determinants of Health’ as she presents a most appropriate model plan for health promotion for the phenomenon of menopause as it is a multilevel integrated health promotion plan. “Multilevel integrated health promotion involves collaboration work between organizations across sectors, using a mix of health promotion at distinct levels of action” (p. 120). Keleher also states that planning for health promotion is “both an art and a science” which involves the “science of high quality planning and the ‘art of strategic thinking’” (p. 120).

Because health promotion is about making a difference to people’s health and the conditions that support health, Keleher lists the basic principles that characterise health promotion initiatives. These principles when put into action for menopausal women will provide a much more comprehensive and integrated model to support women’s health. This would be a shift in focus from treating the so-called disease to supporting the health of the woman through the transition. The social determinant of equity and therefore social justice are addressed here. Also Rootman et. al. (2001) in their article Evaluation in health promotion, have outlined basic principles that I have also identified as necessary health promotion for the phenomenon of menopause. The basic principles are:

- **Empowering:** enabling individuals and communities to assume more power over the personal, socio-economic, and environmental factors that affect their health.
• **Participatory:** including all concerned at all stages of the process.

• **Holistic:** fostering physical, mental, social, and spiritual health.

• **Equitable:** guided by a concern for equity and social justice.

• **Sustainable:** bringing about changes that individuals and communities can maintain once initial funding has ceased.

• **Multistrategy:** using a variety of approaches – including policy development, organisational change, community development, legislation, advocacy, education, and communication - in combination (pp. 4-5).

These basic principles, characterizing health promotion initiatives, have also emerged from this research as essential to enable a shift to a more wholistic model. It therefore seems essential that these principles should be put into action to enable empowerment for menopausal and ageing postmenopausal women.

Keleher (2004a) also proposes a ‘Two-Tier Health Promotion Plan’. This plan contains the “‘essential steps for integrating the determinants of the problem on which the plan is focused’, and also includes ‘steps to build in an equity focus’. Both integrate steps for equity” (p. 114). The two tiers are, firstly, a conceptual framework for health promotion program planning and, secondly the technical program plan. Keleher recommends that this two tier Health Promotion Plan be built by first developing the conceptual framework, and then the technical plan.

**CONCLUSION**

Finally, the following by Keleher et.al. (2007c) sums up what has been expressed, together with the importance of this chapter.

An equity-focused approach to health promotion recognises that the social, environmental, and economic determinants of health are necessary foundations for practice, and it follows that understanding and knowledge of the social determinants of health among populations underpins the ability of government, organizations, and their programs to deliver effective health promotion (p. 21).
The necessity of this equity-focused approach to health promotion for both the phenomenon of menopause and the communities and populations of menopausal and ageing postmenopausal women is now critical.

The final chapter reviews the research and draws together the main concepts that inform the shift to a wholistic paradigm. It also explores recommendations, a new approach to health promotion, an enhanced primary health care (EPHC) program for menopausal women and explores the implications of this recommended approach.
CHAPTER SEVEN – REVIEW AND FINAL RECOMMENDATIONS
Introduction

The initial aim of this research project was to search for factors that prevent or inhibit evolutionary thinking within individuals and within disciplines regarding the phenomenon of menopause. This chapter reviews and brings together the results of the main points that have emerged from the research. It also addresses issues, which having emerged, indicate that a different approach is necessary. The different approach was revealed to be the need for a paradigm shift. The implications of this different approach will then follow, and then an explanation of the strategy I recommend. My final recommendations then follow.

Review, Results and Main Points of Chapters

The first chapter of this thesis, I outlined the aims and objectives of the research. They are listed in the Introduction. Through my own experience of menopause, going back thirty years now, which was an acute and premature occurrence, I realized that the phenomenon of menopause was more than just a loss of hormones. I had intuitions and an internal sense about what was occurring but my medical practitioner did not think these were relevant and he continually prescribed HRT/HT only for me for many years. This did not remedy the many changes that were occurring for me on various other levels. My life was not easy as I had two very young children and three teenagers at the time. Therefore, this research project has been my passionate search to enable me to reveal other knowledge that was more relatable. I suspected that I was not alone in my difficult experiences and that other women may have had similar experiences. I chose texts as my vehicle of exploration as I regard books as highly informative and influential. I was also interested in the thinking of doctors, and in addition I was interested in the thinking of women who had experienced the phenomenon themselves.

In the first chapter I also briefly outlined the methodology I was to employ and also the methods I considered to be appropriate. This chapter also includes a statement regarding the terminology of HRT/HT, and a brief historical exploration of the medicalization of women’s health and the medicalization of menopause, and how my research thesis expands on previous research. My research question was ‘What knowledge construction of menopause and ageing women more clearly reflects an alternative to a disease model?’
The second chapter explains in more detail the methodology including feminist principles, and also a thorough exploration of postmodernism drawing on a text that gave me very good insights into postmodernism. It was then that I realised the value of affirmative postmodernism. I also included an exploration of the contributions of postmodern philosophers including Lyotard, Foucault and Derrida. I have also briefly included the methods and the journey I took to find a most suitable second method for the postmenopausal women’s texts as the biomedical concept of menopause as disease did not ring true for me and I was searching for a more appropriate method. It was this journey that spoke to me, but was rejected, as it would not allow for evolutionary thinking. Rather it reflected a more positivist and reductionist approach. I explored further, and realised that the method of creating conceptual meaning would be the most relevant and would allow diversity, difference and a new way of thinking, about postmenopausal women’s experiences.

The third chapter explored, with the use of discourse analysis, seminal medical texts that were highly influential in cementing hormone replacement within the medical profession as the preferred and prescribed prescription for menopause. One of these texts in particular was highly influential in the public domain as well as the medical domain. This exploration was achieved through discourse analysis of the texts; as such discourse analysis was my first method of choice. The discourse analysis revealed the inconsistencies, contradictions and reductionist methods involved in the Western scientific dominant paradigm of menopause as disease and endocrinopathy. In addition, it revealed the underlying philosophy of body/mind split promoted by the French philosopher Rene Descartes. Descartes method is explored and reveals the dualism which separates body from mind, and ignores body and mind unity, therefore ignoring internal connections and also external connections that also affect the woman. In the case of menopause only the loss of hormones and the deterioration of ovaries were addressed by medical practices thereby omitting other internal connections and external connections that also occurs for the woman. The pathological language revealed negative constructions of menopausal women. The discourse analysis revealed the power of the medical profession to determine common practice in the management of menopause which was to prevent women from changing but to remain feminine forever.
Chapter Seven – Review and Final Recommendations

The fourth chapter begins with a discussion of the work recent female philosophers. This chapter also explored texts authored by postmenopausal women themselves of their own embodied experiences of menopause. These texts were written by professional women who have knowledge from their own discipline of practice as well as their own embodied experience, both internal, that is subjective, as well as objective knowledge, thereby presenting a more wholistic representation of the phenomenon. Through the utilization of creating conceptual meaning the identification of concept contrary to the medical model enabled the development of a wholistic model of menopause. The phenomenon of menopause presented was relevant and a realistic reflection of the experience of the women who wrote the texts. What became clear through this chapter was that menopause was a health issue rather than a medical one. This was evident as the women indicated a process was occurring which involved addressing the positive aspects. The concepts and processes of transition, rebirth, and transformation emerged from their experiences resulting in positive development. It became very obvious to me through these postmenopausal women’s experiences that health is about searching for the positives, whereas biomedicine is about searching for the pathology only. This had been my own intuitive understanding of my own experience of menopause. An adult life cycle developmental process has also been hidden behind the pathological disease diagnosis. The contradictions between the biomedical texts and the postmenopausal women’s texts were presented.

Chapter five explored health, holism and wholistic approaches, including systems thinking and theories. Emerging from this chapter was the wholistic health model as more relevant to the phenomenon of menopause rather than the biomedical objective reductionist pathological approach. Against the backdrop of a brief historical exploration of various philosophers and philosophies, health emerged as a positive process as it is based on a philosophy of connections (more wholistic) rather than separations (reductionist). Emerging also from this chapter was the obvious value of wholism, and therefore the urgency and necessity of a shift to a wholistic paradigm. In addition, both the value of connections and interconnections, which are characteristic of this women’s issue of menopause were highlighted. Consequently, systems thinking, together with a social model of health were revealed as vehicles of possibility for a more ethical health framework. Within wholistic thinking and systems theory, unconventional therapies and complementary and alternative medicines are included.
A social model of health is also recommended. Most significantly, a wholistic paradigm allows both an evolutionary impulse, as well as a co-evolutionary focus of the organism and the environment together. This is a more ethically sound stance toward the phenomenon of menopause.

Chapter six acknowledged health as sensitive to social environments and how political and social change are necessary to refocus the emphasis of menopause from a pathological philosophy, science and episteme of our time, to one that is positive and acknowledging of the empowering aspects of this health transition for ageing menopausal and postmenopausal women. And, from a postmodernist stance, this chapter presents my visions and directions for how this could happen. This will require a cultural change.

Chapter six also referred to the social determinants of health that are relevant for this women’s health issue of menopause. These social determinants were gender and equity and the research explored how these are intimately linked in women’s health issues. This chapter highlighted the social model of health as more appropriate and useful for the phenomenon of menopause as both gender and equity are recognised as significant within this model. It is within this model that gender blindness and equity omission can be addressed. This is in contrast to the reductionist objective biomedical model, which does not address equity issues or other social determinants of health.

In chapter six, as a researcher working from basic feminist principles, it was also necessary to create social change through critique and political action. In practical terms this means lifting the status of ageing women by allowing postmenopausal women and their texts to be the vehicles of knowledge for programs for menopause, to develop policies, programs and health promotion. In addition, PHC was explored as preferable to PC, and one strategy suitable for change for menopausal women. However, EPHC was my final recommendation.

Therefore, chapter six also builds further on the postmodern visions and directions and picks up the momentum of the feminist aspect of the methodology and defines in more detail, specific strategies and recommendations, specifically an EPHC strategy. The presentation of the recommendations and recommended strategy is more characteristic of feminist
methodology and therefore more congruent with the feminist research component of this thesis. The implications of this now follow.

**IMPLICATIONS EMERGING FROM THE RESEARCH**

Emerging from the narratives of the postmenopausal women was their need for information regarding the phenomenon of menopause. It was obvious that the biomedical information had not been sufficient for their needs. These women went beyond biomedical knowledge to enable them to work with the wholistic aspects that were occurring for them. Their knowledge can also assist other women to honour the experience on other levels that are also occurring at the time of menopause. These women whose narratives have been explored are not the only ones who have desired more information about menopause than they had received. This notion is revealed in the following words of Hunter & O’Dea (1999):

> Women generally desire more information about the menopause than they receive (1). Such information might enable them to understand what is happening during the menopause and how best to manage any changes that occur. Lack of knowledge is likely to impede decision-making about treatment, rendering women unequal partners in medical consultations ... Lack of information may also result in the over-attribution of symptoms to the menopause, which may have some other underlying cause … (p. 249).

And conversely, according to Hunter and O’Dea “increased knowledge is likely to empower women and increase their sense of control or self-efficacy in relation to the menopause” (p. 249).

Meleis (2000) and colleagues too have drawn our attention to the importance and need for much information and increased knowledge regarding the transition process. More definitively they state, regarding preparation and knowledge: “[a]nticipatory preparation facilitates the transition experiences, whereas lack of preparation is an inhibitor. Inherently related to preparation is knowledge about what to expect during a transition and what strategies may be helpful in managing it” (p. 21).
In addition, if women only learn and hear about the negative need for medicalization in the form of hormone replacement therapy to correct their so called pathological problems, and do not receive appropriate information about the positive adult life cycle process, they can become confused by the fact that they need medicalizing. In turn may become depressed as their adult developmental processes are not being supported on a wholistic level. Moreover, Hunter and O’Dea (1999) have stated that “there is some evidence to suggest that negative beliefs held beforehand might increase the likelihood of emotional and physical symptoms when women reach the menopause; balanced information might reassure such beliefs” (p. 249). Although Hunter and O’Dea’s work is about health education in primary care and refers mainly to the choices about HRT/HT, it does acknowledge the importance of the emotional as well as the practical aspects of menopause. They also recommend health education interventions for mid-aged women as follows:

Empower women by providing information and group discussion, thus increasing their knowledge of what to expect during the menopause and what services might be available should they be needed. They are relatively easily carried out and could be included as an adjunct to menopause services in general practice (Hunter & O’Dea, 1999, pp. 254-5).

To address these issues and to ensure that women have more wholistic informed knowledge regarding menopause and to ensure and make clear that menopause is not a pathological ageing process requiring only hormone replacement therapy to correct it, and for women to learn that it is an adult developmental process, I believe the following points are worthy of reflection and guidance:

- Menopause requires us to confront the stigma of aging;
- Menopause is not a disease, but a challenge;
- Optimal treatment of the menopausal woman needs the informed and educated participation of the patient (Cobb, 1990, p. 226).

This requires a different model, one underpinned by a wholistic philosophical approach. A wholistic paradigm, which includes a systems approach and a social model of health, has
emerged from this research as more appropriate to enable postmenopausal women to work together with menopausal women. The Figure 7.1 illustrates components of the wholistic paradigm for menopause and menopausal women.

![Figure 7.1 Summary of the Components of a Wholistic Paradigm](image)

**A MORE COMPREHENSIVE MODEL**

It has become obvious now, through the research, that a more comprehensive and integrated approach to the phenomenon is necessary and critical as menopause is a health issue and not a medical issue. Therefore I recommend that a comprehensive primary health care system is
more appropriate. A comprehensive primary health care system is preferable to selective primary care system for health. Keleher states that “selective primary care concentrates on providing medical interventions aimed at improving the health status of the most individuals at the lowest cost” (2001, p. 59). In the case of menopause this is the limited diagnosis of disease as truth and the recommended prescription of HRT/HT. This is selective primary care. In addition, this prescribed prescription and the dominant paradigm, controls and prevents the implementation and use of alternative and wholistic paradigms by both medical practitioners and women. The employment into policy of other knowledge sources and therapies also need addressing.

Therefore my recommendation for an enhanced primary health care (EPHC) within a comprehensive health care system, together with a social model of health based on a wholistic paradigm, would act as appropriate strategies to accommodate and deal with the other variables that are also impacting on the woman at this very significant and important time within her life cycle, a time when not just the woman’s body is changing but also her mind and spirit. Therefore these strategies could provide more appropriate support for this process. The process is a very significant adult developmental life cycle process, one where consciousness raising has been marginalized, rejected, ignored and hidden behind the pathological diagnosis of disease. Consequent to this menopause has predominantly been medicalized. Whilst PHC is preferred to PC, it is EPHC that I believe is the most preferable for menopausal women.

Briefly then, a Primary Health Care (PHC) model as preferable to the Primary Care (PC) model, and in contrast to Primary Care (PC) it focuses on, and incorporates the health aspect whereas primary care, as Keleher states, is drawn from the biomedical model and “practised widely in nursing and allied health, but general practice is the heart of the primary care sector” (2001, p. 57). However, also according to Keleher, although reforms are occurring in primary care, “the focus on reforms in primary care has little to do with the increase in concern about health inequities” (Keleher, 2001, p. 58). Concern about health inequities is required as it is a determinant of health and therefore also a human rights and social justice issue.
As noted before in this thesis, menopause is a gender equity issue, or more correctly a gender inequity issue, one of gender blindness and of omission. Regarding the concern about health inequities, Meleis and Im have concluded that, “[a] more integrated model that encompasses a special consideration of a history of inequity” maybe required to “drive the development of more gender-friendly knowledge” (2002, p. 221).

Therefore, the practice of primary care is inadequate to deal with the health issues that arise for menopausal women, as it is reductionist, too limiting, and does not address inequities and therefore social justice principles. Health equity approaches are then required. Regarding equity approaches, Keleher states that “in policy, health actions, and research are about making visible the sources and characteristics of inequity and actively taking policy decisions and programmatic actions directed at improving equity in health or in reducing or eliminating inequities in health” (ISEqH 2005, cited in Keleher et al., 2009, pp. 35-36).

Also according to Keleher, the above equity approaches are “steps that any organization can take to ensure it is addressing inequities but surprisingly few actually do incorporate specific health equity steps into health promotion planning” (Keleher et al., 2009, p. 36). This is a social justice issue.

The following by Keleher are also important. Keleher et al. cite the UK Health Development Agency and their definition of health equity as the process by which partners:

- Systematically review inequities in the causes of ill health and in access to effective services and their outcomes, for a defined population

- Ensure that action required is agreed and incorporated into local plans, services, and practice

- Evaluate the impact of actions of reducing inequity (Keleher et al., 2009, p. 36).

In the case of menopause, the defined population would be all women from middle age, approximately 35 years onwards (necessary to inform about exercise and nutrition) or
alternatively 42 years onwards. The defined population assigned to bring new knowledge to ageing women from midlife and beyond would be from postmenopausal women who have positively transited the experience themselves. Postmenopausal women who understand and have knowledge of the potential of this adult positive developmental process and the potential developmental energy that simmers, smoulders, or rumbles below the surface. Effective services are needed to address this.

In addition, a comprehensive model would include additional modalities, such as unconventional therapies and CAM that can also be supportive in empowering women to access their potential developmental energy at the level of each individual woman’s needs. I now turn to what could assist to put the above steps into action.

**RECOMMENDED HEALTH CARE PROGRAM FOR MENOPAUSE – ENHANCED PRIMARY HEALTH CARE (EPHC)**

To address the need for these other knowledges and CAM, a program initiative that provides a framework that includes a multidisciplinary approach to health is most desirable. These other knowledges have emerged as holding more critical information that will inform women and are essential to assist women moving into their adult developmental process. Therefore my recommendation would be for an “Enhanced Primary Health Care Program” (EPHC). This would enable multidisciplinary knowledge to also be included in the programme. This would also expand on the already current Enhanced Primary Care Program (EPC) that has existed in Australia. This EPC program the Enhanced Primary Care Programme “provides a framework for a multidisciplinary approach to health” (Department of Health and Ageing, 2008). However the EPC, because it is a primary care model only, and not a health care model, it is also based on biomedical scientific practices.

Whilst an EPC programme has been introduced it was implemented “to provide more preventative care for older Australians and improve coordination of care for people with chronic conditions and complex care needs” (Department of Health and Ageing, 2008). It is also a Primary Care programme only, rather than a Primary Health Care programme, and therefore does not include the ‘Health’ component. This health (wholistic) component,
having been noted earlier in chapter five of this thesis as essential for the phenomenon of menopause, menopausal and postmenopausal women. The wholistic aspect is not included in the primary care program as it is initially based on the reductionist biomedical model and not a health model and in addition does not deal with inequities as Primary Health Care does.

Therefore an EPHC program is preferable, being a health care program, it includes the ‘health’ (wholistic) aspects. It addresses equity issues and is more suitable to allow for the gender and inequity issues to be taken into account. However, because the enhanced model also includes multidisciplinary knowledge, knowledge from a variety of postmenopausal women practitioners together with their own internal knowledge would also be instrumental in enhancing and informing the learning process for all women. In addition, it would provide the space for alternative therapists experienced in art processes and writing processes to contribute to the programme. These are important as they can present additional knowledge regarding the creative processes that can assist the women in their developmental process. Therefore I recommend the Enhanced Primary Health Care (EPHC) model as I believe it most appropriate for the phenomenon of menopause. Practitioners and therapists from various disciplines including the arts would contribute rather than just biomedical practitioners. I believe this presents the most authentic health strategy, as a variety and diversity of information would be available to meet each woman’s needs.

Keleher (2001) has explained that links between primary health care and health promotion are critical regarding health inequities. In addition, health promotion is a strategy of public health.

When conducted from primary health care foundations, health promotion is a transformative practice. Health promotion is also a strategy of public health. Health promotion is at the health gain end of the continuum, sharing the social justice and equity principles of primary health care because both aim to create enduring social change… The links between health promotion and primary health care are critical if health inequities are to be overcome (Keleher, 2001, p. 59).
From this perspective the links between PHC and my proposed EPHC would also be critical to address the gender equity and health inequities of menopause. In addition because health promotion is a strategy of public health, health promotion for menopause, menopausal and postmenopausal women, together with the links to the Enhanced Primary Health Care program could be addressed as a responsibility of new public health.

New Public Health has been referred to by Davies et.al. (2001, p. 1) in relationship to health promotion as being based on a changing paradigm lead by the WHO and articulated in The Ottawa Charter of Health Promotion and various “major international, health promotion conferences and meetings”. In addition they elaborate further that:

> Education and training programmes for health promotion should therefore be based on a philosophy of health rather than disease prevention, and in that respect they should concentrate on conceptual development and the ability to reflect on practice ... The values and principles that underlie health promotion, as in many other forms of training, are a belief in social justice and equity. But in addition, approaches and learner empowerment strategies, together with an ecological understanding of health determinants and interdisciplinary methods are also of central importance. These issues are best achieved through a learning environment that encourages critical thinking, teamwork and reflective practice (Davies et.al., 2000, p. 2).

It is these issues that I believe can be addressed within my recommendations for health promotion as the conferences themselves will be based on teamwork (multidisciplines), which in turn will result in stimulating critical thinking, and reflective practice, not only for the presenters, but also for the women present.

**HEALTH PROMOTION STRATEGY**

Therefore as the health promotion strategy, I propose and recommend the employment of women’s health conferences as the first and preliminary step towards the EPHC program, for all women approaching menopause, menopausal women and postmenopausal women. Postmenopausal women generally to be included in order enable these women to access the
knowledge that they have been deprived of. These conferences as a health promotion strategy would be presented by postmenopausal women philosophers together with those who present from different disciplines therefore maintaining gender equity and social justice as the base from which the conferences are designed.

Included also would be a range of presentations from multidisciplinary practices, the including the biomedical model based on scientific principles. It is acknowledged that some women will choose HRT/HT and other medical treatment and should be fully informed of the benefit and risks associated with this choice. Also complementary and natural therapies through to therapists who present from artistic perspectives, e.g. writers and artists could contribute effectively to the development of women’s knowledge. The conferences, by supplying and presenting various knowledges would be effective in stimulating women’s learning. They would be the first step in presenting transdisciplinary knowledge for all women regarding this transitional process. In addition this type of health promotion is a process that is an example of healthy structural and political change.

Health promotion for menopause in the form of conferences would be lead by postmenopausal women trained in various disciplines together with lay postmenopausal women who have published their own experiences to direct the conferences and also present the content and share their own perspectives and theories. It is important that it is specifically the community of people who have experienced the phenomenon as those who are most appropriate to participate in processes of change. I therefore concur with Keleher when she refers to “the mobilisation of communities to enable the people most involved to participate in change processes” (Keleher, 2001, p. 59). This would be the community of postmenopausal women who have transited the experience themselves. I have already addressed how the knowledge and value of postmenopausal women can be acknowledged and shared in the previous chapter.

I believe conferences, as a health promotion strategy, would be also a place of learning for ageing women. Learning as distinguished from education as women listen to a variety of disciplinary input and are able to choose what is most relevant to their situation. They are then able to make wholistic informed decisions themselves.
The conferences would be available to all women as a means of relaying multidisciplinary knowledge and a variety of information to them. Information is critical to empower women to enable them to participate in their own health care, as empowerment is central to feminist healthcare practice. Andrist states the importance of access to information when she said:

When clients become empowered and have access to information, they are able to participate in decision-making surrounding their health care. This is central to a feminist model of healthcare practice. The concept of ‘participation’ is important; providers must consider that people will vary regarding their ability and desire to share in decision-making. Feminist practitioners are teachers and co-participants, and expect that patients are potentially knowledgeable participants (1997, p. 271).

Therefore it is important that women can have access to knowledge and information. It is particularly multidisciplinary knowledge, including also postmenopausal women’s perspectives and theories and ways of knowing. These have emerged from the research as those marginalized, ignored and omitted in the dominant paradigm of western biomedical processes that we have inherited as the episteme and dominant Western paradigm of our time. The conferences present a space where diversity of knowledges are presented giving women a very good overview of the multi-level aspects that are involved in the phenomenon. This preparation would in turn facilitate the transition experience (Meleis et.al., 2000), as the women would be exposed to information that would assist them in deciding which practitioners included in the strategy package would be best to help them manage the phenomena. It therefore enables them to make conscious and more self-directed decisions about what further assistance they may require which will be helpful and enable them to manage in a wholistic health directed way.

**Details of the EPHC Program**

The EPHC program, will allow the women’s body, mind, spirit and positive valuable connections to be addressed. This is in contrast to the PC program, which is the pathological biomedical strategy which splits body from mind. In addition the EPHC will also address the social aspect and connections that also affect the woman. Finally, each woman from age 42 years, after attendance at conferences, which eventually would be run regionally, would have
access to seven practitioners as part of the Enhanced Primary Health Care (EPHC) programme.

Ongoing groups for women would also be available locally as follow up of both the conferences and the EPHC sessions to enable connection with other women. This will lend ongoing support to each woman, as well as developing stronger connections between the women. This also affirms the feminist literature that connections rather than separations are important, and have also been identified as a very high value for women by (Gilligan 1982) in her text 'In a Different Voice.'

Secondly the Enhanced Primary Health Care Program would be available for women as follow up from the conferences. Firstly, through the EPHC women would have access to four postmenopausal women practitioners to provide the following for each individual women, biomedical knowledge, naturopathic knowledge (including natural and complementary therapies), nutritional knowledge (including nutritional medicine), and nursing care knowledge regarding environmental and context issues (thereby explaining and expanding on the social model of health). The women would then have a choice of three additional postmenopausal women therapists who could assist in exploring and clarifying the direction of the new energy as a result of their brain that is changing and whilst the energy is rising and causing heat to rise (hot flushes). This would enable the women themselves to choose the practitioners and therapists most suited to their context and contextual issues and the women would be able to make more conscious, calculated and informed decisions regarding their needs at this time, therefore empowering each individual woman to make her own choices.

These last three would also be postmenopausal women therapists to enable women to work towards their new creative selves. These would include postmenopausal women psychotherapists trained in Jungian theory, as Jung was the first to acknowledge that women have different developmental paths than men. Jung also identified and concentrated on the spiritual aspects of the second half of life, whereas Freud only concentrated on the aspects of the first half of life. In addition, postmenopausal women art therapists and postmenopausal women editors and publishers could be accessed to supply writing and artistic skills thereby
supporting women to develop their particular talent or gift to the world. Because it is difficult for medical practitioners, trained in reductionist processes to be proficient in multidisciplines, a multidisciplinary team of postmenopausal woman practitioners could bring education and knowledge from both their own discipline as well as their own internal knowledge.

**FINAL RECOMMENDATIONS**

The recommendations below provide women with the opportunity to experience learning about menopause; seeking treatment, (EPHC), or utilizing women’s support groups.

1. **Learning Opportunity: Health Promotion for Menopause: Conferences**

   **Multidisciplinary Conferences:**
   - Initially National - Group Follow Up
   - Then State - Group Follow Up
   - Then Regional - Group Follow Up – Locally
   - Multidisciplinary Conferences presented by:
     - Postmenopausal biomedical practitioners
     - Postmenopausal natural, complementary and alternative practitioners
     - Postmenopausal women philosophers
     - Postmenopausal women nurses (socio-economic and stress issues)
     - Postmenopausal women psychotherapists and counsellors, (including partner issues).

2. **Enhanced Primary Health Care Program:**

   **EPHC Practitioners Including:**
   - Biomedical Postmenopausal Woman Practitioner
   - Complementary Medicine/Naturopathic Postmenopausal Woman Practitioner
   - Nutritional Postmenopausal Woman Practitioner
• Nurse Postmenopausal Woman Practitioner, addressing socio-economic issues and stress issues
• Jungian Postmenopausal Woman Psychotherapist
• Postmenopausal Woman Art Therapist
• Postmenopausal Woman Editor, Publisher, Writer

3. **Seminars, Workshops and Forums:**

- Postmenopausal women’s seminars, workshops and forums for non-health experts
- Resource material based on non-health experts experiences of menopause to be provided to participants

4. **Local Group Follow Up available after all sessions:**

This concludes my recommendations and strategies for menopause, perimenopausal, menopausal and postmenopausal women.

**Implications of Lack of Status for Ageing Women**

I hereby concur with Mary Gergen who states that she is “not the only investigator who has suspected that menopause has been construed as a detrimental factor in women’s lives. A study comparing attitudes about menopause indicated that women did not view menopause as negatively as members of the medical professions” (1989, p. 85). In addition, drawing on Bart (1971) Gergen contends that depression associated with menopause is not just related to hormonal changes but is associated with a lack of life choices. Moreover she argues that depression is predominantly found in those cultures “where women’s status decreases after menopause” (1989, p. 85).
FINAL CONCLUSION

What I have not researched in this project are the texts of black or indigenous women’s experiences of menopause. This is an omission on my part. However, much cross-cultural research indicates that postmenopausal women in other cultures move to positions of status and power after middle age. They become valuable cultural assets and agents for social change. Various anthropological researchers, in their cross-cultural studies indicate that women gain higher status and positions of power in their culture after menopause. Quite often they become cultural assets as healers.

Regarding further research, because the bulk of research on menopause has been on the risks and benefits of HRT/HT as the prescription for the disease, I conclude that postmenopausal women now be able to define and develop wholistic health policy, educational programs and health promotion on menopause as research projects to correct the imbalance that has occurred in the dominant paradigm and episteme of our time. There evidence for the urgency in this regard in order to respond to equity issues. The main research emphasis could then shift from the medicalization agent to the adult developmental life cycle process of the woman herself. In addition multidisciplinary research would enable a focus on wholistic philosophies, episteme and discourses, which have been marginalized, omitted and ignored in the dominant paradigm of our time.

Further philosophical research that explores the contribution of concepts such as complexity theory, systems thinking and self-organisation would enrich, and could deepen the understanding of Wholistic Health. I consider this as a necessary further research project.

Both the recommended health promotion programme and additionally the links with the Enhanced Primary Health Care program that I have proposed as a result of this research would initially be addressed as a responsibility of new public health and as new public health issues, to enable addressing the inequities that have emerged for women through the Western scientific reductionist pathological diagnosis, and thereby addressing the historical imbalance that has occurred for menopausal women.
REFERENCES


References


References


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Menopause: The Need for a Paradigm Shift from Disease to Women’s Health Margaret T.C. Harris


References


APPENDIX ONE

MARGARET T. C. HARRIS
SUBMISSION TO
THE COMMONWEALTH GOVERNMENT ON
THE NEW NATIONAL WOMEN’S
HEALTH POLICY

20 November 2009

Nicola Roxon,
Department of Health and Ageing,
Commonwealth of Australia,
Canberra. ACT. 2600.

20.11.09
Attention Helen Rankin - Re: New National Women’s Health Policy

Dear Helen,

I hereby attach a submission for the new National Women’s Health Policy.

The two headings I have employed for this submission are the same as on the new NWHP State and Territory Consultation Sheet (blue paper) which was completed at the Forum, Windsor Hotel in Melbourne, 27/10/09.

1. What are your priorities?
2. What could be done about these?

In the second section I have also addressed the five principles underpinning the new NWHP, in relationship to my priority issue.

This is an individual submission.
Thank you for the opportunity to submit. You can contact me further on 0430 182 751
Or   mharri10@scu.edu.au

Yours faithfully,

**Margaret T. C. Harris.**
B.Soc. Sc. - A.C.U.
Grad.Dip. – Women’s Health,
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New National Women’s Health Policy

SUBMISSION - SECTION ONE - My Priorities

I am offering this submission in support of the new National Women’s Health Policy (NWHP) and whole-heartedly endorse the Social Model of Health. However, my PhD research indicates there is an equity issue for ageing women that requires more attention. The issue is specifically the women’s gender health issue of menopause and is relevant to all menopausal and postmenopausal women.

I propose that the following five crucial points be addressed in more detail in the new policy.

That menopause be considered as a Priority Issue or reinstated, as in the first National Women’s Health Policy (NWHP 1989. p. 27-28) as a ‘Specific Health Issue’.

That menopause is a Gender Equity Issue and therefore it has a prominent place within the first of the five principles underpinning the new NWHP.

That a paradigm shift from the dominant paradigm of the reductionist scientific biomedical model of menopause, which is underpinned by Descartes’ Cartesian dualism, body/mind split, and was defined pathologically as a disease by Wilson (1966) and Utian (1978), to a wholistic model is required, to enable menopause to be addressed more comprehensively and within the social model of health.

That A Life Course Approach (NWHP p. 10) is very appropriate to address this issue of menopause as ‘it recognises key developmental and transition points in women’s lives, and the cumulative effects of experiences over time’. Menopause as a wholistic1 adult developmental process, and therefore as a transition, has not been formally acknowledged in policy design, educational programs for doctors, or educational programs and health promotion. I believe postmenopausal women should define policy and lead in these areas as they have, through their own embodied experiences, more knowledge of women’s needs.

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1 I am using ‘w’ in ‘wholistic’ rather than ‘holistic’ as wholistic paradigms can be identified by connections and interconnections, and where the whole woman is implicated by biological, psychological, emotional, and spiritual connections, together with the connections she has with her context. (social).
regarding the wholistic aspects, which include the psychological, spiritual and social, in addition to the physical.

That the term ‘life-cycle’ be included to define women’s internal embodied experiences of menstruation and menopause. This term can define the internal processes as distinct from the ‘Life Course Approach’, which includes the external events and context that also impact on the woman over time from birth to death. The life cycle would then be included and developed within a ‘life course approach’.

The World Health Organization’s Commission on Social Determinants of Health (WHO 2008), regarding tackling ‘the inequitable distribution of power, money and resources’, calls for, among others, the following regarding health and gender equity:

“Health equity to become a marker of government performance that a gender equity unit to be created and financed gender Equity to be promoted through enforced legislation”

www.who.int/social_determinants/thecommission/finalreport/closethegap_how/g  Accessed 9/9/09

Regarding Inclusion of Postmenopausal Women

With reference to the new NWHP, (2008.p. 9) - I believe that the responsiveness of the health system to both menopause and menopausal women can be improved by employing postmenopausal women to define and develop policy on menopause for menopausal and postmenopausal women. Program managers for menopausal programs can be postmenopausal women and service providers too. Initially, these would need to be practitioners and professionals, specifically those postmenopausal women who have published their narratives and texts of their personal embodied experience, as their texts could be the guides for future educational programs. This would give status to our ageing and postmenopausal women as they would become the ones who could pass down the wisdom, and act as the guides of this significant transitional experience to many other women. Their participation is essential.
In relationship to the five principles underpinning the new National Women’s Health Policy I submit the following regarding menopause, menopausal and postmenopausal women. The five principles underpinning the new NWHP are:

Gender Equity
Health Equity Between Women
A Focus on Prevention
A Strong and Emerging Evidence Base
Life Course Approach

Regarding the First principle underpinning the new NWHP – Gender Equity

(a) The positive dynamic aspects of adult development of the normal menopausal life-cycle process are also necessary in the development of policy, educational programs for both professionals and women, and also health promotion for menopause. This is a gender equity issue. What is required to address this gender equity issue is that practitioners and professionals who are postmenopausal women, specifically those who can contribute through their own experiences of menopause or have published texts on their own experiences, are to be defining and developing policy for menopause. In addition, the use of their texts, as contributions to the development of educational programs for medical and all allied health professionals and women too is necessary. Also their texts can be the guides and templates for health promotion programs for women. These programs would be imbedded in a social model of health, as gender and equity are social determinants of health. In addition, social-economical and socio political aspects all play a part in how the individual woman experiences the menopausal phenomenon. Collaboration would also be an essential aspect of the new paradigm for menopause, menopausal and postmenopausal women and is referred to in the section below.

(b) To instigate the paradigm shift from the dominant reductionist biomedical model to a wholistic model my recommendations are initially the development and actualisation of inaugural National conferences for health professionals and women also. Keynote speakers for the conferences would be postmenopausal women. I refer specifically to international
gynaecologist Dr. Christiane Northrup MD., as her text *The Wisdom of Menopause* is highly significant and would be very informative regarding the wholistic life-cycle development process. Her text, through her own embodied experience indicates a more wholistic approach as she explains the body/mind connection that both Wilson (1966) and Utian (1978) dismissed. For more on Northrup’s approach refer Northrup’s own text, *The Wisdom of Menopause*. I can also recommend various other international postmenopausal women authors. Funding for six monthly National Conferences to come from Federal Government.

In addition, more local female medical doctors would be included, those who have also experienced the transitional process, specifically and on the more local scene. For example, Australian postmenopausal practitioners, Prof. Kerryn Phelps and/or Dr. Sandra Cabot. In addition, collaborative postmenopausal practitioners from allied health professions to be included as speakers, including those from psychology, psychotherapy, counselling, and the arts; in addition, those who can also be instrumental in supporting and encouraging the adult developmental process through drama, artistic practices, writing and literature publication, to name a few. Also postmenopausal women nutritionalists and women’s exercise specialists. Last but not least, postmenopausal practitioners from complementary and alternative medicine as each has something to contribute. Menopause being a wholistic phenomenon requires women practitioners and professionals from multiple disciplines, rather than just from scientific biomedicine.

**Sustainability and Collaboration**

I believe these conferences would be the impetus for future sustainability. State conferences and workshops funded initially from State Governments, could then be organised, utilizing our own national postmenopausal women practitioners, together with groups formed at more local levels, as a result of the conferences. The follow up groups would include the input from individual women and would provide support from within the groups to help to define what each woman needed. The conferences would act as the inaugural event for women and serve as stimulus to an ongoing process, endeavouring to include all women’s voices through the emergence of women’s groups as a result of the conferences. These groups would function similarly to the process we women ourselves went through at the NWHP State and Territory Consultation Forum, Melbourne, 27/10/09. The process could probably be a bit
more specific, with initially smaller groups (maybe 4-6 in group) than we had at the forum, to enable each woman’s real needs to emerge. These ongoing groups could then be supported by local and rural women’s health centres (e.g. the rural women’s health centre in the area where I study), where particular women’s health needs, when required, could be met initially by the most suitable multidisciplinary and/or interdisciplinary practitioner for each woman, whilst the women transited the process.

This would require collaboration from a vast range of disciplines, (as listed above) in their agreement that each of the disciplinary practitioners and alternative practitioners maybe as necessary and as essential as medical practitioners to meet the initial and diverse particular health needs of particular women. Further, as the women move through their own processes, they too, through the assistance of the group processes (local women’s health centres), individual women can define and develop their particular strengths and gifts, and through their own empowerment and wisdom, can then be instrumental in passing on their embodied experiences to the younger generation of women as they too move into their menopausal years.

These postmenopausal women then, in turn, become our elders, and in addition, any woman who can publish their own experience of the process of this adult life-cycle developmental process can contribute to the educational and health promotion programs. These texts would, through an inclusion of multiple postmenopausal women’s voices, also act as additional guides and templates for many women. Finally after women have received this new more wholistic knowledge via the conferences and women’s groups, inclusion of partners and husbands in programs would be appropriate so they too can be educated also regarding the phenomenon, and also learn how they can assist and support their women through the transition, as this can in turn, provide a learning process for them also. Finally, future income generated from conferences could support future conferences in the local areas, whereby postmenopausal women from their local areas can be involved in organizing future conferences.
Conference Program

To ensure that we have herstory regarding wholistic embodied experiences of menopause, I have developed a draft conference program to be presented initially by multidisciplinary postmenopausal women health professionals and practitioners. I would be happy to discuss further details regarding this draft in consultation with women’s health stakeholder groups, peak bodies and health professionals groups to develop this conference program further. This National conference program could be offered to all practitioners and in addition, to women also, as it is important that women learn the same knowledge as the professionals themselves so they can make their own informed decisions. This particular conference program has emerged from my research, and will also be embedded within a social model of health, as this model allows for a new (wholistic) framework for the phenomenon of menopause as well as socio-economic and socio-political aspects. I can provide ideas for how participation in decision making from women themselves can occur regarding these conferences, and also the groups that will develop as part of the follow up. The importance of decision making from women themselves has been stated in the new NWHP, (2008. p. 9). In addition, collaboration with community agencies, and both State and National governments will be necessary.

As a result of the new paradigm, aging postmenopausal women would gain some status in our culture. In addition, postmenopausal women could be involved in running the future conferences. Rather than being constructed negatively and being defined pathologically, and considered dysfunctional, diseased and chronic patients, ageing women would develop status and become an asset to our society. They would be important in passing down the wisdom and knowledge of this powerful life cycle process to the younger generations of women. As noted by Astbury, “increasing women’s status as human beings” is a change that needs to be made for “women’s right to good mental health” (2006. p. 389). Therefore increasing postmenopausal women’s status would also be beneficial to aging women.
Regarding the Second Principle underpinning the new NWHP – Health equity between women

What I have suggested here in this submission can be relevant for all women from midlife onwards. As the programs would be women centred, each woman has the opportunity to tell her own story and her context. Listening to the woman as an individual within her own life situation with a focus on her context allows for her specific individual diverse needs to emerge. Therefore I believe it meets strongly the principle of health equity between women. In addition it would support health equity between women as all women can be included and respected for their own individual adult life cycle developmental process and, with it, enjoy and deserve the status of elder within the culture. Appropriate questions would be instigated to enable and ensure that each woman’s needs would be addressed.

Regarding the Third Principle underpinning the new NWHP - A focus on prevention

It has a focus on prevention as the multidisciplinary presenters presenting to all women from middle age, or from 35 years, are providing information and education for women for the second half and the rest of their lives. It has been noted that “Anticipatory preparation facilitates the transition experience, whereas lack of preparation is an inhibitor. Inherently related to preparation is knowledge about what to expect during a transition and what strategies maybe helpful in managing it” (Meleis, Sawyer, Im, Hilfinger, DeAnne, and Schuumacher (2000). This education would be inclusive of information on body, mind, emotions and spirit. Importantly, nutritionalists and exercise practitioners would be part of the program too. All these contribute to a focus on prevention.

Regarding Fourth Principle underpinning the new NWHP – A strong and emerging evidence base

A strong and emerging evidence base regarding the social model of health, including the social determinants of health, as the appropriate model for menopause is present in my research.

According to the World Health Organization, regarding the social determinants of health:

“The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power
and resources at global, national and local levels, which are themselves, influenced by policy choices”. [www.who.int/social_determinants/en/] Accessed 09/09/2009.

Also, as stated by Broom (1991)

“The advent of the social model of health enables women’s health activists to resist the medicalized model that attributes all women’s difficulties to our defective bodies and constitutions, an approach which depoliticises women’s protest and trouble by ‘naturalising’ symptomatic behaviour” (p. 53).

In addition, the Australian Women’s Health Network (AWHN) in their Submission to the Commonwealth Government on the New NWHP state that ‘The WHO Commission on the Social Determinants of Health identifies gender as one of the fundamental social determinants of health’, and

“The Commission produced an impressive body of evidence on social determinants and AWHN strongly recommends that the Commonwealth Department of Health and Ageing (hereafter the Department) use the findings and recommendations of the Commission as the foundation for all health policies including the new NWHP” (AWHN, 2009.p. 1).

In addition, the new NWHP Consultation Discussion Paper (2009), states that “The women’s policy will recognise gender as a basic determinant of health, which gives rise to different health outcomes and different needs for women and men” (p. 1.).

**Regarding the Fifth Principle underpinning the new NWHP – Life Course Approach**

This principle too, is very prominent and obvious for this particular gender equity issue of menopause as menopause is specifically a life course occurrence for every woman who reaches middle age.

However within the life course for women, there also needs to be included and inserted the ‘life cycle’. This is because life cycle is specifically and only a woman’s issue and life cycle acknowledges the woman’s internal monthly cycle. The life course has more specific reference to the outer happenings of her life, which of course represent her context and are also implicated, and will emerge through women’s voices and stories. However life course
omits the internal cyclical aspect, which is solely a women’s experience, and not a man’s. Life course applies to both women and men. Life-cycle would apply only to women. At present this is a gender omission.

I believe ‘life cycle’ is required in addition as it is more appropriate for this specifically women’s gender experiences, and it also validates and recognises the value of her cycle by naming it specifically for women only. It also acknowledges her female history as her whole reproductive system is cyclical, and this health issue of menopause is also part of that cycle which has been repeated monthly, the life and death of her eggs. In this case it is the cycle of death and rebirth, death to the reproductive system and rebirth of a productive system. Within this cycle, menopause is both a death and a positive rebirth.

(End of submission to new WHNP)
APPENDIX TWO

Women’s Health Agency Interview

Process

1. Face-to-face semi-structured interview.

2. Transcription of interview.

3. Member Check.

4. Returned from interviewee with additional material.

What was revealed in the transcript as a result of the interview follows.

(a) Whilst the first interview with the manager of a Women’s Health agency indicated that the service did not discriminate against aging women, aging women and their issues were not a priority for this women’s agency. The priority was stated to be: to accommodate young women’s issues and also indigenous women’s issues. It was their practice to refer women with menopausal issues to another women’s health service/agency within the same geographical area which focussed on menopausal issues. This first interview highlighted a gap in the service of this Women’s Health agency as aging women’s health had not been included as a priority in their operational plan. This was disappointing as this Women’s Health agency operate from feminist theories and perspectives. However the WH agency was willing to correct gaps, and most importantly was willing to work in collaboration with the other women’s health agency in the area.

(b) [Raising] the status of aging women [is viewed as an] advocacy issue.

(c) [There is a need to revise] gaps and increase capacity through new initiatives.
(d) [One initiative would be to seek] increased funding. [Given that the] new National Women’s Health Plan outlines priority areas [it would be important to seek] additional funds to increase our capacity. [But] money is only available for growth areas such as mental health and acute care. [Also] the NGO Grants program is currently being reviewed in NSW. We would need to have the project first, then apply for Women’s Health Funding and philanthropic trusts.

(e) The agency could also collaborate and assist in the following areas:

Conferences: [Contribute] expertise in the planning stage of the conferences. [Utilise the] knowledge of other Practitioners [such as the] naturopath. [Facilitate] group discussions.

Workshops: To educate and assist women in defining possibilities for their future journey into menopausal years and to identify socio-political, socio-cultural, and soci-economic factors that may be relevant to their wholistic development, and which may assist them to change.

We would be willing to work with male partners, as this was also an important aspect in Family Planning Education.

Groups: [Facilitation of] groups in addition to the above.

Counselling: We have a counsellor employed at the centre who uses Sandplay (Jungian), Voice Dialogue and Narrative Therapy approaches, who would be able to assist with this process.

What else would you like to comment on or add now?
In our culture we do not honour aging women. Some cultures have rituals, menstrual rites of passage that are important for people. We live in a youth obsessed culture where we are not valued as we grow older.

*We target aboriginal and young women. However we would be willing to work in collaboration with the women’s health agency which focuses on menopause.*

END OF INTERVIEW