CHANGING BODIES, CHANGING DISCOURSES:
WOMEN’S EXPERIENCES OF EARLY MENOPAUSE

by

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INTRODUCTION

Early menopause has been constructed by discourses of biological determinism as an untimely, but natural, failure of the female body. Medical discourses in particular have interpreted early menopause as a congenital irregularity and a rare anomaly of menopause at midlife. In this thesis I challenge the notion that early menopause is an innate imperfection related only to women’s age. I propose that early menopause is dependent upon the cultural interpretations of individual women and is constituted through the mercurial and multiple discourses of women who have this embodied experience. Moreover, I reveal that early menopause is a contemporary condition and that its location in history is inextricably bound to discourses of risk, naturalism and the self. Further I make the assumption that having an early menopause both affects and is an effect of women’s fertility, sexuality and subjectivity.

I have drawn upon a broad range of sources to provide a sociological analysis of early menopause. Literature on early menopause is dominated by positivist discourses, yet many alternate discourses negotiate these influential constructions. I suggest here that the perception of early menopause as a natural fault is merely a construction by medical discourses and does not incorporate the dynamic discourses of early-menopausal women. Moreover, the restriction of early menopause to a genetic female failure excludes the majority of women who have an early menopause through iatrogenesis. This omission occurs through the failure of positivist discourses to accommodate diversity in discourses.

Recent sociological and feminist studies have vindicated menopausal women. They have reconstructed menopause through notions of embodiment and have removed the veil of negativity used by the medical sciences to contain menopausal women (Komesaroff, Rothfield and Daly 1997). The visibility of menopausal women, however, remains connected to age. Menopause has been created as a predictable consequence of aging and as such has come to be synonymous with middle age. Nowadays, even men are said to experience menopause at midlife (Carruthers 1996).

But early menopause is constituted within the discourses of women who have this experience. Medico-scientific discourses, based upon theories of genetic inevitability, disregard this perspective. Consequently early menopause is subsumed by naturalistic discourses that relate menopause to midlife. Such restraint reflects the unease created by menopause that does not coincide with prescribed life stages. Women’s experiences of their changing bodies are largely unheard. Thus, women who have an early menopause are faced with a chasm of ‘cultural non-recognition’ (Fraser 1997).

Conjointly with this discursive repression early-menopausal women face social imbalances that are transacted as both cause and consequence of early menopause. In particular the contemporary creation of early menopause is bound to the social and historical location of women as a group. Women are exploited by the institution of medicine, “exposure to environmental toxicity” (Fraser 1997: 11) and commercialization as causes of early menopause. Yet the corporeal effects of practices of risk avoidance (Beck 1993), social practices (Shilling 1993) and Western consumerism (Lupton 1994) fail to be recognized.

I address these problematics through a poststructural and feminist critique that assumes moments of commonality among women, while at the same time recognizes shifting and multiple differences (Nicholson 1999). I suggest here that early menopause falls into cultural misrecognition in Fraser’s (1997) terms and argue that it is united concurrently with the gender injustice of androcentrism (Fraser 1997: 21). Fraser (1997: 16) suggests that it is only by relating these dual problematics that we are able to make
sense of current dilemmas. Thus I have critiqued early menopause through a connection between individual embodied experiences of early menopause and early menopause as a modern phenomenon that is specific to women. I have attempted to unravel these arguments that simultaneously call to “... abolish gender differentiation and to valorize gender specificity” (Fraser 1997: 21) while at the same time acknowledging their interconnectedness. An approach of merely combining women’s discourses with overarching social issues would be inadequate as not only do these problematics intersect but they also can be opposed. As Fraser (1997: 25) notes with her theory, redressing one aspect of cultural or social analysis can further imbalance another.

For instance making visible the diversity and uniqueness of individual experiences of early menopause could detract from acknowledging the contemporary construction of early menopause through social inequality. Crucial to this understanding is a destabilizing of the binary construction of differences between the sexes that makes way for a reconstruction of early menopause through ‘sexual slippage’ (Matus 1995). In this thesis I look for a subtlety between the particular and the collective that views early menopause as concurrently a singular and changeable experience as well as imbedded in social practice. I suggest that these concepts are entwined as interactive effects of early menopause. Thus I have analyzed the bivalent problematics of the embodiment and social location of early menopause as imbricated, dynamic and unending discourses.

From this perspective I reviewed the literature that was available on early menopause. In Chapter One I look to descriptions of early menopause and note that it has disappeared into a conglomeration of disparate, mostly medical, discourses that are contradictory. Nevertheless medical discourses offer ‘conclusive’ definitions of early menopause that are based on naturalistic views of the body (Shilling 1994). The determinants used are inconsistent and do not include women’s discourses of early menopause. Thus, dominant medical discourses obscure women’s embodied experiences of early menopause and ignore the contemporary causes of early menopause.

In Chapter Two I examine the causes of early menopause as a way of explaining the disparity between medical discourses and my anecdotal observations of early menopause as a fairly common contemporary occurrence. The relatively recent escalation in gynaecological surgery, especially hysterectomy, appears to account almost single-handedly for early menopause as a current phenomenon. Moreover, the extraordinary number of women who have their uterus removed at hysterectomy can be interpreted as a modern implementation of ancient anxieties. Women’s sexuality has been constructed throughout history as problematic and this unease has been translated through women’s bodies as dangerous and in need of control (Greer 1992). Thus social concerns which have evolved historically have emerged through the representation of a woman’s uterus as an unseen, dark and mysterious risk (Beck 1993). Medical discourses define this risk and are able to negate the so-called dangers of women’s sexuality through the surgical removal of their organs. Widespread negotiation of medical discourses is apparent, as hysterectomy in the modern Western world is the most common of all surgical operations (Hufnagel 1989). It is overwhelmingly the most common cause of early menopause as well.

I examine also the historical condemnation of infertile women and how this anxiety has been transposed to the modern world through the commercialization of reproduction. Transactions of this social unease can cause early menopause. For instance the medical technology of in-vitro fertilization (I.V.F.) has been offered as a panacea for the infertility of early menopause but, paradoxically, can cause early menopause as well. Conception through technology has been normalized as a viable option for women who
are unable to conceive and understandings of I.V.F. have moved into everyday discourse. Medical discourses have constructed fertility as a saleable item and infertile women expect that they can purchase this merchandise. Human eggs have become lucrative commodities that now are available in the market place. Egg ‘donation’ for I.V.F. programs can hasten the attrition rate of eggs and can cause early menopause in some pre-menopausal women (Rowland 1992: 24). Even the recycling of a woman’s uterus supposedly has become a possibility through the transferring of this ‘used’ organ at hysterectomy to a recipient woman who can use the other woman’s uterus as a ‘gestational garage’ (Rogers 1998). In this way women have been disembodied as mechanical systems with inter-changeable body parts and the potentially detrimental consequences of these commercial transactions are ignored.

In addition I show how early menopause can be caused by the connection between the self and the social structure. Women’s subjectivity is constituted through the cultural discourses available to them and these discourses affect social behaviour (Lupton 1995). For instance smoking and dieting have been identified as causes of early menopause. These activities have been related to the creation of women’s bodies as hetero-sexually desirable and are endemic to young women (Evans-Young 1995). This suggests that cultural causes of early menopause are transactions of sexual politics. Yet there is a paucity of literature that acknowledges the relationship between women’s subjectivity and early menopause. Thus the second chapter exposes a link between sexual politics and causes of early menopause through women’s relationships with risk, naturalism and the self.

In Chapter Three I deconstruct early menopause through theoretical considerations. I rely on an overarching poststructuralism that embraces the concept of fragmented plural discourses and the subjectivity of menopausal women as a continuous process (Komesaroff 1997: 61). I have woven these variables through broad feminist critiques (Leonard 1997). Through this eclectic approach I hoped to find some loose alignment between the corporeal, ontological and embodied dimensions of early menopause. The recurring themes of sexuality, fertility and subjectivity emerge through deconstructing discourses of sexual difference as immutable and non-negotiable; exposing ‘premature ovarian failure’ as a discursive construction that censures early-menopausal women; and acknowledging the discourses of individual women as unique, diverse and dynamic. I looked to a method of exposing some of these individual discourses and in Chapter Four I describe a critical research process aimed at understanding early menopause as a lived experience.

In the remaining chapters I align these ontological arguments with an analysis of the discourses of women who had experienced or were experiencing an early menopause. This section partly relieves the ‘cultural non-recognition’ of the discourses of early-menopausal women. I recorded the narratives of fifty early-menopausal women through in-depth interviews and used this empirical data to direct the study. This data provides the opportunity to understand early menopause as an assortment of embodied experiences. For instance women’s experiences of age at commencement of menopause spanned over three and half decades. They did not reflect the age specifications prescribed by medical discourses. Rather women interpreted their experiences within their own discourses and determined their menopause as early based upon the expectations of their cultural context. Many of the women experienced changes attributed to menopause at midlife. It was not these changes that were significant to early-menopausal women it was how each woman translated these changes that provided meanings of early menopause.
In Chapter Five I introduce the women through a table that connects the varying experiences of each woman. This profile shows that, in the main, the women’s experiences of early menopause were unexpected. I suggest that this is due to the disparity between early-menopausal women’s experiences and the current age and social norms of menopause. By bracketing the women into cohorts patterns emerged displaying differences between women who had menopause in their teens, twenties, thirties and forties. Adolescent women had intense feelings of abnormality and despair. Women who were in their twenties were less devastated by menopause than the younger women but described their sexuality and self-identity as changing. And although some women in their thirties were shocked or dismayed to have an early menopause others were ambivalent or happy. These women also described their sexuality and self-identity through changing discourses. A number of the women who were in their forties said that they were ‘too young for the menopause’ but were far less despondent than the younger women. It seemed that the greater the distance between age norms and social norms the more negatively women responded. Age norms that determine the social norms of women’s lives through a ‘biological clock’ are constructed to reflect social values. But age is a social construction that changes over time. Thus it would appear that women’s changing bodies and changing discourses of early menopause are in the process of recreating age and social norms around menopause.

In Chapter Six I draw upon women’s narratives that describe a connection between early menopause and sexuality. Yet the respondents were not unified in their constructions of sexuality. For instance a number of the women rejected the containment of their sexuality as absolute and defined in terms of bi-lateral hetero-sexual opposition. The discourses of these women constructed their sexuality as continuously flexible. Some early-menopausal women described this sexual mobility as an equivocal relationship between their sexuality, reproductive capacity and female organs. Other women articulated their sexuality as vacillating, ambiguous and unrepresentative of the so-called ‘true woman’. Several felt that they were not meant to have female reproductive organs at all. Nearly one third of the women had had their uterus removed at hysterectomy and the reproductive organs of two women were rudimentary.

Women’s narratives showed that the social value of fertility influences constructions of early menopause. In Chapter Seven I record the contrast between the poignant responses of women who wished to have a baby of their own and other women who resisted discourses that entwine reproductivity with being a woman. For instance some women negotiated fertility through economic discourses of consumerism with the expectation that they could purchase conception as a commodity. Other women welcomed their early menopause as freedom from contraceptive concerns and others had no interest in reproduction at all. Thus discord arose through discourses that problematize early-menopausal women as non-reproductive and discourses that value variability.

In addition many of the women’s accounts constructed their subjectivity as mobile, challenging the notion that discourses of the self are immutable. Chapter Eight presents narratives which suggest that the subjectivity of many women was altered continuously by early menopause. Yet some of the women rejected the construction of their subjectivity as unfluctuating. These contradictions reflect the uncertainties of the contemporary world. Nevertheless most respondents found that the tethering of menopause to constructions of midlife was incongruous with their own experiences. Many women refused to accept the label of social redundancy attached to middle-aged women. They moved their subjectivity beyond the reproductive body to a shifting and tractable identity of the self.
This thesis demonstrates that the medical construction of early menopause as a rare and natural female flaw varies from women’s experiences which suggest that early menopause is common and discursively constructed. This disparity has occurred through the privilege placed upon the construction of bodies as immutable and sexually static. This privileging has obscured the multi-dimensional causes of early menopause and given preference to a mono-causal theory. By exposing the variety of causes of early menopause the medical construction of women through a universal and unalterable body of reproduction is challenged. Moreover, women’s discourses of early menopause demonstrate that the medical reduction of early menopause to a spontaneous bio-chemical malfunction has ignored the volatility of women’s embodied experiences. Women experience early menopause variously and through mercurial discourses.

I suggest here that women’s discourses of their experiences of early menopause reflect recurring and restructuring philosophical quandaries of fertility, sexuality and subjectivity. While there can be no representative claims made from this thesis it contributes to an understanding of the embodied experiences of early menopause. It provides an understanding of the creation of early menopause through social practices and goes part way to redressing the problematics of what Fraser terms ‘cultural non-recognition’. But, more importantly, it acknowledges early menopause as a variety of experiences where women interpret their changing bodies through changing discourses.
CONSTRUCTIONS OF EARLY MENOPAUSE

Chapter One

Elusive Early Menopause

Abjection is characterized by ambiguity, by that which “disturbs identity, system, order.” The ways in which we deal with the abject help to define it; we repress, control, exclude, and ritualize that which we fear. ... I shall explore the links between abjection and menopause to try to determine what makes our reaction to menopause one of fear, control, and regulation. Rogers 1997: 226.

Introduction

There are innumerable discourses that undulate to shape and reshape constructions of menopause. To a lesser or greater extent these discourses relate menopause to women’s experiences of midlife. In this thesis I use a sociological analysis to reveal that menopause is not always associated with this life stage. I argue that there are many women who find their experiences of menopause are dislocated from midlife and consider that their menopause is early. I question the discourses of medicine that construct early menopause as a rare anomaly of nature and show that early menopause is not rare or ‘natural’. I propose that it is a transient product of varied and volatile discourses. I suggest that the construction of early menopause as an uncommon accident of nature does not reflect the experiences of individual women but reveals the monopoly of the discourses of medical science. I look at how, where and by whom knowledge of early menopause is produced and examine what is regarded as knowledge of early menopause (Weedon 1989: 7). Underpinning these analyses I use the basic principles of poststructuralism that look to a plurality of language and fluidity of meaning (Weedon 1989: 85).

Through a process of critical analysis and using a combination of sociological and feminist perspectives I will relate these theoretical considerations to the discourses of women who have experienced an early menopause. Thus a link can be made between individuals and the world in which they live. The fluidity of women’s accounts of early menopause cannot fix this experience to a single scientific event. Rather women’s discourses reveal the interplay between capricious and contradictory narratives while contributing to these changing discourses of early menopause themselves.

An examination of the sparse literature on early menopause reveals that its dominant image has been constructed through the language of medical science. In this chapter I examine the medical discourses of early menopause and propose that their base in a naturalistic view of the body (Shilling 1993) limits these interpretations. Naturalistic constructions of the body look to a fixed biological base to define individuals and their social structures (Shilling 1993: 41). These views have exerted considerable influence over perceptions of the body and are apparent in medical discourses that define early menopause as the premature malfunction of a woman’s ovaries (Davis 1997: 96). In other words medical discourses reduce the experience of having an early menopause to an untimely failure of the natural female body. This argument is one-dimensional in that it takes no account of historical or cultural influences on the body, nor does it account for the embodied experiences of what it is like to have an early menopause.
In later chapters I will view early menopause through the experiences of individual women. Women’s discourses present early menopause as an embodied process that has a physical dimension which itself reflects social and historical influences. The biological dimension, however, is not static. It is, as Grosz (1994) states, capable of diversity and change. Put simply, women experience early menopause as cessation of periods and other physical symptoms. However, the social causes are variable with fluctuating expressions in and on the body. For example, age of onset is inconstant, symptoms vary and women’s experiences of the phenomenon differ. This diversity is lost in naturalistic constructions that reduce early menopause to a female malfunction as ‘premature ovarian failure’.

Nevertheless, medico-scientific discourses have been identified as powerful social mediators (Lupton 1995). They have created specific contexts in which the reduction of early menopause to an untimely bio-chemical fault largely has been accepted. But medical knowledge is one version of history (Weedon 1989: 115). It is founded in culture and as a socio-historical process is a site of social tensions. Although claimed to be value-neutral and objective, medical discourses will only search for and accept scientific justification for the human condition. Social, cultural, historical and other influences are marginalized by the medical sciences and subjective experiences explained through various forms of biological reductionism (Turner 1992: 32-33). Medico-scientific discourses thus obscure other knowledges through a process of recontextualization. Exclusive knowledge is used with complex terminologies that serve to devalue, redefine and exclude other understandings of early menopause. Accordingly, the discourses of medical science have constructed a restricted interpretation of early menopause. In Chapter Four I will show that this form of ‘cultural non-recognition’ (Fraser 1997) is problematic for women when they experience early menopause. Women negotiate these discourses as they interpret their own experiences. Moreover, women’s discourses reveal resistances to the exclusiveness of medico-scientific discourses of early menopause.

Menopause and early menopause: similarities and differences

Until relatively recently menopause escaped specific attention in Western cultures as it was interpreted as an inevitable female life process of little consequence. The majority of women were able to pass through the transition from fertility to post-fertility without particular scrutiny. During the twentieth century and specifically in the last two decades medical science has expanded its surveillance of women through their fertile years to include women beyond their reproductive period. This time is known as menopause and post-menopause. It is said to be age-dependent and commence at midlife. But this interpretation does not recognize the variability and differences among female bodies; nor does it account for the many women who experience menopause before they anticipated that this would occur.

The failure to acknowledge differences in women’s experiences of menopause simultaneously marginalizes early-menopausal women as deviating from menopausal age norms and includes them in the negative discourse of social norms for menopausal women. The construction of menopausal women as old, non-reproductive and socially redundant not only influences the identity of menopausal women at midlife but also influences the identity of younger menopausal women.

In this context early menopause is confusing as it alienates young menopausal women from the age and social norms of their peers; and it isolates them from the age norms of middle-aged women as well. Many early-menopausal women feel different form their peers but resist moving into the social norms of midlife. Yet the negative construction of women at midlife influences the identity of early-menopausal women who
are unable to remove themselves from images of loss of sexual attractiveness, infertility and decaying bodies. Not only does early menopause carry all the negative cultural meanings of menopause at midlife but it also absorbs the subjective condemnation of ‘premature ovarian failure’.

Even though the physical symptoms of menopause and early menopause can overlap, women’s experiences of menopause differ at different ages. Women in their middle years do not threaten the age and social norms of menopause, while younger menopausal women are anathema to the social expectations of young women. Falling outside age and social norms can be problematic physically, emotionally and psychologically for some early-menopausal women.

Definitions of early menopause: reflections of power

Medical discourses state that early menopause is a rare accident of nature (Coulam, Adamson and Annegers 1986: 604-606). This explanation views the body through a foundationalist framework that is based in the natural bio-chemical properties of the body. This naturalistic approach takes no account of the lived body. It ignores non-foundationalist theories of the body that regard the individual as a subjective and embodied person, defined and constrained by historical, social and cultural forces (Turner 1992: 240). Although these theories are not mutually exclusive (Turner 1992: 14), naturalistic explanations of early menopause dominate most literature and obscure understandings of early menopause as a variety of embodied experiences. In this way early menopause has been reduced to an ill-timed bio-chemical failure and subsequently problematized as a pathological event. Moreover, an analysis of the medico-scientific explanations for early menopause reveals historical power struggles between the sexes. These tensions are reflected in the contemporary negative social role placed upon menopausal women and, by extension, early-menopausal women.

These medico-scientific explanations of early menopause follow positivist paradigms that claim the only ‘true’ knowledge is scientific knowledge (Jary and Jary 1991: 506). Yet women interpret early menopause variously. They translate their experiences within their own cultural contexts and from the impact their changing body has upon their lives. For instance one young woman explained her feelings at having an early menopause.

Two months before the wedding I received that letter. It was curt, unemotional. It said, ‘Ovarian failure’ – those two small words that condemned me to a lifetime of torment. ...

Words came into my mind: ‘barren’, ‘childless couple’, all those words you’ve heard in the past about others and that, when they suddenly apply to you, have more power to hurt than you ever believed possible.

Above all, the words that stuck in my mind were IT IS NOT REVERSIBLE. It cannot be reversed. The emotional torment was unbearable. Hadn’t I suffered enough? I thought I must have done something really dreadful to deserve this life. Melanie 1997: 6.

Melanie did not interpret her early menopause through biological discourse but she constituted her experience through her own cultural discourse. Melanie’s story shows
how early menopause is significant within the context of her entire life. She does not view her ovaries as faulty body parts separate from herself; her physical body is part of her whole being. Furthermore her changing body changes her subjectivity. The medical interpretation of her circumstance as a failure of her ovaries provides only a partial meaning of Melanie’s experience of having an early menopause.

Medical discourses, however, effect a dominant role in relation to the bodies of women and consequently have constructed the prevailing definitions of early menopause. Medical discourses have constructed women through bio-chemical determinism and defined women through disorder and disease. They have located the anxieties that surround constructions of the female body as a pathology of early-menopausal women. These medical definitions of early menopause as a naturalistic female organ failure and hormone deficiency disease reflect historical conflicts over gender and power.

Although various interpretations of menopause have shifted from finite medical definitions to the embodied experiences of women during midlife, the same has not occurred with interpretations of menopause before midlife. Medical discourses have transferred the interpretation of menopause as a naturally-occurring disease state to early menopause as a peculiarity of nature; the result of genetic dysfunction and auto-immune disease (Conway 1996). According to a British consultant gynaecologist lecturing medical students, early menopause “… is due to the design fault of the female body” (Kingsland 1997). Yet, within a social constructionist paradigm Foucault argues that disease is the product of discourses that reflect dominant ideologies and that:

[M]edicine made its appearance as a clinical science in conditions which define, together with its historical possibility, the domain of its experience and the structure of its rationality. Foucault 1973: xv.

In other words medical science itself is shaped by its socio-historical location. In particular it has been claimed that from the eighteenth century medical discourses have used a naturalistic interpretation of women’s bodies to solve ideological problems. Many theorists have noted that a biological basis was constructed to justify the inferior social role consigned to women (Shilling 1994: 44). An understanding of the cultural context of medicine has led medical sociology to accept that what is considered to be a natural pathology is rather “… the outcome of socio-historic processes” (Turner 1991: 11). Thus it can be construed that the representation of early menopause as a malady, a female bodily failure, does not necessarily represent the reality of individual women but merely is a construction by mainstream medical discourses. Yet:

[W]ith the current obsession for locating the genetic precursor of illnesses, diseases and behaviours, the knowledge base of scientific medicine has encroached even further into defining the limits of normality and the proper functioning and deportment of the human body. Lupton 1995: 1.

In this way medico-scientific discourses have used the notion of the naturalistic body (Shilling 1993) to construct early menopause as an inherent female fault and not as a diverse range of experiences that are socially and historically based. Moreover, genetic determinism has been used within the context of sexual politics to devalue women as unstable through ‘nature’ (Rowland 1992: 43) by assuming that menopause is strictly
related to age. Concepts of the time frames of chronological age have been challenged and the “... persuasion is becoming ever more compelling that lives are indivisible” (Neugarten, D. 1996: 402).

Even though there are several interpretations of the significance of menopause these discourses have tended to neglect early menopause. Discourses on menopause vary. They range from medico-scientific views that suggest beyond the reproductive body woman is redundant (Stoppard 1994: 7) to sociological and feminist discourses that have refuted this argument as reductionist and maintain that it is used as a form of social control (Komesaroff, Rothfield and Daly 1997; Greer 1992). But even these varying interpretations associate menopause with midlife (Kenton 1996: 3; Coney 1993: 13).

Consequently there is very little representation of early menopause outside medico-scientific discourses (Petras 1999). Menopause before midlife has been noted in anthropological (Martin 1987: 173) and psychological (Williams 1987:275) literature but receives no particular analysis. Popular literature on the lived experience of early menopause is confined to brief articles in books or magazines (Petras 1999; Hawkridge 1999; Davis 1997; Company 1998), the newsletters of support groups (Update 1995/6/7/8/9) or an occasional television health documentary (Channel 4 1997a). Medical literature is sparse and hidden in exclusive publications (Coulam, Adamson and Annegers 1986; Hague 1992; Baber, Abdalla and Studd 1991). The paucity of analytical discourses on early menopause allows medical science to dominate the constructions of early menopause. Yet medical discourse that connects menopause exclusively to age is not supported by the experiences of many women who have menopause years, even decades, before midlife occurs.

One of the reasons women’s experiences of early menopause are overlooked is that mainstream medical discourses do not recognize how frequently early menopause occurs. Early menopause is said to be embedded in nature and occurs spontaneously through genetic or auto-immune dysfunction to one woman for every hundred who is under the age of forty years (Coulam et al 1986; Stoppard 1994:14). This portrayal disallows other causal factors that may result in an early menopause. When iatrogenic, environmental and cultural causes of early menopause are included in studies, the incidence of early menopause is far greater than is recognized by mainstream medical discourse. Feminist medical practitioners have suggested that early menopause is common. For instance, in the United Kingdom (U.K.) it has been suggested that due to a combination of causal factors early menopause may now be experienced by at least ten women for every hundred (Northrup 1995: 420). In the United States of America (U.S.A.) a massive twenty-five women for every hundred are estimated to have an early menopause due to surgery alone (Hufnagel 1989: 61). These studies indicate that the portrayal of early menopause as mono-causal and rare is misleading.

However, even the discourses that have politically constrained early-menopausal women by reducing them to a biologically-determined body lack cohesion. Within medico-scientific discourses analytical dissent occurs over definitions of early menopause. There is no consensus on what constitutes an early menopause.

As the epidemiological studies necessary to make such a definition meaningful are rarely, if ever, available it is not surprising that a number of arbitrary age-related definitions of premature menopause have arisen. Baber et al 1991: 209.
Some researchers suggest a division between naturally-occurring and iatrogenic early menopause (Coulam et al. 1986) although no studies have articulated how this distinction is achieved. Other studies vacillate over the bio-chemical stimulus for an early menopause (Ojeda 1993: 26; Grant 1994: 143). This professional pluralism reduces early-menopausal women to scientific jargon and excludes other discourses, including those of women, which may make visible the increasing tendency and the actual experience of early menopause. Nevertheless scientific definitions are unified in their construction of early-menopausal women as a universal and malfunctioning reproductive body. Early menopause is reduced to the status of a woman’s menstruation and quantifiable hormone levels that are deemed atypical during a specific life-stage. But even medico-scientific discourse suggests that in identifying early menopause:

\[\text{T}he \text{ diagnostic triad of amenorrhea [no periods], estrogen deficiency, and elevated gonadotrophin concentrations [menopausal hormone levels] is too strict.} \quad \text{Aiman and Smentek 1985: 13.}\]

This confusion within medico-scientific discourses over the cause and diagnosis of early menopause extends to the age that early menopause is said to occur as well. Although there is a wide variation in age at menopause, including early menopause, medico-scientific discourses attempt to categorize these according to chronological age. This essentialist argument is problematic. For instance, one survey of women who said they had experienced an early menopause showed that their menopause commenced anywhere between the ages of sixteen and fifty years (Tomlinson 1997: 20). Thus the reduction of early menopause to a specific chronological age suggests an inability of biochemical discourses to fully explain women’s life experiences. It appears that medico-scientific discourses confine all menopausal women to the cultural expectations of midlife and define women who experience menopause outside this parameter as abnormal.

Although attempts have been made to offer an average age at menopause it has been suggested that surveys of the age at which menopause occurs have had methodological faults and that these have resulted in divergent data (Ginsberg 1991: 1288). In any case lack of uniformity between research methods makes direct comparisons and absolute assessment of menopausal-age difficult. Yet medical discourses state that in Western industrialized societies menopause is said to occur somewhere between the ages of forty-five and fifty-five years with an average age around fifty years (Fraser and Porter 1986: 37; Sheehy 1993: 18; Ginsberg 1991: 1288).

Researchers have suggested that the age at which menopause commences varies historically. While some researchers suggest that age at menopause has changed little in the last few centuries others have challenged this assumption (Flint 1976). One researcher investigating the onset of menopause in medieval times disbelieved the figures available and stated that “... [they] are so wide ranging as to invite wholesale rejection” (Post in Flint 1976: 80). Yet this data was used to propose a hypothesis that age at menopause in medieval times differed little from that accepted in the mid-twentieth century (Flint 1976: 80). This construction of the commonality between menopausal age in medieval times and the twentieth century appears to reconstruct the cultural context of the researcher under the guise of objective neutrality. The skepticism placed upon women’s accounts of their menstruation suggests a lack of reflexivity about a value bias rather than an impartial assessment of age at menopause.

Similarly studies of age at menopause in classical Greek and Roman times have generated an average age of fifty years from a range of thirty-five to sixty years. This
same data was used originally to interpret the average age of menopause as forty years (Amundson and Diers, in Flint 1976: 80). Other research states that in Classical times most women ceased menstruating when they were about forty years old and that no woman over fifty years old was known to bear children (Ginsberg 1991: 1288). It appears that doubt over the validity of evidence may have prompted reconstruction of data to support the cultural expectations of modern researchers. This conjecture is supported by an assessment of (unreferenced) medical discourse that proposes that menopause occurs consistently around the age of fifty years and that:

... the time of the last menstrual period does not appear to have altered over the centuries, usually occurring between the ages of 49 and 51 [sic].


This limited age span appears unlikely as there is no agreement of age at menopause even within the current era. For instance, medical discourses vary and report that menopause occurs at almost any age between forty and fifty-eight years (Youngson 1992: 389; Zinc 1988: 48, 155; Scott 1978: 536; Stoppard 1994: 13). Other discourses repeat this wider range (Hall and Jacobs 1994: 9; Greer 1992: 26). This uncertainty is compounded by contradictory results of research that state age at menopause is becoming later or earlier, or that the average remains the same (Ojeda 1993: 24: Stoppard 1994: 13).

A fairly recent sample of five hundred menopausal women in the United Kingdom revealed that:

[T]heir average age at the time of their last period was forty-six years; the youngest was twenty-three [my italics] and the oldest fifty-seven. This sample had experienced their menopause some four years earlier than the general population.


This study highlights the broad range of age at menopause. Further it makes no particular reference to at least one young woman in the sample group who clearly is nowhere near what generally is accepted as middle age.

Anthropological studies of menopause reveal this same expansive age range without comment. For instance, in a study of Indian South African women a significant number of women (nearly fifteen for every hundred) claimed to experience menopause before the ‘average’ age of forty-five years and older (du Toit 1990: 35-6). While no cross-cultural assumptions are suggested this study indicates the inadequacies of an essentialist paradigm that confines menopause to a narrow and finite definition that is dependent solely upon chronological age. Even though various discourses of menopause are presented by different doctrines these meanings merge across disciplinary boundaries at the point of age-definition. Non-essentialist constructions have not critiqued the age-definition of menopause and menopause has come to symbolize a generic midlife stage. For instance, this same socio-cultural anthropology of aging and menopause merges menopause into the climacteric of life-stage expectations of both men and women.

Increasingly during the past decade or two, researchers have started to recognize the climacteric as a phase of the life cycle ...

It is interesting to note that most researchers also recognize a male climacteric. Though men do not undergo menopause and do not reach a
postreproductive stage, changes due to aging do occur in male physiology and lifestyle. du Toit 1990:

In Western cultures the construction of the ‘male menopause’ has emerged through medical discourse. Middle-aged men are now reported to be experiencing menopause as the ‘climacterium virile’ (Carruthers 1996; Oudshoorn 1994: 101). This indicates a mutation of the term menopause. These differing interpretations of menopause indicate a vacillating discursive field around definitions of menopause. They modify perceptions of early menopause as well. Medical discourse reports that:

\[ \text{[P]remature menopause should, ideally, be described as ovarian failure occurring two standard deviations in years before the mean menopausal age of the study population.} \]


When there is no agreement on an average age of menopause, or even if it only happens to women, this sort of definition is confusing. In any case other medico-scientific discourses define early menopause as beginning anywhere from under thirty-five years (Stoppard 1994: 14) to under forty-nine years (Torgerson, Avenell, Russell and Reid 1994: 83). Definitions of early menopause that are related only to definitions of age at menopause are problematic. For instance, the most common age range of menopause cites forty-five years as the lower age limit (Stewart 1995: 17) and the most usual age definition of early menopause nominates forty years as an upper limit (Hague 1992: 252). This makes no allowance for women between the ages of forty and forty-five years.

The entwining of menopause with age, specifically middle age, can be contested through uncovering the wide variation in age at menopause. Although menopause has been recorded as occurring across a vast age span, this diversity has been disregarded by the dominant discourses of medical science. These discourses of naturalism construct women through sequential biology focusing upon their reproductive capacity. In this context they confine menopause to midlife and restrict constructions of early menopause to medical discourses as aberrant.

Although age at menopause differs many women find that it does coincide with life changes related to midlife. However, the exclusion of peripheral experiences of menopause binds younger and older women to midlife categories. In general their experiences are obscured altogether. The representation of menopause as specific to midlife is misleading. It presents the average age of menopause as the ‘norm’ and disregards variants as ‘abnormal’. In other words, the assertion that menopause occurs only at midlife supports the biological reduction of women to a universal reproductive body. This naturalistic model categorizes women according to chronological life-stages, shackling the cessation of menstrual periods to middle age. It is argued here that this binding of menopause to midlife mirrors the cultural constraints of researchers. More seriously it provides a definition of menopause as mono-causal and biologically-determined by age. I will argue in Chapter Three that acceptance of this unilateral model of menopause has restricted a full understanding of early menopause. I will propose that early menopause is not related to women’s age per se but is dependent upon the cultural interpretations of individual women.

Unsynchronised clocks: the divergence of chronological and social norms
To some extent the discourses of individual women reflect dominant constructions of early menopause. This is evident particularly around translations of the timing of menopause. The use of chronological age to determine ‘normal’ menopause coincides with ‘normal’ social expectations. By definition early menopause falls outside the current age and social norms of menopause. Age norms are established through discourses that prescribe “age appropriate behaviour” (Neugarten, D. 1996: xiii). In other words biological ‘norms’ are aligned with social ‘norms’ through an assumption of fixed universality amongst people.

Thus age has been constructed as an automatic predictor of social events. Mechanical terms are used to tie the physical to the social as if bodies are removed from the lived experiences of individuals. For instance women are said to have a biological clock that winds down at menopause. This biological clock is tied inextricably to a social clock that determines the appropriate age norm for women to reach menopause. Menopause occurring outside this age norm is said to be abnormal.

Men and women are not only aware of the social clocks that operate in various areas of their lives, but they are aware also of their own timing and readily describe themselves as ‘early’, ‘late’, or ‘on time’ with regard to family and occupational events.


Early menopause differs from menopause both chronologically and socially. Positivist discourse constructs early menopause as an anomaly of nature. The so-called biological clock of young menopausal women is not synchronised with the social clock of women as an entity. In this way women who have an early menopause are marginalized as rare as they are said to sit outside age and, therefore, social norms. Yet throughout history there has been movement within age norms that reflects movement within social norms.

The meanings of age at any time in our society typically are convenient constructs that we use to serve our social purposes.

Maddox 1996: 19.

For instance, the current ‘average’ age range of menopause is expanding to some extent to incorporate younger women. This mobility of age norms is a direct response to contemporary social change. However, this fluctuation in menopausal age norms has been constructed by positivist discourse that fails to account for the unending fluidity of expressions of the body. In other words, while positivist discourse allows for some alteration in age norms and social norms it does not include the ‘unscientific’ discourses of younger menopausal women. Yet an inquiry into the individual experiences of early-menopausal women provides an understanding of the continuous transience of the human experience.

It is not news that age-related norms are socially constructed. What is news is that such norms are, under conditions of social change, continually reconstructed.


Marginalized and devalued: cyclicity versus stability
Early menopause exemplifies the perpetual reconstruction of age norms as it is apparent that early menopause lacks consensual definition in terms of age of onset, causation and level of incidence. I have shown that naturalistic interpretations of early menopause tie this to the construction of menopause as age-related. Yet women have a multiplicity of experiences of early menopause. In Chapter Two I will expand upon the idea that the different causes of early menopause influence its construction. I will suggest that the majority of women who have an early menopause are disregarded by the discourses of medical science that typically ignore cultural and social influences on the body. Moreover, I will reveal that early menopause has little representation outside the bio-chemical interpretations of medical discourses and that women’s experiences of early menopause have been marginalized as rare and inconsequential.

I have drawn upon Fraser’s (1997) argument of ‘cultural non-recognition’ specifically to explain the hegemonic process whereby women’s discourses of early menopause systematically have been marginalized as ‘unscientific’. Fraser’s (1997: 20) concept of gender as both culturally valutational and socially variable places early menopause within the problematic of recognition and gender injustice. It opens the argument that early-menopausal women simultaneously are marginalized as a peculiarity of nature and devalued as ‘non-reproductive’ by discourses of biological determinism.

For instance, when a woman is unable to stimulate any eggs from her ovaries, or when she has no more eggs left to develop, or if she does not have ovaries, she will experience menopause. This can happen to young women well before midlife. Early menopause becomes apparent if a woman’s reproductive cycle stops before she anticipated it would or is never established. Unable to release a mature egg she will not ovulate, her menstrual periods will stop, or will not start, and she will experience an early menopause. In this way interference with the delicate and complex bio-chemical actions of a woman’s body can cause an early menopause. This can happen through damage to genes and chromosomes or through other bio-chemical effects such as compromised autoimmunity. Even though these causes of early menopause account for only an infinitesimal number of early-menopausal women they receive medical endorsement as primarily significant to interpretations of early menopause (Conway 1996).

Medical discourses of early menopause are directed particularly to the absence of a woman’s menstrual cycle. Menstruation overtly indicates the cyclicity of the female body. This vacillation is imbued with anxiety and has been pathologized by medical discourses. Not only has the cyclicity of women’s bodies been used to problematize women throughout history but, ambiguously, its absence also provokes social anxiety (Oudshoorn 1994: 60).

During the nineteenth century the pessimistic connotations which surrounded the biology of menstruation became distinctly pathological and menstruation itself was seen consistently as a disorder. Paradoxically menopause also was regarded as a disaster that was likely to increase the incidence of disease (Martin 1993: 35). This historical construction of menopause as a pathological event remains evident today. The negativity of this interpretation has been transferred to early menopause as a social catastrophe. In this context early menopause has been constructed as a premature and, therefore, problematic ‘failure’ of the female body.

Complex physiological and chemical aspects of female fertility and post-fertility have been carefully documented by the medical sciences. Scientific explanations of the life processes of women have centered upon the bio-chemistry of ovulation, menstruation, pregnancy and more recently menopause. These medico-scientific interpretations use economic metaphors of production and loss of production to explain women’s lives.
Pregnancy is interpreted as a tangible asset and ‘ovarian failure’ is constructed as the bankruptcy of a ‘non-reproductive’ female body. Thus in medico-scientific terms women are valued through their reproductive capacity as a ‘reproductive body’ (Turner 1991). They are constructed as passive bodies cyclically ovulating in preparation to receive the male sperm. It has been contended that pregnancy and birth, the potential products of conception, have prompted the anxiety of the bio-sciences to contain female reproduction (Foucault 1985: 121; Willis 1989: 93). With advantageous social value placed upon the ostensible stability of men, the construction of the cyclic changes related to women’s reproductive capacity as unstable reflects wider social tensions and anxieties.

Kristeva (1986) falls into a form of biological essentialism when she suggests that an opposition between linear and cyclic time establishes differences between men and women. She contends that men conceive time as chronological with a beginning and an end, whereas women’s subjectivity is focused upon the cyclicity of their natural biological rhythms (Waters 1994: 287). Posited against this is the notion that both men and women experience cycles within their lives (Furman 1995: 15; Pool 1993). These rhythms can rotate hourly, daily, monthly and seasonally, often with barely perceivable effects. The most readily identifiable sign of female human cyclicity is the monthly bleed, or period, of the menstrual cycle of a woman. A menstrual period occurs within this cycle and is an overt indication of the elaborate bio-chemical reactions taking place within the body of a woman.

Medical discourses that describe early menopause as “premature ovarian failure” (P.O.F.) (Coulam et al 1986) supposedly describe the bio-chemistry of early menopause without any value judgements. However, the claim that bio-chemical determinism alone can explain the complete human experience represents people as separate from their bodies and divorced from cultural, psychological, social and spiritual aspects of their lives. I argue that all of these aspects make up the embodied individual and are so interwoven that each affects the other.

Yet bio-chemical discourses represent women through their ovaries and hormones suggesting that these alone are responsible for what makes a woman ‘woman’ (Laqueur 1990: 149). Certainly these organs and their hormones are significant and damage to a woman’s ovaries can cause an early menopause but women are more than an isolated pair of ovaries. Moreover, the bio-chemical definition of early menopause is a negative interpretation of the so-called naturalistic body.

Firstly, by maintaining that the changing function of women’s ovaries at menopause is a ‘failure’ denies that menopause is a normal part of women’s lives. Medical discourses that construct menopause as a natural mistake use the life expectancy of previous generations to support this construction (Stoppard 1994: 7). Looking at figures of life expectancy without analysis can be deceptive. For generations there have been women who have lived long lives well beyond menopause. Moreover, women who have an early menopause do not necessarily have a reduced life expectancy (Baber et al 1991), which puts this naturalistic assumption into question.

Secondly, the expression ‘premature ovarian failure’ is a double damnation for women whose menopause occurs before middle age, as the timing of their menopause is deemed inappropriate. The bio-chemical explanations for early menopause reduce women to two organs and their hormones thus diminishing women’s social value. These implications do not escape early-menopausal women and they may describe feelings of inadequacy, failure and invisibility (Update 1996).

‘Premature ovarian failure’, then, signals the contradictory condemnation of a woman’s menstrual cycle. The cyclicity, which has been used to remove women from the
public sphere, creates a conundrum by its absence. The interpretation of early menopause as a bio-chemical failure of nature reflects discourses that devalue women generally. The medico-scientific construction of women as dependent upon their ovaries and reproductive hormones for their cyclicity supports the separate social status of women from men. Men and women produce the same hormones; it is the quantity of these that vary (Pool 1993). Yet medical discourses present sex hormones as specific to women or men rather than belonging in varying quantities to both sexes.

Thus medical discourses use knowledge bases as a form of political power. Threats to this power base are eluded constantly. For instance, the decision to unify medical terminologies across the world will specifically remove lay discourse from anatomical terms (Bradshaw 1997: 13). Complex terminologies are unintelligible to the lay person and unscientific knowledge, such as women’s experiences, is debunked and marginalized which further removes scientific discourse from the realms of lay people. Seclusion of early menopause is ensured by adoption of terms such as the Latin “climacterium praecox” (Dorland 1994: 1013; Zinc 1988: 48) as a description of early menopause. This exclusionary discourse has no place in the language of the lay person. Obscure terminology thus mystifies science, authenticates its knowledge-base and, most importantly, removes it from the jurisdiction of ordinary people, especially in this case women who experience an early menopause.

Medico-scientific discourses maintain that the premature failure of a woman’s ovaries is due to the diminished production of the hormones oestrogen and progesterone (Wilson 1992). In this way women have been reduced by scientific definition to the actions and reactions of minute molecules within their bodies. Female hormones are represented as having powerful effects, not only on biological behaviour but also on psychological and social behaviour. Apparent identification of the bio-chemistry behind the female enigma has allowed the discourses of sex endocrinology to present an interpretation of early menopause that purportedly exposes the innermost functioning of the female body. Medical science thus provides an elaborate explanation for the physical and chemical complexities of a woman’s menstrual cycle and its cessation at menopause. These events have been presented as rigid and predictable with menopause constructed as a bio-chemical failure that occurs at midlife. But menopause is not an absolute or fixed occurrence.

For instance research reveals that some women who have an early menopause don’t ever start their menstrual periods. Probably the eggs of these women have been lost before puberty, or the ovaries of these women did not ever develop. Sometimes the remnants of these ovaries are left behind and are called ‘streak’ ovaries (Davis 1997). Knowledge of these vestiges can affect the identity of early-menopausal women when their construction of womanhood is underpinned by the presence of ovaries (Update 1996).

Other young women who have an early menopause initially menstruate and may have a regular menstrual cycle but this stops at a later date. One girl described having two menstrual cycles at the age of twelve just before she became early-menopausal (Tomlinson 1997: 31). Women also may have infrequent periods prior to menopause. This means that although their periods are consistent in length and amount of blood loss they are irregular with a cycle that is longer than thirty-five days. This can happen from puberty or later after a woman has established a regular cycle (Tomlinson 1997: 4).

Irregular cycles can have many origins but the different menstrual experiences of early-menopausal women indicate either that their cycle was never established or that something happened to alter and eventually stop it. Sometimes the ovaries and eggs of a
baby girl can be damaged before she is born or the rate at which a woman’s eggs are lost is excessive and she may not have enough viable eggs to release a matured one each month. Any acceleration of the loss of a woman’s eggs can result in an early menopause (Grant 1994).

Medical science explains this process through a bio-chemical framework. Each egg of a woman is contained in a follicle lined with cells, which can produce the hormone oestrodial, the most potent natural oestrogen. Usually each month follicle-stimulating hormone causes one egg follicle to become dominant and release its egg. The ovaries of women who have an early menopause generally contain follicles. However, these may not develop to release a mature egg. This may be due to unformed, or desensitized, sex hormone receptor sites. Hormone receptor sites are essential for hormone response as they bind the hormonal chemicals together (Zinc 1988).

In the bio-chemical terminology of medical science menstruation and the cessation of menstruation are regulated by a series of sex-specific hormones. These hormones are produced in the brain by the hypothalamus and the pituitary gland as well as by women’s reproductive organs. Each hormone is released sequentially and is inter-dependent upon other hormones for the quantity produced. A negative and positive feedback relationship results when more of one hormone is produced then less or more of another will be produced. The relationship is intrinsically cyclical and medical science states that it appears to be initiated with the production and secretion from the brain of the hormone that stimulates the sex glands (Stoppard 1994). This hormone stimulates the pituitary gland, which in turn releases the sex hormones, follicle-stimulating hormone (F.S.H.) and luteinizing hormone (L.H.). The increased amount of luteinizing hormone bursts the developing egg follicle and the woman’s egg is released into one of her Fallopian tubes ready for fertilization. In medical terminology this process is known as ovulation.

In early-menopausal women the process of ovulation can be disrupted before this stage. The capacity of the hormone receptors is regulated by the presence of hormones. The hormone oestrodial is necessary to increase the capacity of follicle-stimulating hormone receptors and the presence of oestrodial is necessary for follicle-stimulating hormone to increase receptors for both follicle-stimulating hormone and luteinizing hormone. If hormone receptors are not adequately formed then the follicles may be insensitive to the hormones which stimulate women’s ovaries (Jewelwicz and Schwartz 1986: 219-236). This can interfere with the process of ovulation in early-menopausal women. Early menopause doesn’t always happen instantly and some women can ovulate spasmodically for years.

Providing ovulation has occurred, the ruptured egg follicle becomes established as a yellow body that secretes the hormones oestrodial and progesterone. If a woman’s egg is not fertilized this yellow body degenerates in a process known as luteolysis. During this process the levels of oestrodial and progesterone fall, resulting in the disintegration of the tissue lining the surface of a woman’s uterus. The bloody waste tissue is expelled through menstruation. The fall in the levels of the hormones, oestrodial and progesterone, triggers the release of the hormone that stimulates the sex glands in the brain. A woman’s menstrual cycle continues and is maintained through hormonal interaction (Parr and Young 1965).

For some time before her last menstrual period the number of egg follicles from a woman’s ovaries which are capable of responding to follicle-stimulating hormone and luteinizing hormone decreases, usually when there are about one thousand eggs remaining. With less response from the egg follicles, less of the hormone oestrodial is produced. This involves a negative feedback system that prompts the production of more
follicle-stimulating hormone and luteinizing hormone. It is reported that the increase in follicle-stimulating hormone, and to a lesser extent, luteinizing hormone, can occur for up to two years before menopause (Jewelwicz and Swartz 1986). This process can fluctuate and generally ovulation begins to occur less frequently and then ceases. Medical discourses state that this is a single age-related event occurring over a period of three to seven days (Furman 1995). I will argue later that early-menopausal women show that menopause can be experienced at any age and that it is not an isolated incident but a dynamic process influenced by each individual’s own cultural discourses.

**Menopausal movement: the flexibility of embodiment**

Bio-chemical accounts of early menopause are limited as they do not allow for the mobility of the body. They construct women through automatism as if their history is fixed at birth according to their biological destiny. Women are reduced to a universal, mono-functional and chronological body. They are valued through their reproductive capacity and are constructed as deviating from this reproductive body only through rare accidents of nature. Thus medico-scientific discourses that are concerned particularly with the body have constructed early menopause as a bio-chemical entity that is removed from cultural interpretations.

But the body has been identified as more than anatomical; it has been revealed as a site of power (Leonard 1997: 55). Conflicting discourses of the body produce different meanings and interpretations of sexual biology have been fundamental to expressions of tensions between the sexes (Weedon 1998: 127). Thus when early menopause is located in naturalism it sustains a form of social imbalance that subordinates women through discourses of biological determinism. This interpretation defines women through their reproductive capacity as if this is constant throughout their years of adulthood. Early-menopausal women, then, are problematized as anathema to ‘woman-as-reproductive’.

The concept of ‘woman-as-universal reproductive-body’ is challenged by the construction of early menopause as a significant cultural phenomenon. Reconstruction of early menopause as a diverse range of experiences removes this conundrum. It allows movement within the discourses of early menopause. This becomes possible through a poststructuralist feminism that exposes “… the plurality of language and the impossibility of fixing meaning once and for all” (Weedon 1998: 85). Thus the concept of embodiment allows the body to be understood as flexible. This understanding challenges the construction of early menopause as static and embraces the importance of the social and historical context in explaining variations in women’s reproductive capacities and how women impose their own meanings on this process.

Using poststructuralist theory I expected to find in the existing literature an array of competing and complementary discourses employed to elucidate early menopause. However, there is a paucity of written information about early menopause (Petras 1999). What does exist incorporates discourses of the positivist paradigm. For instance the following text that combines psychological and medical discourses repeats the inflexible relationship between age and early menopause. These discourses construct early-menopausal women as having deviated from so-called ‘normal’ menopause. Moreover, they imply that women have caused this themselves.

The menopause can occur earlier than this [forty years], although this is unusual. If it comes before the age of 40 [sic], it is usually called premature menopause, and premature menopause has different implications to normal menopause. It may bring a woman face to face
with infertility in a way that later menopause doesn’t, for instance, and it also gives rise to more acute worries about health and self image. It can happen for a whole variety of reasons – anorexia is one – and if you believe it may be happening to you, you should consult your doctor.

Hunter and Coope1993: 79.

Another account of early menopause written by a neurobiologist repeats the medical construction of early menopause as a failure of the ‘natural’ body. Further, medical ‘cures’ are suggested for infertility. I will discuss the tenuous relationship between medicine and birth technologies later.

Premature menopause is most commonly diagnosed in women aged 35 to 40, but women in their 20s and early 30s can also find themselves past menopause. Doctors do not know why menopause comes so early for some women. Heredity may play a role since premature menopause also occurs among the mothers and sisters of 13 percent of the women who experience an early end to their reproductive years. Other authorities speculate that premature menopause is caused by an autoimmune reaction. ...

With special medical help some women have been able to become pregnant after premature menopause. ... About 20 percent of the women who have the hormone treatments become pregnant, but only about 8 percent give birth. ... The chance of a successful pregnancy after premature menopause is small ... Furman 1995: 73-74.

It has been reported that the silence around menopause at midlife has been broken (Daly 1998: 160) but the same has not occurred for early menopause. It appears that early menopause has been absorbed into medical discourses as an aberration of menopause at midlife. To some degree this is due to the subordination of other discourses by the discourses of medico-science. In particular, the narratives of women have been silenced through a cumulative process of exclusion from the construction of knowledge. Women’s experiences of early menopause have been omitted from medical accounts and knowledge of early menopause is limited (Update 1996).

A support group in the United Kingdom for women who have experienced an early menopause was successful in raising some media interest in their dilemma. One of the participants commented that:

[W]atching the programme was a nerve-wracking experience and seeing a little potted history of one’s life edited up for public viewing is quite bewildering. ... I have come to realise how important it is make people more aware of this condition.

Very few people realise quite what it means to be a young woman, with exams, commitments, careers, the ambitions of youth, and to be saddled with the symptoms of menopause and the associated ill-health it can produce.
The more people know about premature menopause, the more understanding we can hope to gain.

I’m amazed at the number of acquaintances who have come up to me recently to tell me of a relative or friend who had an early menopause.


The cultural non-recognition of early menopause has occurred through the dominance of the construction of bodies as unchanging and mechanistic. This construction of the natural body has denied the fluidity of the body. It has made no allowance for the body as an alterable condition. As Grosz (1994) states bodies are not absolutely the same, neither are they static.

Not being self-identical, the body must be seen as a series of processes of becoming, rather than as a fixed state of being. Grosz 1994: 12.

When women experience an early menopause they negotiate various discourses around the body. The experience of having an early menopause is not reflected by language; its meaning is constituted by language (Weedon 1998: 85). In constructing an understanding of their experiences, women can be influenced by medico-scientific discourses of early menopause. For instance, one woman interpreted her experience of early menopause as a deception by her body. Her story was reported in a women’s magazine:

... the blood test had shown I had a very high level of FSH (follicle stimulating hormone), which indicated that my ovaries weren’t functioning properly. FSH is secreted by the pituitary gland and usually stimulates the ovaries to release an egg, after which the level of hormone drops. If the ovaries don’t respond, however, and no egg is released, more FSH is produced and the level increases. The doctor said I wasn’t releasing any eggs because I didn’t have any – I’d started the menopause 30 [sic] years too soon. ...

I go through stages of being angry with my body. ... I feel betrayed by my body. Company 1998: 62-3.

Even though this woman was influenced by medical constructions of early menopause she was able to transform the meaning of her experience by drawing upon her own understandings. She goes on to say:

To me the diagnosis was every bit as bad as being told I was at death’s door. ...

Going through the menopause makes you question all your previous ideas about your sexuality. As far as I was concerned, my identity as a woman had always been linked to having periods and being able to have children. Now at the age of 26 [sic] I didn’t feel like a woman any more. ...
I do worry about the effect that not producing oestrogen will have on my long-term health. No one can tell me exactly what’s going to happen. Even if someone does develop a form of HRT [hormone replacement therapy] that doesn’t carry a risk of blood clots, there’s no telling what prolonged use of it could do. Doctors don’t know what happens to your body if you take HRT for ten or 15 years, let alone 30 or 40 [sic].

Going through the menopause isn’t something I can discuss with my friends – they can't even begin to relate to it. And all the books written on the subject treat it as rite of passage for older women – they talk about ‘moving into new areas of your life now the children have grown up’, and I sit there thinking, ‘Well, no. That doesn’t apply to me’.

I’ve had to deal with it though, so I found a good support group, which does help. On bad days, however, when I hear that someone’s pregnant or I’m not feeling that great, it feels like no one can help. ...

My mum’s been really supportive through all this. Obviously, she’s upset for me ... and no one can tell us why this has happened. As a result, she thinks it must be her fault and constantly blames herself – did she eat the wrong thing while she was pregnant with me? Perhaps she did something she shouldn’t have?

But what’s odd about all this as far as I’m concerned is how I’m going through the menopause before her. When mum eventually goes through it, I’ll be able to advise her. And that’s weird. Company 1998: 63-64.

This woman’s interpretation of her experience not only shows that she is able to negotiate medico-scientific discourses but also how she is able to reconstruct her own discourse to account for the flexible embodiment of early menopause. Moreover, she displays subjectivity as a process (Weedon 1998: 33). Through her experience of early menopause she articulates a continually changing subjectivity.

Medico-scientific discourses that construct early menopause as a bio-chemical failure of the naturalistic body make no allowance for this sort of menopausal movement. Embodiment and subjectivity are not seen as dynamic processes and the embodied experiences of early-menopausal women are marginalized. No account is taken of cultural influences on the body and the embodied experiences of women have been subordinated through discourses of health and illness. Medical science has sought to define the experiences of early-menopausal women through bio-chemical failure. This bio-chemical construction of early menopause can be viewed as a discursive site of tension between the sexes.

**Unstable genes: mutating nature**

Medico-scientific discourses claim that underlying the bio-chemical changes of early menopause are faulty genes (Conway 1996). Medical publications on early menopause produced for the lay public state that “[G]enetic disorders are the most common known causes, affecting about 25% [sic] of women with premature menopause” (Tomlinson 1997: 11). This unreferenced statement is in stark contrast to reports that the genetic origins of early menopause affect an infinitesimal number of women (*five percent*...
of one percent of all women) (Conway 1995: 4). When compared to a quarter of the population of women in the U.S.A. (twenty-five percent of all women) who reputedly have a surgically-induced early menopause this figure pales into insignificance (Hufnagel 1989).

In addition it is difficult to understand how the genetic origins of early menopause can be transferred from one generation to another when these women frequently become menopausal, and therefore infertile, during adolescence. Nevertheless, the medical construction of genetic determinism has become a dominant idiom of the day (Lupton 1994). In this way the magnitude of early menopause as the result of medical intervention or iatrogenesis has been shielded by discourses that construct women as a unified and unerring naturalistic body (Goleman 1997).

Although genes can cause women to have an early menopause they are not the unique agency for this; nor are they an unchangeable anomaly of nature. The genetic origins for many human conditions have been identified and genes determine bodily features and inheritable traits but they do not have solitary control over the fate of individuals. Bio-chemical discourses, which claim the genetic origins of early menopause as a singular and static demonstration of nature, provide only a partial perspective. Yet medico-scientific research and documentation on genetic causes of an early menopause is endorsed institutionally even though these reasons account for only a minority of women who have an early menopause.

Nevertheless, sometimes a fault in a gene can be the reason menopause arrives early and genetic and chromosomal abnormalities are reported as the most common reasons teenagers and very young women experience early menopause (Baber et al 1991). According to medical discourse a gene is a portion of each chromosome that individuals receive from their parents and is responsible for single inheritable traits or bodily features. At the time of conception the fusing of a sperm with an egg forms an individual embryo with twenty-three pairs of chromosomes from each parent. Coiled molecules of deoxyribonucleic acid (D.N.A.) make up the structure of chromosomes, which contain the complete code for the automatic development of each human being. The genes represent this code and many thousands of them are strung out along the chromosomes. Together, genes determine many aspects about the life of an individual. Genetic traits, which have been related to early menopause, have been categorized as chromosomal anomalies, immunological deficiencies and metabolic disorders.

One of the basic characteristics of chromosomes is that their combination can trigger the sexual development of a baby. Out of the twenty-three pairs of chromosomes, twenty-two are the same in men as in women. Only one pair of chromosomes is different. Usually this pair has the combination of XX for a female and XY for a male. All foetuses start off as females and will remain so without a genetic prompt to become male. It is not until the eighth week of development that the Y chromosome initiates the development of the testes which then produce masculinizing hormones. The Y chromosome has only a few genes which are unique and it appears that the hormonal environment of a pregnant woman’s uterus has more influence than chromosomes in determining if a person will be male or female (Pool 1994: 70). In other words sexual difference is created as much by environment as it is determined by biology.

Sometimes slight chromosomal irregularities occur which confuse sexual development. For instance, some people have extra sex chromosomes. Usually if a woman has an extra X chromosome she will develop as a woman (as a male with an extra Y chromosome will develop as a man). If there is a crossover, as there can be more than
one extra sex chromosome, this individual can develop with an ambiguous sex and, if
gendered as a woman, may have an early menopause.

Other women might have the male combination of XY chromosomes. This occurs
through a variation in the hormone receptors. About one in every twenty thousand genetic
males have hormone receptors which will not respond to androgenic sex hormones. Hence the naming of this occurrence as Androgen Insensitivity Syndrome (A.I.S.). This
occurs during foetal development and this foetus will continue down the female default
line. The baby will appear to be a girl at birth and will develop breasts and a woman’s
body at puberty. She is able to do this by transforming her male sex hormones to
oestrodial, which stimulates her female development (British Broadcasting Corporation
Education 1997). Usually she will look and feel a woman and often is tall and slender
hipped. But, without a uterus, ovaries or eggs, she will not menstruate and may consider
herself to be early-menopausal.

Some women have only a single X chromosome. During their foetal development
neither ovaries nor testes mature and with little hormonal stimulation they will develop as
a female. These women are unable to develop into sexual maturity without the use of
exogenous hormones and may feel sexually ambiguous. Without functioning ovaries they
will have an early menopause. These women are classified by medical terminology as
having Turner’s Syndrome. This condition is relatively rare as about one in two thousand
five hundred women have a sole female chromosome. Yet these women are represented
prominently in medical literature on early menopause (Tomlinson 1997: 11).

Recent research into genetic causes for early menopause has suggested that a
missing piece on an X chromosome could prove a genetic predisposition to early
menopause in certain families (Conway 1997: 2). Although this finding has been hailed
as a breakthrough, a possible predictor for hereditary early menopause, this is an
extremely rare cause of early menopause. Yet studies of the genetics origins of early
menopause are institutionalized through government, medical, financial and media
endorsement and divert attention from the significant number of women who have an
early menopause for other reasons. As self-testing for genetic faults is reported to be a
possibility (Farrell 1997: 6) this cause of early menopause will probably gain greater
acceptability despite its rarity.

Underplayed in this scenario is the potential for genes to mutate or change. This
can be influenced by a number of factors. For instance, environmental chemicals can
imitate hormones and act as messengers to rearrange genes. A deficiency in zinc can
interfere with the synthesis of proteins that regulates the genetic process and in this way
the function of genes can be altered (Rogers 1995: 25). The health and habits of both
parents can affect genes. For example, if either parent smokes or is poorly nourished the
health of sperm, eggs or a developing baby can be affected adversely. Other social factors
can change the bio-chemistry of genes before birth as conception and foetal development
are influenced by the environment within the mother’s uterus.

Genes can be damaged by X-rays or drugs as well. It has been proposed that even
the smallest dose of radiation can mutate genes causing developmental defects in a foetus.
Even though low-dose radiation has been demonstrated as destabilizing genes this has
been disbelieved by mainstream medicine through disjointed evidence and because it does
not fit into existing paradigms (Channel 4 1997; Edwards 1997: 36-40).

It has been proposed that Saddam Hussein’s chemical experimentation against his
own people ten years ago may turn out to be a slow release disaster causing genetic
mutation of immense proportion. A female British geneticist stated on a television
documentary that the chemicals used can change and mutate genes irreversibly and that
this already has resulted in the infertility of some women and for others will be a hidden
time bomb for future generations. Moreover, she claims that these chemicals destroy the
germs of genes “... causing premature ovarian failure [early menopause]” (Gosden
1998). Thus, we could see an entire ethnic community unable to reproduce through
widespread genetic mutation causing early menopause.

In addition, certain auto-immune conditions have been cited as causing an early
menopause. This situation refers to a process whereby the body fails to recognize parts of
itself and sets up a hostile reaction to a specific component. This response usually is
described physically, for instance when a woman’s ovaries might be damaged mistakenly
by her immune system while trying to fight an infection. But the immune system is far
more complex than had been thought for many years and recent research in the United
States of America has shown links between the immune system, the central nervous
system and emotion. These links are essential for proper immune function and when they
are broken down, for instance by stress, this can damage the immune system (Goleman

Even though there are specific auto-immune conditions that have been identified
as predisposing women to having an early menopause the relationship fluctuates. For
instance, some medical research reports that early menopause can occur several years
before an auto-immune disorder becomes apparent (Baber et al 1991: 211). Yet women
report that auto-immune conditions and early menopause are so inter-related that they
cannot be separated as distinct aspects of their lives (Update 1996). This puts into
question the ordered scientific argument of cause and effect and indicates the vacillation
of human experience which defies linear description.

Metabolism, too, affects women’s bodies. The function of women’s ovaries can be
altered by an intolerance to sugars if these are included in the diet. These sugars or their
by-products can act directly upon women’s ovaries and cause an early menopause.
Removing sugars from the diet can avoid this. A medical practitioner told one woman,
who had erratic and uncomfortable periods, constant headaches and a craving for sweet
food, that at thirty-five years old she was going through an early menopause. This
diagnosis was based on blood levels of oestrogen and progesterone, which were said to be
low. Hysterectomy was the treatment offered. Rejecting the medical definition of her
condition and the drastic ‘remedy’ this woman investigated other reasons for her
symptoms. She discovered that she was allergic to many substances, in particular various
foods including sugars. Dietary changes have led her to have normal regular periods and
loss of her other symptoms for the past fifteen years (National Women’s Health Advisory
1996). Thus, the diagnoses of bio-science, which are presented as absolute, are
compromised by other knowledges.

Listening to women’s experiences questions the relevance of applying strict
criteria to definitions of early menopause as a genetic fault. Even from within the bio-
chemical sciences defining the genetic origins of an early menopause as categorical has
been criticized. This is demonstrated by a study of identical twins. Only one twin had an
early menopause so it was proposed that there might be two variations of the one
syndrome. It was suggested that a severe form of childhood measles might have caused
early menopause in one twin leaving the other twin undamaged (McDonough and Byrd
1977: 251; Verp 1983: 101-111). Although this instance demonstrates that there are
causes of early menopause other than genetic, it also shows that the changeability and
vacillation of women’s bodies is constructed by medico-science as problematic. This
language of medico-science constructs bodies as singular and stable, ignoring causes of
early menopause which do not support the so-called predictable paradigms of the
‘naturalistic’ body (Shilling 1995).

‘The body as a metaphor’: subsumed and subordinated

Many authors have noted that the medical construction of women through their
reproductive ability reflects social anxieties and sexual tensions (Turner 1987: 82; Diprose
1994: 1; Matus 1995: 22; Lupton 1995: 132). The physical body is constructed as a
system that reproduces social interests (Douglas 1970) and in this way the individual body
can be seen as interacting with the social body. This accord between agency and structure
has been viewed as crucial to the sociology of the body as this provides a:

… broad appreciation of the body as a metaphor of social relations and
an integrating focus for the study of the relationship between medicine

For instance, early menopause is constituted within the cultural tensions of wider
social instabilities. Medico-scientific discourses that construct early menopause as a rare
bio-chemical failure reflect a desire for order and predictability. Positivist accounts of
early menopause are chronological and commence with the construction of menstruation
as the marker of a supposedly inexorable progression towards fertility. Childhood and old
age are differentiated from ‘womanhood’ by the ability to reproduce and positive social
value is placed upon adult women as reproductive.

Reproductive ability ends at menopause with the cessation of menstruation and
this process is marked variously through discordant discourses. The expectation that
women will remain in a perpetual state of fertility, at least symbolically, has been created
by discourses that construct ‘woman-as-universal reproductive-body’. When menopause
occurs out of chronological context it threatens this predictable and linear status quo. The
medical construction of early menopause as a ‘disorder’ or a rare deviation of nature
regulates this tension. Thus the true incidence of early menopause is denied and early-
menopausal women are subsumed by discourses of order. This concept interacts with, and
is bound by, the social anxiety created by women who are ‘non-reproductive’.

Du Toit (1990: 11) expresses this social unease through a political economy
approach in his anthropology of menopause. He maintains that menopause is constructed
as a symbolic representation of the disregard afforded the unproductive in a society
focused on capital production and consumption. In this context he suggests that the end of
female fertility can be viewed as an analogy for the loss of productivity within the
capitalist system. This correlation reflects the inverse relationship between technological
development and the status of the aged. A negative construction of menopause is apparent
in medical discourses that transfer this social anxiety to early menopause. The
incongruous connection between life-stage and early menopause is not examined. Nor is
the extent of early menopause or the discourses of women’s embodied experiences. Thus,
the early arrival of menopause disappears into a cultural void of ‘non-recognition’ and
social ‘disorder’ is controlled by the discourses of biological determinism.

Early menopause is problematized further through the paradoxical anxiety that
surrounds female sexuality which is unrelated to reproduction. In her psychology of the
female body Ussher suggests that:

[W]omen’s sexuality is categorized in our society as being intrinsically
related to reproduction. The premenarcheal and postmenopausal
female is viewed as asexual, which serves to cloak female sexuality
divorced from reproduction in a mantle of secrecy and shame. Yet at the same time as defining a woman as sexual if she has the capacity to reproduce, the sexual element in menstruation, pregnancy, and the menopause is denied or ignored, creating further consternation and confusion.


Anxiety arises also through the emotional turmoil women are presumed to experience at menopause. The quantifying of hormones as deficits has the potential to exclude early-menopausal women from the work force. It has even attracted its own medical label of ‘climacteric dysphoric disorder’ (Nechas and Foley 1994: 16). Thus, the contradictory situation exists where women who have been excluded from the public sphere because of their reproductive capacity continue to be excluded based on the alleged trauma of its loss.

Positivist discourses disregard cultural concepts, which take account of the flexibility of embodiment. By merging the paradigms of nature and culture early menopause appears as a distinct bio-chemical process, which simultaneously is constructed as a lived experience (Turner 1994). Bodies, then, can be conceptualized as mobile biological and social phenomena which can be transformed, within certain limits, as a result of “…entry into, and participation in, society” (Shilling 1993: 12).

Early menopause needs to be analyzed as conjointly an individual and varied experience as well as a collective phenomenon. Fraser’s (1997) theory of ‘recognition and redistribution’ allows for an understanding of the potentially contradictory standpoints of these bivalent problematics. It allows early menopause to be approached simultaneously as subsumed by naturalistic discourses of the body and subordinated by discourses of ‘woman-as-reproductive’.

Nicholson (1999) observes a tension between identifying women concurrently as varying individuals and as a political collective. She uses a construction of ‘gender’ to articulate the ontological difficulties that have occurred through, on the one hand, insisting on unity among all women, and on the other, recognizing women as unique agents. This problematic can be applied to early menopause. It is only by addressing these opposing constructions together that we can understand early menopause as both an experience that women have and as a sexually-specific social phenomenon.

For instance, Fraser’s theory of ‘recognition and redistribution’ calls for this alignment. She suggests that we need to simultaneously acknowledge marginalized groups and embrace cultural diversity while also uniting gender inconsistencies. These appear to be opposing viewpoints but, as Fraser points out, interact and entwine right throughout the social structure. For instance, the construction of early menopause as an individual biological fault fails to look at contextual factors as epidemiological. In other words the weight given to the genetic origins of early menopause imbalances the extent of other causes. In doing so the narratives of early-menopausal women are marginalized as they are thought to belong to an insignificant group. This is a form of ‘cultural non-recognition’ that needs to be conceded before there can be any inclusive understanding of early menopause.

This cultural limitation can be overlaid by the social anxieties related to the binary division of the sexes. For instance the construction that unifies women through reproduction is shattered by the infertility of early-menopausal women. Early-menopausal women, then, are devalued socially as ‘non-reproductive’. This social inequality is based upon a biological conundrum where early-menopausal women are simultaneously grouped through ‘reproduction’ yet subordinated through ‘non-reproduction’.

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For instance, social anxieties that arise from ‘non-reproductive’ women are transacted through medical technologies. The most recent of these aimed at treating the “... sterility caused by premature menopause” (Highfield 1999: 1) involves grafting ovarian tissue from a ‘reproductive’ woman to a ‘non-reproductive’ woman. It is intended that this process reverse the so-called ovarian failure that occurs at early menopause.

This surgery has gained endorsement as sensational news even though so far it is based on only one instance worldwide (Connor 1999: 3). Moreover, it appears that the menopause was not reversed and the woman whose ovary was transplanted continues to have menopausal symptoms. Yet the surgeon who performed the operation considers the operation a success. This makes clear the problem is assigned to the ‘patient’ who the surgeon labeled as “less than ideal” (Connor 1999: 1). This sort of medical technology appears to raise more problems than it addresses. For instance, it is based on having prior knowledge that a woman will have an early menopause. It also assumes equal access to medical treatments by all early-menopausal women. And it opens ethical issues that are outside current discussions.

Throughout this thesis I will address the bivalent problematics exposed by Fraser (1997) and Nicholson (1999). I will try to show how the construction of women as universal and reproductive bodies has contributed to the creation of early menopause. In part this will add to an understanding of early menopause as a social transaction of sexual inequalities. In addition, I will try to make way for cultural interpretations of women’s experiences of early menopause that largely have been muted due to the dominance and general acceptability of the scientific paradigm that embraces the naturalistic body. Along with this precarious alignment I will make way for varying and mobile expressions of the body. I will look to constructions of the body as metaphors for social anxieties and tensions and view the silence that surrounds early menopause as a representation of the disquiet that changing bodies place upon the construction of women as a universal reproductive body.

**Conclusion**

In this chapter I have exposed early menopause as a neglected area of social and feminist research. I have suggested that this oversight has been due to the dominance of medical constructions of the body. These naturalistic discourses have disregarded early menopause as a significant contemporary phenomenon and constructed it as a rare anomaly of nature. Medical constructions of early menopause do not represent a so-called objective reality but reveal conflicts between political, economic and gendered discourses. Although scientific discourses claim value-neutrality, they are produced socio-historically. They represent social tensions and partisan struggles through the construction of early menopause as a pathology and individual failure of the naturalistic body.

Medico-feminist discourses reveal that early menopause is common. They nominate iatrogenesis as central to the higher incidence of early menopause, not a fluke of the naturalistic body. However, mainstream medical discourses are powerful social mediators (Lupton 1995). They dominate constructions of early menopause through a position of institutionalized power and authority (Willis 1989: 21). Yet there is no consensus, even within medical discourses, on the incidence, age of onset or cause of early menopause. Moreover, medical constructions of a naturalistic body overlook cultural interpretations of the body.

A more expansive interpretation of early menopause can be gained by a poststructuralist feminist paradigm that acknowledges the mobility of discourses. For instance this theory allows an understanding of the limitations of the medico-scientific
constructions of early menopause. It is only through an analysis of the full discursive field around early menopause, including women’s discourses that an understanding of early menopause as an unstable and inconsistent construction emerges.

Central to this thesis is the concept of early menopause as a process that is constantly being defined and redefined. In later chapters I will present the discourses of women who have experienced an early menopause and suggest that the embodied experiences of early-menopausal women are constituted through discourse. I will show that these discourses of early menopause are not linear and ordered but are circuitous and open-ended expressions of sexuality, fertility and subjectivity. In Chapter Two I will challenge the medico-scientific constructions of early menopause as genetically-determined and suggest that this single focus has both subsumed and subordinated the discourses of early-menopausal women. I will bring into relief the iatrogenic, environmental and cultural origins of early menopause and suggest that they are entwined with discourses of risk, naturalism and the self which themselves traverse recurring philosophical themes of sexuality, fertility and subjectivity.
Chapter Two

Manufacturing Menopause

If biomedical science, as a field of knowledge, is implicated in the production of sexed identity and difference, the ethics of biomedical science does not begin with its practice of fixing ‘broken’ bodies. Nor does it begin with the objectification of women’s bodies in the consulting room, research clinic or hospital ward. Rather the ethics of biomedical science begins with its knowledge of bodies through which it is not only complicit in the regulation of the wellbeing of women’s bodies but may also provide the conditions for the possibility of their brokenness. Diprose 1994: 130.

Introduction

Medical discourses that describe early menopause as a genetic or auto-immune disease neglect the majority of women who experience an early menopause. In this chapter I examine some of the physical dimensions of early menopause by exposing its iatrogenic, environmental and cultural origins. I suggest that early menopause is not a neutral pathological state but is an altering aspect of social and cultural interaction (Turner 1987: 215). I demonstrate how discourses of risk (Beck 1992) and the medical management of so-called risk contribute significantly to the creation of early menopause. In addition I propose that discourses such as the ‘naturalistic body’ (Shilling 1993) disregard the changeability of bodies and create an environment that can cause an early menopause. Further I will show how constructions of the self (Weedon 1998) impact upon corporeality and in some instances can cause an early menopause. In other words:

[B]ehaviour and environment can alter physiology, and these conditions, it is claimed, are actually in the process of producing a new kind of reproductive female body. Matus 1995: 6.

In the remaining two sections of this paper I will view these changing bodies through ontological and embodied dimensions. I will suggest that women’s experiences of early menopause highlight the connection of risk, the naturalistic body and constructions of the self with the related concepts of sexuality, fertility and subjectivity. All of these observations will be seen within the context of varied discourses of the body. These discourses undulate between individual, social and political bodies (Lupton 1994: 21-2). Within sociological discourses, the individual body can be seen as a metaphor of social organization and anxieties as:

[T]he body is the dominant means by which the tensions and crises of society are thematized; the body provides the stuff of our ideological reflections on the nature of our unpredictable time. Turner 1992: 12.

These interpretations vary between historical era and cultural milieu and in this chapter I show how early menopause is constituted within the discourses of contemporary anxieties. Throughout history there have been women who have experienced menopause at a young age. However, the number of early-menopausal women appears to have
escalated in contemporary Western cultures due to iatrogenic, environmental and cultural causes. Despite intense, extensive and expensive attempts to increase the years of female fertility this appears to be decreasing (Northrup 1995). Medical discourses diminish the incidence of iatrogenic, environmental and cultural causes of early menopause through the dominance of naturalistic constructions of the body (Coulam, Adamson and Annegers 1986; Verp 1983; Rowland 1992: 24, 62; Hague 1992: 252). The sparse findings of the causes of early menopause remain within the confines of specialist medical papers and no one paper addresses all variables. The general public is not privy to this information. Nor do all medical practitioners access this material. Consequently there is little conventional knowledge about early menopause. And some causes of early menopause are excluded from studies which further removes early-menopausal women from view.

I attempt, at least partially, to redress this form of cultural ‘non-recognition’ and social devaluation by looking in detail at the origins of early menopause and contextualizing this phenomenon within contemporary Western societies. The unilateral focus of medical discourses that excludes ‘other’ discourses fails to construct early menopause as vacillating, variable and unquantifiable. Medical science seeks only biological causes of early menopause. It focuses on genetic malfunction and ignores socio-historical contexts. A review of the causes of early menopause displays the impact socio-historic location has upon the corporeality of women. I show specifically that modern living is causing early menopause. Further, I suggest that early menopause can be constructed as analogous with the continuously changing global risk, consumption and uncertainty as we enter the second millenium.

**The medical management of risk**

In the first section of this chapter I expose the iatrogenic origins of the most significant number of women who have an early menopause. It has been estimated that in the West between eight and twenty-five percent of all women has an iatrogenically-caused early menopause (Northrup 1995; Hufnagel 1989). This staggering figure receives little attention due to the dominance of the medical construction of the naturalistic body and early menopause as a genetic fault. Although an early menopause usually is not an intended consequence of medical treatments, this effect is common and often deleterious suggesting that it is worth analysis. Even though the purpose of medical treatments is to improve the wellbeing of individuals, sometimes the side effects of medical treatments are harmful. Often these adverse consequences have been tolerated as the advantages of treatments have been thought to outweigh the disadvantages. But an early menopause can be a negative event for many women and sometimes be the beginning of long-term health problems. Moreover, women interpret their changing bodies through changing discourses that continuously alter constructions of their sexuality, fertility and subjectivity. Yet early menopause rarely is investigated as a side effect of medical treatments even though it seems apparent that in many instances an iatrogenically-caused early menopause could be avoided.

The increased incidence of early menopause caused by medical intervention is minimized as an unintended consequence of medical treatments and sometimes is called an ‘artificial’ menopause (Dorland 1994: 1013). It concurs with notions of risk (Beck 1992) and risk avoidance that deny the changeability of the body and promote ‘fixing’ the ‘broken’ female body through the mechanics of gynaecological surgery. The iatrogenic causes of early menopause originate from common medical procedures. These include hysterectomy, multiple Caesarian sections, tubal sterilization, drugs used in in-vitro
fertilization (I.V.F.), and the cancer treatments of radiotherapy, chemotherapy and tamoxifen.

Overwhelmingly the most common cause of early menopause is hysterectomy (Riedel, Lehmamn-Willenbrock and Semm 1986: 598; Hague 1992). This is the major reason for early menopause occurring but it is the most infrequently acknowledged. Many studies on early menopause even specifically exclude women who have had a hysterectomy (Hague 1992; Coulam et al 1986: 604). Hysterectomies vary in quantifiable status as different organs are removed with different hysterectomies. This vague exclusion not only lacks clarity but it removes many women who have experienced an iatrogenically-caused early menopause through hysterectomy. Some studies of early menopause exclude women who have had both ovaries surgically or chemically removed (Coulam et al 1986). These women inevitably experience an early menopause and their removal from studies specific to their circumstance reveals the medical preference for a naturalistic and universal body. Even when a woman’s ovaries are retained during surgery, thirty to fifty per cent of these organs will perish following a hysterectomy. Research suggests that the majority of women who have a hysterectomy are young and that, as a consequence of surgery, over fifty percent of these women will have an iatrogenic early menopause (Hufnagel 1989; Siddle, Sarrel and Whitehead 1987).

The medical construction of ‘risk’ and the ‘hysterical’ woman

Although it has been known for over one hundred years that hysterectomy can cause an early menopause this does not appear to be common knowledge. Even within the medical sciences this information has been obscured. In part this is due to the acceptance of research that specifically excludes medical causes of early menopause (Coulam et al 1986), or by other studies, which minimize the importance of this (Siddle et al 1987: 94-100). Yet gynaecological surgery is common in Western societies and an extraordinary number of young women are hysterectomized annually. One report from the U.S.A. estimates that up to fifty percent of all women will have their uteri removed at hysterectomy (Hufnagel 1989: 61). The majority of these women is under forty-four years old and will have a surgically-induced menopause within four years of this procedure (Siddle et al 1987: 97). Moreover, it has been estimated that nearly ninety percent of hysterectomies are unnecessary (Hufnagel 1989: 64; Sellman 1997: 25).

An understanding of the scale of these surgeries lies in history. The relationship between the medical profession, women and women’s bodies has been interpreted and handled in various ways over the centuries. Women have been and are viewed still as a reproductive enigma. With the scientific developments following the Industrial Revolution this ‘mystery’ was explained unilaterally through the discourses of medical science. This version of women’s lives has been used to define women as a unified and mechanistic reproductive body. The construction of women through reproductivity was used to justify various medical treatments. Through the possession of scientific knowledge medicine has moved beyond the immediate healing role to a professional organization. As an institution medicine has become a powerful social influence. Today the institution of medicine undertakes a dominant role in defining health and illness and in offering services for people when they are unwell. This right has been sustained through the social value placed upon perceptions of health and the role of medicine in maintaining and improving this (Hillier 1991: 175-184). Although it has been claimed that the medical profession is merely responding to the demands of the population the institution of medicine has been criticized for creating the demand for the services it provides and for assuming the exclusive right to define sickness and health (Coleman 1994).
Medicine fortifies this position through scientific definitions and management of risk (Beck 1992: 56-7).

Risks are defined as the probabilities of physical harm due to given technological or other processes. Hence technical experts are given pole position to define agendas and impose premises a priori on risk discourses. Lash and Wynne 1992: 6.

Even when risk is unobserved it is constructed and identified through expert scientific discourse. Surgery allows this silent risk to be exposed and the unseen to be observed. This modern day extension of the origins of obstetrics “to stare” (Northrup 1995: 356) acts as a form of panoptic surveillance (Foucault 1977: 195). It serves to control the uncontrollable and make visible the invisible.

The lived body is not a transparent object, neither for the subject of experience herself nor for the doctor’s gaze. Indeed, the very opacity of experience is the reason why it is the subject of philosophical investigation. Rothfield 1997: 35.

Surgery to the reproductive organs of women has been reported as originating as a form of social control of women’s sexuality (Greer 1990). From the mid-nineteenth century the practice of the surgical removal of both of a woman’s ovaries and her clitoris became standard treatment for the ailments of women for which no physical origin could be found. Women’s ovaries were thought to be what defined them as a ‘woman’ and yet the removal of a woman’s healthy ovaries at surgery became an instant success as a cure for the ‘behavioural’ problems of women. This was advocated for dilemmas such as:

… hysteria, excessive sexual desires, and more mundane aches and pains whose origins could not be shown to lie elsewhere. Laqueur 1990: 176.

However, removal of women’s ovaries was contradictory. This was thought to make women more like men, yet at the same time to prompt behaviour which was more in keeping with social expectations of female behaviour. Removal of a woman’s ovaries results in loss of menstruation, loss of fertility and an immediate early menopause. Medical interest vacillated between women’s ovaries and their uteri as central to ‘femininity’. Derived from the Greek word hystera a woman’s uterus carried the negativity associated with uncontrolled ‘female’ emotion (Turner 1991: 89). It was proposed that a ‘hysterical’ woman could be controlled by the removal of her uterus. This ‘de-hysterizing’ of women has not lost favour as the practice of surgical removal of a woman’s uterus at hysterectomy and often her ovaries as well continues today on an unprecedented scale.

Spayed by default: medical myopia

As the most commonly performed gynaecological operation today, it appears that hysterectomy does have a legitimate place in medical treatment. Hysterectomy is reported as a successful treatment for cancer of a woman’s uterus, cancer of the lining of her uterus, invasive cervical cancer, or uncontrolled bleeding after childbirth. In addition cancer of a woman’s ovaries is treated by the surgical removal of her ovary or ovaries. Yet gynaecological cancers and uncontrolled bleeding after childbirth account for only
just over ten percent of women who have a hysterectomy (Hufnagel 1989: 64). Hysterectomy also is performed for endometriosis, fibroids, prolapse of a woman’s uterus and miscellaneous reasons. It has been reported that these afflictions could be treated successfully by other less invasive methods such as:

... conservative surgery, medication, diet, nutritional supplementation, alternative medicine or, in the case of fibroids, waiting until you reach menopause, when they will shrink. McTaggart 1996: 273.

Some gynaecologists suggest conditions such as endometriosis, fibroids or a prolapsed uterus rarely warrant treatment by a hysterectomy (Hufnagel 1989). Yet:

[From 1965 to 1984, the number of hysterectomies performed for endometriosis has increased by 176 percent [sic - my italics], more than for any other diagnosis, despite the fact that successful surgical techniques and drugs which can conserve organs have been developed during the last twenty years. Hufnagel 1989: 91.

These findings do not appear to have been followed up by mainstream medicine. Perhaps this is due to the medical construction of women’s reproductive organs as redundant after menopause. For instance, it is accepted medical wisdom that beyond reproduction a woman’s uterus has no role. In addition medical discourse states that women’s ovaries cease to function after menopause (Studd 1994). This construction makes it possible to promote the surgical removal of a woman’s healthy ovaries as beneficial and preventing disease. However, specialist research suggests that these assumptions are not supportable (Siddle et al 1987; Riedel, Lehmann-Willenbrock and Semm 1986; Zussman, Zussman, Sunley and Bjornson 1981; Oldenhave, Jaszmann, Everaerd and Haspels 1993).

For instance, the validity of the scale of hysterectomy has been under intense scrutiny by lobby groups and a few feminist gynaecologists (Simpkin 1996; Hufnagel 1989). They have revealed that women’s healthy ovaries often are removed unnecessarily at the time of hysterectomy, sometimes without consent (Hufnagel 1989). Mainstream medical discourse claims that this is “... to prevent ovarian cancer which can be very difficult to detect at a later date” (Amarant Trust undated). Admittedly cancer of a woman’s ovaries is a terrible and often fatal disease. Also it is difficult to diagnose. Nevertheless the effectiveness and ethical dimensions of the indiscriminate removal of women’s ovaries has been questioned (Simpkin 1996).

Despite the unprecedented number of women’s healthy ovaries removed at hysterectomy there has been no change at all in the death rate from ovarian cancer in the past thirty to forty years (Simpkin 1996; Studd 1994). Simpkin (1996: 5) reports that even though there has been an increase in the number of women diagnosed and treated for ovarian cancer, the death rate remains high. There appears to be no connection between women’s healthy ovaries removed opportunistically and women who develop ovarian cancer (Pitkin 1994).

The suggestion that the surgical removal of women’s healthy ovaries prevents disease appears to be unsupportable. There is no evidence that this forestalls ovarian cancer. This surgical practice exploits women through the unnecessary dismembering of their bodies. Some women have maintained that this surgery makes it difficult for them to
think of themselves as complete women again (Richmond 1997). Not only are practices
that induce early menopause condoned but also their perpetuation is encouraged. Medical
experts recommend the validity of these practices to one another as “... major preventive
medicine” (Studd 1994) rather than assessing the indications from careful perusal of
medical statistics. It is apparent that women need all of their healthy organs throughout
life. Ironically the reproductive organs of women, contrary to the legal rights of
individuals, are considered guilty until proven innocent. A woman needs her uterus and
her ovaries, and a woman’s uterus and ovaries need each other.

For instance, a woman’s uterus and ovaries are part of her endocrine system. That
is they belong to a group of related organs that forms a complex matrix of hormone-
producing glands. A woman’s uterus and ovaries lie close together in the pelvic area of
her body and are connected by muscles, ligaments, nerves, Fallopian tubes and a shared
blood supply. Her ovaries, uterus and its lining (the endometrium) are important sources
of hormone secretion. Each organ interacts with the other through a feedback system. In
other words a woman’s ovaries, uterus and endometrium all produce more or less of a
hormone depending upon the amount produced by the other organs. Removing a
woman’s uterus and endometrium at hysterectomy interrupts this feedback system.
Without the hormones produced by her uterus and endometrium the hormone secretion
from a woman’s ovaries can slow down or stop. This lowered, or missing, hormone
production can be permanent and can cause an early menopause (Hufnagel 1989).

Advocates for women’s health are influenced by medical discourses that state that if one or both of a woman’s ovaries are left ‘intact’ at hysterectomy that these ovaries will
continue to function ‘normally’ (Kelly 1990). Research results on the effect of
hysterectomy without removal of women’s ovaries suggest otherwise. Not only can a
woman experience a number of adverse side effects after this surgery but many of these
women also will have an early menopause (Hufnagel 1989: 25). Yet women who report
menopausal symptoms, such as hot flushes, to their doctors following gynaecological
surgery have been “… disbeliefed or told that this is natural menopause occurring
coincidentally” (Coney 1990: 108). Medical discourses construct the after-effects of
hysterectomy as benign. They state that a hysterectomy ends reproductive ability only and
will not cause an early menopause (Mackenzie 1997: 273). They do not explain why after
hysterectomy, “… a natural menopause may occur a little earlier for some women”
(Sheriff, Feast, Hopper and Stanton undated).

Moreover, discourses of the psychology of menopause use medical discourses to
separate body from mind. For instance, premature menopause is said to result only if both
of a woman’s ovaries are removed. Menopausal symptoms after a ‘simple’ hysterectomy
are constructed as psychological. It is suggested that:

… if the ovaries are left intact the supply of estrogen [sic] is unaffected
and menopausal symptoms would not occur any sooner than they
would have otherwise. Williams

This detachment of body from mind is reinforced by use of the impersonal
pronoun ‘the’ in relation to women’s ovaries. Moreover, despite evidence to the contrary
(Hufnagel 1989: 63) cancer is cited as the most common reason for hysterectomy and its
prevention is used to justify this procedure (Williams 1987: 277). Medical knowledge,
then, is used uncritically in other bodies of professional knowledge and impacts upon their
interpretations. The construction of a young woman’s distress following a hysterectomy
as totally psychological (Williams 1987: 279) no doubt is influenced by the acceptance of medical knowledge as scientifically neutral and objective.

Yet thirty to fifty-seven percent of women who have a hysterectomy without removal of either one of their ovaries, and at least fifty percent of women who have one of their ovaries removed, experience an early menopause. Younger women in particular are more likely to have an early menopause following hysterectomy. They also are more likely than older women to have a hysterectomy in the first place as:

... the majority of women who lose their uteri are between 19 [sic] and 44 [sic] years of age – when women are reproductively active.


This ensures that the iatrogenesis of an enforced menopause is confined to the young. Even when both of a woman’s ovaries are not removed, women under forty years old have a fifty percent chance of their ovaries perishing. As long ago as the end of the last century researchers noted that hysterectomy with both of a woman’s ovaries left intact can:

... cause ovarian failure phenomenon [early menopause] and the appearance of climacteric [menopausal] symptoms.


This finding has been confirmed by other studies (Zussman, Zussman, Sunley and Bjornson 1981; Oledenhave, Jaszmann, Everaerd and Haspels 1993) supporting the argument that, even with retention of one or both of their ovaries, the majority of women are spayed by default at hysterectomy. Moreover, these women are reported as having more sudden and severe menopausal symptoms than women who have an age-related menopause (Oldenhave et al 1993: 765; Hufnagel 1989: 25-45).

This abrupt reaction can happen through damage to a woman’s ovaries during the surgical removal of her uterus. These organs are situated close together and share the same blood supply. Nourishment is brought to a woman’s ovaries and her Fallopian tubes through her uterine and ovarian arteries. The amount of blood that comes through each artery differs between women but up to two-thirds of the blood supply to the ovaries of some women comes directly from their uterus (Hufnagel 1989: 26). When the uterine and ovarian arteries are cut during surgery the blood supply to a woman’s ovaries can be permanently disrupted (Hakverdi et al 1994: 51-56). Thus, the surgical removal of a woman’s uterus can have an acute effect on the blood flow to her ovaries. This can injure, and often completely destroy, a woman’s ovaries and her eggs. It has been estimated that hysterectomy reduces the blood flow to a woman’s ovaries by between fifty-two and eighty-nine percent (Janson and Jansson 1977 in Siddle et al 1987: 94-100). If the blood supply to her ovaries is reduced dramatically a woman will produce less of her hormones oestrogen and progesterone.

These hormones are produced in a woman’s ovarian blood stream with the aid of oxygen. Oestrogen requires between three and eight times more oxygen for its production than progesterone (Cattanach 1985: 847-849). Therefore the reduction in oxygen to a woman’s ovaries after hysterectomy may account for the ‘oestrogen deficiency syndrome’, and probably early menopause, often reported after hysterectomy. This may depend upon a woman’s cycle as well. For instance, if a hysterectomy is performed when a woman is in the follicular phase of her cycle then there may be an acute drop in her levels of oestrogen.
A woman’s ovaries also can be damaged after surgery. Scar tissue can adhere to and surround her ovaries, literally squeezing them to death, binding them so tightly that they are unable to develop and release eggs and ovarian hormones into the woman’s pelvic cavity (Hufnagel 1989: 26). In addition a woman’s ovulation can be affected by the removal of her uterus. The cyclic changes of her uterus and a chemical produced in her uterus (prostaglandin) contribute to ovulation. With no uterus a woman’s ovulation relies upon the chemical response from her pituitary gland. The hormone secretion from her pituitary may not be adequate to maintain ovulation. The monthly release of a mature egg at ovulation might stop and this in turn can cause an early menopause (Hufnagel 1989).

These findings contradict the assumption that a woman’s uterus and her ovaries function separately and that after hysterectomy there is no loss of ovarian function. The majority of women after hysterectomy, even when their ovaries are not removed, will have an early menopause (Hufnagel 1989). Without her uterus the ovaries of a woman often will fail to thrive confirming that a woman’s uterus is intrinsic to the wellbeing of her ovaries.

A hysterectomy, euphemistically referred to as a ‘simple’ hysterectomy when women’s ovaries are not removed, rarely is acknowledged as causing an early menopause. One of the reasons for this is that medical practice is disjointed. For example, a surgeon who performs a hysterectomy on a woman may see her only once beyond the operating theatre. While the operation itself may be considered successful there may be far reaching consequences of which the surgeon is unaware. General medical practitioners, who usually are consulted when symptoms appear at a later date, may not relate these to the woman’s prior surgery. This disconnection between different medical practices unintentionally disguises the fact that many women’s ovaries are destroyed by ‘simple’ hysterectomy. Further it displays acceptance of the construction of women as a universal and mechanistic reproductive body which can be mutilated and manipulated without consequence. However, research has revealed that without her uterus a woman can be chemically, physically and psychologically spayed (Hufnagel 1989).

Ovarian persecution: ‘gelding the lily’

Apart from proven cancer or uncontrolled bleeding there appears to be no reason to remove a woman’s ovaries. Yet, between twenty and thirty percent of women who have hysterectomies have their healthy ovaries removed (Hufnagel 1989: 64). Some medical specialists defend this practice as preventive surgery (Studd 1994). In other words, it is assumed that the random removal of women’s ovaries will prevent them from becoming cancerous at a later date. The medical construction of ovarian cancer as a major health risk is used to justify this devastating surgery. Yet opportunistic surgery, or removing healthy organs during surgery just because they are accessible, has not been proven as a successful preventive technique for any disease. Using discourses of risk to interpret statistics of the rate of ovarian cancer and to intimidate women, and surgeons, into believing that the removal of women’s healthy ovaries is good medical practice is misleading. For instance, it has been postulated that ovarian cancer is more common in women who have had a hysterectomy or a tubal sterilization (Hufnagel 1989: 214). This likely connection, no doubt due to damage to a woman’s ovaries during or after surgery, implies that if there were fewer hysterectomies and tubal sterilizations that this alone would lower the death rate from ovarian cancer. Instead, surgeons are taught to remove more and more healthy ovaries in the name of prevention, or risk avoidance, when gynaecological surgery is suspected as a cause of, not a cure for, ovarian cancer.
This issue is not resolved amongst gynaecologists who debate the virtues or the disadvantages of the indiscriminate removal of a woman’s ovaries at hysterectomy, ‘humorously’ described at a medical conference as “gelding the lily” (McKay Hart 1994). If a woman’s ovaries are removed at hysterectomy she will have an immediate early menopause with long-term consequences affecting her entire life. Medical discourse describes this as a ‘surgical’ or ‘artificial’ menopause as if the experience is detached from a living woman. As it appears that almost all hysterectomies are unnecessary and the majority of hysterectomies result in the destruction of a woman’s ovaries, this debate is a serious issue for women. Women’s discourses, however, are excluded from medical discussion. Women are expected to, and often do, seek guidance from general medical practitioners trusting that they will be able to provide ‘objective’ advice. But general medical practitioners have to negotiate discourses that often are contradictory and no doubt follow a preferred discourse of their own cultural context.

The rationale supporting the surgical removal of women’s healthy ovaries is questionable. Especially as following hysterectomy seven to twenty percent of women experience ovarian pain (residual ovarian syndrome); many women experience the symptoms of pre-menstrual syndrome (ovarian cycle syndrome); and twenty-five percent of women’s ovaries perish within four years of surgery causing an early menopause (Studd 1994; Hufnagel 1989). Even though these conditions are caused by surgery, further surgery is offered as their panacea. Concern over women’s suffering is not extended to why and how the surgery is done in the first place. Medical practitioners are taught that if women want to retain their ovaries at hysterectomy that this is for “… psychological, sentimental, illogical, or irrational reasons” (Studd 1994). This trivializing of other discourses and using exclusivity to identify risk helps maintain the dominant position of mainstream medical discourse. Thus the medical construction of women as a defective and uncontrolled reproductive body is used to legitimize mass surgery.

Nevertheless, surgical techniques are constantly under review and minimally-invasive surgery aimed at reducing trauma and ‘unpleasant’ side effects for women is increasingly advanced. Controlled research, however, is extremely limited and although superficially appealing this has not provided any long-term solution for the original problem. Further to this the skills required differ from traditional surgical techniques and training is not readily available. Medical experts maintain that these obstacles are surmountable and that most hysterectomies could be replaced by hysteroscopic surgery where a woman’s uterus is approached through her vagina (Richardson and Magos 1989: 310-311). This modified surgery removes the need to access and remove a woman’s uterus through a large abdominal incision thus avoiding damage to her uterine and ovarian blood supply. Substituting minimally-invasive surgery for hysterectomy would allow a woman’s uterus to maintain its many functions including menstruation and the production of hormones. It would also reduce the temptation to remove women’s healthy ovaries opportunistically.

Attempts have been made by radical surgical gynaecologists and women’s advocates to inform both mainstream medical profession and women about the benefits of conservative surgery (Hufnagel 1989: Richardson and Magos 1993; Sellman 1997). Recently in the U.K women’s advocates campaigning against hysterectomy were able to instigate the formation of an independent body to monitor gynaecologists and general practitioners performing hysterectomies (Roland, personal communication: 1999). However, change is slow and women continue to have unnecessary gynaecological surgery in enormous numbers.
Surgical intervention: the hidden costs

The number of women who have an early menopause through other gynaecological surgery compounds the large number of women who have an early menopause through hysterectomy. Sometimes the same women are doubly jeopardized as throughout their lives some women come ‘under the knife’ more than once. Accumulated bodily damage cannot be ruled out, including that caused by stress.

Multiple Caesarian sections have been nominated as a cause of early menopause. The reason for this has not been clarified but damage to a woman’s blood vessels, which supply her ovaries, may be a contributing factor. In the U.S.A. a greater number of women undergo Caesarian section than undergo hysterectomy. In Britain one woman in seven gives birth by Caesarian section. Her right to deny this was removed through the Mental Health Act, which has provoked heated public debate (Kitzinger 1997). This act ensures that a doctor’s ‘clinical decision’ takes precedence over a woman’s express wishes and perpetuates the antiquated construction of a woman’s uterus as a source of ‘hysteria’ or deviant behaviour. Moreover, if a woman has ever had a delivery by Caesarian section it is usual medical protocol for subsequent deliveries to be by Caesarian section. This is a cautious medical practice that unintentionally may cause an early menopause. Medical criteria used to determine when a Caesarian section is appropriate have been challenged as inadequate (Kitzinger 1997).

Sterilization for contraceptive purposes can cause an early menopause as well. The surgical procedure when a woman’s Fallopian tubes are crushed, burned, tied, or cut sometimes offers more than sterilization. It can cause a woman’s ovaries to become dysfunctional and stop ovulating. In addition it can exacerbate menstrual bleeding to such a degree that the risk of a woman having a hysterectomy is dramatically increased. As at hysterectomy damage to a woman’s delicate blood vessels around her ovaries occurs through surgery and can cause her to have an early menopause (Turney 1995).

During tubal sterilization, sections of a woman’s arteries that run close to her Fallopian tubes are almost always blocked off or disrupted. This obstruction causes a localized increase in ovarian blood pressure. Such pressure can injure small blood vessels and the parts of ovaries normally fed by these fine arteries can die. If a woman’s ovaries are impaired they are unable to produce hormones as efficiently as before and the ratio between oestrogen and progesterone is disturbed. The after-effects of the techniques used in tubal sterilization can be far reaching. In addition to early menopause they have been cited as causing the symptoms of low oestrogen (oestrogen deficiency syndrome), bleeding from a woman’s uterus which interferes with her life, and prolonged menstrual bleeding (Janson and Jansson 1977). Bleeding disorders alone following tubal sterilization are said to increase the risk of having a hysterectomy by three or four times. If a woman is under twenty-five years old when she has a tubal sterilization then this risk is doubled (Turney 1995) further increasing the risk of these young women having an early menopause.

Although this and other gynaecological surgeries are constructed as beneficial, and in some cases they may well be, little emphasis is placed upon potential long-term and knock-on effects. In fact recent medical information on a popular television program stated that following tubal sterilization a woman will have “... no effects to any other organs in her pelvis” (McMaster Fry 1999). This is not consistent with research that shows otherwise (Turney 1995) but the significance and scale of changes women experience following surgery is lost in the exclusiveness of mainstream medical discourses.
Repeated abortion has been related to early menopause as well (Gosden 1985: 13). Procedures for abortion are different from abdominal surgery unless both are performed at the same time. During an abortion there appears to be no interference to a woman’s blood supply but there are hormonal changes, and perhaps stress, which may account for some women experiencing an early menopause after an abortion. The connection between early menopause and abortion has not been researched thoroughly nor compared to miscarriage. Given the number of women who have an abortion despite the availability of sophisticated contraception this association warrants further research.

**Test tube: credit or deficit?**

In-vitro fertilization (I.V.F.) is hailed as the salvation for early-menopausal women who wish to have a baby. Paradoxically, drugs used in I.V.F. to super-ovulate women can cause them to have an early menopause. I.V.F. and now several other methods of assisted conception were developed to help infertile couples conceive. Originally this was designed for women whose Fallopian tubes were damaged or blocked, often after untreated infection. Now I.V.F. is increasingly used for other conditions. These include endometriosis, low sperm counts, immunological problems such as antibodies that damage sperm, couples with unexplained infertility (Bryan and Higgins 1995: 91) and women who have an early menopause.

Both eggs and sperm are required and sometimes donors are needed if a woman has no eggs or a man has too few or poor quality sperm. Often a woman is able to use her own eggs for I.V.F. but usually early-menopausal women rely upon the donated eggs of another woman. I.V.F. occurs outside the body of the recipient woman. Sperm and eggs are brought together in the laboratory and forty-eight hours later, after fertilization has occurred, the tiny embryos are inserted directly into the recipient woman’s uterus.

The donor woman, whose eggs are to be used, is given fertility drugs, which stimulate her ovaries to mature more eggs than the usual one per menstrual cycle. Up to forty eggs at one time can be matured through fertility drugs (Rowland 1992: 23). The significance of this is that lost eggs cannot be renewed and their rapid consumption through super-ovulation can lead to an early menopause (Verp 1983: 101-111). Although it appears that a woman produces an overabundance of eggs, most of these are lost spontaneously throughout her life and generally only a maximum of five hundred eggs are brought to maturity.

A variety of drugs is used to super-ovulate women. These drugs are used if a woman is having difficulty with her own fertility or that of her partner; if she is donating eggs for another woman; if she has been asked to donate eggs before a hysterectomy; or through egg-sharing when a woman undergoing super-ovulation gives half of her eggs to another woman. Fertility drugs impose a rapid loss of eggs through stimulation of different bio-chemical reactions. One drug, Buserelin:

... actually throws women into premature menopause. Together with [other drugs], Buserelin makes it possible for scientists to control a woman’s body cycles totally. One drug blocks the natural cycle, another stimulates the ovaries by working on the brain, and yet another stimulates the ovaries to mature and release eggs by acting directly on the ovary itself. Rowland 1992: 25.
Donor women appear to be unaware that participating in I.V.F. programs can exhaust their own fertility through consumption of their eggs (Rowland 1992: 76). In the discourse of political economy women’s eggs can be constructed as a finite asset with their enforced loss incurring a deficit. Public controversy surrounds the expansion of I.V.F. programs and ethical issues have been raised regarding questions such as surrogacy or egg sharing. Although in the U.K. the British Human Fertilization and Embryo Authority (H.F.E.A.) supervises the potential of this burgeoning industry, longer-term effects of ovary-stimulating drugs are still being studied (Ballantyne 1997: 17-21).

### Beyond medical therapies

Radical medical treatments have been incorporated into everyday living and cancer is a high priority medical dilemma. When medical practitioners are confronted by women who are ill, they are concerned with cures, not causes, of disease. Drastic eradication of cancer cells has a proven track record and many women embrace these treatments as life saving. However, methods that destroy cancer cells can kill women’s eggs and cause an early menopause. Radiotherapy, chemotherapy, and tamoxifen have all been identified as causing early menopause. The combination of radiotherapy and chemotherapy is particularly toxic to women’s eggs.

Like other causes of early menopause the potency of these treatments is dependent upon many factors. The castrating effect of ionizing radiation on women’s ovaries has been known for some time and during the 1930s radiation was used specifically on women’s ovaries as a means of stopping periods permanently. These days ionizing radiation is used as a treatment for different cancers as it destroys cancer cells more readily than normal cells. Varying doses are directed carefully to the offending cells in order to cause them maximum damage, while hopefully causing minimal damage to the woman. Nevertheless, women’s eggs still can be destroyed. Radiotherapy has been found to cause early menopause, particularly when used for cancers of the lymph tissue. This is contingent upon the dose of radiation and the age of the woman. The higher the dose and the older the woman the more likely it is that her ovaries will be damaged (Verp 1983: 101-111).

Another method of destroying cancer cells is through the use of internal chemical agents or chemotherapy. This generalized treatment often involves the combined use of several drugs that are intended to kill cancer cells. Doses of chemotherapeutic agents used to treat cancer interfere with the synthesis of deoxyribonucleic acid (D.N.A.). They stop cell reproduction and have been identified as causing early menopause by killing women’s eggs (Verp 1983; Baber et al 1991). These eggs become rudimentary and eventually disappear altogether (Baber et al 1991). As with radiotherapy, children and younger women are more resistant to the detrimental effects of chemotherapy. They are less likely to have an early menopause as usually they have a greater number of eggs than older women. A small number of female foetuses exposed to chemotherapeutic agents through the treatment of their pregnant mothers have been studied. It was revealed that the chemical agent busulfan can damage eggs in utero potentially causing an early menopause later in the life of the daughter (Simpson et al 1982: 247-265).

Another drug that has been found to cause early menopause is tamoxifen. This relatively new treatment for breast cancer was synthesized in the 1960s and failed in its first role as a contraceptive. It is a complex chemical that usually opposes oestrogen but sometimes mimics it. Tamoxifen has found a place in the treatment of oestrogen-dependent breast cancer and sometimes is offered as protection for a woman’s second breast. Although its success is modest medical discourse represents tamoxifen as less
harmful than other drug treatments for breast cancer and its benefits have been represented as outweighing the risks.

However, given that tamoxifen also has adverse side effects its use as a drug to protect against potential disease has been criticized. In addition, it has been reported that organizers of drug trials involving tamoxifen misrepresented its side effects to the women involved. Tamoxifen stimulates ovulation, which may explain why some of these women had an early menopause. Some ten to twenty percent of women using tamoxifen experience varying degrees of symptoms, which may accompany menopause such as hot flushes and menstrual cycle abnormalities (Read 1995: 185-208). There are many other side effects including blood clotting and other blood disorders; lung and liver diseases; endometrial cancer; and possibly ovarian cancer (Read 1995). As the treatment for endometrial cancer currently is hysterectomy and women’s ovaries are almost always removed for ovarian cancer tamoxifen should be considered as a secondary as well as a primary cause of early menopause.

In this first section I have shown that medical discourses have contributed to the construction of early menopause through risk and practices of risk avoidance. I will argue in later chapters that the medical representation of women’s bodies as universal and problematic is not only a cause of early menopause but that this discourse impacts upon women’s experiences of early menopause in a variety of ways.

Consuming bodies

In the second section of this chapter I look at the way the environment affects women’s bodies and specifically how this can cause an early menopause. In later chapters I will argue that the connection between women’s bodies and the environment is circuitous, open-ended and dependent upon how women negotiate discourses around their bodies. Initially, however, I will concentrate on the way women’s bodies can be changed by the environment and how this can cause an early menopause.

The concept of ‘the body’ is open to interpretation and constantly is under negotiation. Included in the many constructions of the body is the dominant perspective of the naturalistic body. This view itself is open to various and changing interpretations but commonly naturalistic discourses regard the body as basic to the definition of individuals. Extending from this perspective naturalistic discourses hold that social, political and economic relations stem from the body. Medical discourses that have constructed a naturalistic body start with the premise that the body is given and immutable (Lupton 1994: 9). Some feminist, philosophical and sociological views have modified this naturalistic account of the body by identifying social influences on the body.

Naturalistic views tend to be too busy stressing the ways in which the body gives rise to particular patterns of social relations to recognize how these relations themselves impinge upon the shape and development of bodies. The body is not simply a basis on which society arises, but is itself affected by society. Shilling 1993: 67.

Discourses that recognize the social influence on the body can be taken further to account for the changing bodies of early menopause. Constructions of a changing corporeal body emerge as fluid expression of cultural values.
Far from being an inert, passive, noncultural and ahistorical term, the body may be seen as the crucial term, the site of contestation, in a series of economic, political, sexual, and intellectual struggles.


By locating the body within discourses that acknowledge modification of the body through the social I will expose some of the environmental causes of early menopause. I explore the connection between the infertility of early menopause, the cultural milieu and the environment as a representation and as a cause of early menopause. In doing so I suggest that the changing environment can be seen as a metaphor for the changing bodies of early menopause. This particularly is apparent through the discourses of risk where the global dangers of industrialism are played out at the level of the individual (Beck 1992: 21). In other words a toxic environment can cause the individual infertility of an early menopause. Shilling (1994) describes the disquiet that surrounds the body in contemporary consumer society.

This notion of body anxiety is central to the way many people perceive their bodies as projects and is also linked to the experience of the environment as dangerous and out of control, and the fear of ageing, illness and death. Shilling 1993: 35-36.

**Environmental consciousness: consumption and danger**

Women’s bodies can be altered by the status of the environment and in some circumstances particular environmental agents can cause an early menopause. It is apparent that human life only can be sustained within a particular environment. Whereas many environmental agents are beneficial to humans others can have a detrimental effect. These agents can be innate to the environment or can be the result of human action. Although concern over the condition of the environment has excited certain political groups, interest has been confined to the physical milieu, wildlife and to some extent male infertility and various cancers. The destructive impact of the environment on the bodies of women largely has been overlooked. In essence the relationship between women and their surroundings has escaped critical analysis. Beck sees this perspective as consistent with the ‘risk society’ where the social invisibility of a risk “... is no proof of its unreality” (1992: 45).

Concepts of the environment are constructed through diverse discourses (Hannigan 1995: 30). Different groups, such as the Greens or industry, interpret the environment differently. Although alterations to the environment can modify the lives of individual women, these changes often are insidious and slow acting. Imperceptible changes occurring over a prolonged period can accumulate and cause an early menopause but the environmental origin may not be recognized. Besides, individual sensitivity to environmental chemicals varies and can produce different symptoms in different people. Exposure to environmental chemicals even can increase vulnerability to further environmental components, compounding the effect on individuals. Sensitivity to different environmental chemicals can be compromised by nutritional deficiencies as well. Although chemical sensitivity was recognized over forty years ago it is poorly understood and has only a marginal role in conventional medicine. Besides, medical care is fragmented and different symptoms may not always be connected with the environment. Yet basic “... pathologies of disease can be triggered by any number of everyday chemicals and foods” (Rogers 1995: 25). In addition, toxic environmental chemicals can
jeopardize auto-immunity, injury to which has been discussed already as a cause of early menopause.

Thus environmental changes and the accumulation of these individual problems can affect women. This especially is the case with regard to reproductive capacity. Specific environmental pollutants that can cause an early menopause threaten women’s fertility. Yet this fact has not raised social concern (Gittings 1999: 6). Instead public resources are directed to the development, at huge cost, of the medical technologies of complex and often inopportune artificial ‘fertilization’.

This lack of interest in identifying and influencing the catalysts behind current trends in wellness and illness has resulted in the continued use of environmental pollutants that can cause permanent loss of fertility through an early menopause. The idea that the environment and the bodies of women are limitless and malleable resources has demonstrable acceptance. There is little concession to the connection between the environment and the bodies of women even though the reproductive abilities of each appear to be altering.

Environmental chemicals: fertility goes awry

Contradictions surround interpretations of women’s bodies, which have been described as simultaneously fragile and unpredictable, yet as having a fixed reproductive capacity. Shilling (1993) maintains that there is no such thing as the natural body and that it is dependent upon its interpretation. Interest here rests with some of the unintended consequences environmental technologies can have on individual women and how in some circumstances these have been responsible for the creation of early menopause. The level of concern over the impact of technologies on the environment and on the bodies of women is influenced by fluctuating discourses. For instance, current research on environmental chemicals highlights the detrimental effects these have on the fertility of men (Stuttaford 1997: 5). But environmental chemicals can decrease the fertility of women as well and, moreover, can cause an early menopause.

In Britain media attention has exposed changes to male fertility due to exogenous environmental chemicals in water supplies. This information was suppressed for two years as oestrogen excreted from women using hormonal contraceptives was suspected as the culprit. As up to fifty percent of the summer flow in British rivers is treated sewage effluent the government feared an enormous health scare. However, ethinyl oestrodial, the synthetic oestrogen used in hormonal contraception is not excreted in the urine of women who use these hormones and there appears to be no active oestrogenic effect when ethinyl oestrodial is broken down (Read 1995: 150). Thus, without grounding women were blamed for loss of male virility.

Chemicals that imitate the hormone oestrogen saturate the modern environment and are in everyday products such as plastics, detergents, spermicides, paints and toiletries. Oestrogen-mimics are responsible for the dramatic drop in sperm count, volume and quality. They are reported to exist in the soil, the waterways and even the air (Bryan and Higgins 1995: 55). These environmental chemicals also can cross the placental barrier and result in foetal damage affecting both egg and sperm production, ensuring the effects will be carried into the twenty-first century.

Oestrogen-mimics affect the bodies of women as well. They have been shown to cause an early menopause (Ballantyne 1995: 14). The environmental chemicals that have been implicated in causing an early menopause imitate oestrodial, one of the oestrogen hormones. Although the natural hormone oestrodial is relatively inactive when taken orally, synthetic oestrogens influence the usual pattern of ovulation, the transportation of
eggs and implantation of a fertilized ovum. The action of synthetic oestrogens that suppresses ovulation through the feedback system of the pituitary gland has been used intentionally to manipulate the fertility of women’s bodies through a variety of methods.

Most commonly used and known is the combined oral contraceptive or ‘the pill’. Different doses of the synthetic oestrogen, ethinyl oestrodial and different types of progestogens, imitators of the natural hormone progesterone, are used to inhibit ovulation. This infertility is intended to be structured or controlled but sometimes over suppression occurs, rendering individual women temporarily or permanently infertile. One Swedish example cites a woman as young as eighteen years old who had an early menopause from use of ‘the pill’ (Seaman 1995: 118). Other research suggests that not only can taking ‘the pill’ cause an early menopause directly but that this also can happen to young women who were influenced by exogenous hormones in their mother’s uterus (Grant 1994: 143).

Oestrogen-mimics: silent ‘risks’

Synthetic oestrogens are not always administered intentionally. Unseen and uncontrolled environmental chemicals that mimic oestrogen can damage the reproductive health of women as well (Vines 1995: 23). The presence of environmental oestrogens has not been studied comprehensively but there are thought to be a variety of chemicals that disrupt the usual behaviour of hormones. This disruption can be adverse and affect the reproductivity of women. A chemical (nonyl phenol) that is leached from certain plastics has been identified as an oestrogen-mimic. In addition, pesticides (dichloro-diphenyl-trichoroethane D.D.T. and its metabolite D.D.E.) have been identified as endocrine disruptive chemicals that act as ‘antiandrogens’. These substances work against ‘male’ sex hormones that in women are synthesized in their ovaries (Zinc 1988: 12, 16). These chemicals bind to hormone receptors and, as artificial hormones, behave abnormally and inhibit the usual communication links between the indigenous hormone and a cell (Vines 1995: 25).

Evidence of fungicides and pesticides have been found in the eggs and follicular fluid of women undergoing fertility treatment (Rowland 1992: 258). This finding increases the evidence of a relationship between pesticides and damage to the eggs of women, further supporting the hypothesis that these chemicals can cause an early menopause. Many other chemicals have been identified as environmental pollutants and following a recent report the Danish government has called for urgent environmental research. Particular concern was expressed about the exposure of women of childbearing age to oestrogen pollutants. How this research is undertaken remains a quandary as caution was recommended about relying on existing methods of testing for toxicity as these may not pick up the harmful effects of oestrogenic pollutants (Vines 1995: 25).

This concern over the inter-relationship between the environment and the reproductivity of women is belated. Environmental agents have been implicated for many years as ovotoxins that can lead to an early menopause through chemical destruction of a woman’s eggs and ovaries (Verp 1983: 101-111). This information, however, is hidden in medical culture and exclusive language and barely is discernible even in the current climate of environmental panic.

Conflicts over power emerge as different groups jostle for political endorsement and economic advantage. Interest is directed to how and by whom the connection between the body and the environment is determined. Currently favour is conferred upon cancer studies for investigating the effects of environmental contamination on human health. The warning generated by the discovery in the 1970s of the infertility of the daughters of pregnant women who were given a synthetic hormone (oestrogen
diethylstilboestrol or D.E.S.) has not been heeded as synthetic chemicals must be proven dangerous before anything is done about them.

Even though it has been known for thirty years that synthetic oestrogens have been passing through the food chain and accumulating in body fat and breast milk the food industry escapes critical inquiry. Concern over the wide use of D.E.S. in the 1970s by the farming industry to increase meat yields in cattle and poultry has not been extended to residual oestrogens that were still identified in toxic quantities in the late 1980s. The relevance of environmental oestrogens is concealed in a labyrinth of competing discourses.

This issue is not one that will fade as, consistent with Beck’s (1992) theory of risk, future generations are not protected either. Government scientists in the United Kingdom revealed in 1996 that almost every brand of baby formula on the local market contained a particular chemical (butyl benzyl phthalate or B.B.P.). B.B.P. is one of the oestrogen-mimicking chemicals (phthalates) that are commonly used as softening agents in plastics and packaging. Phthalates are found also in the general environment and contamination is thought to be cumulative occurring at various stages between the field and packaging. Exposure to phthalates can reduce fertility. Calls by the public to reveal the implicated brand names of baby formula failed. Government reassurance that the two hundred and sixty-eight million dollars per annum industry would launch its own investigation was intended to quell this public interest. In any case the European Council for Plasticisers and Intermediates maintained that it was:

… unlikely that the level of human exposure to [phthalates] of their environmental concentrations are sufficiently high to contribute in a significant way to any public health or environmental problem.


Yet there are some sixty thousand environmental chemicals linked to a reduction in fertility and the cumulative effect of these has not been addressed. Although scientists, governments and environmentalists express concern over the possible impact upon human and wildlife reproductivity, competing discourses exclude any possibility of unified remedial action.

For instance, British women soldiers who served in the Gulf War and who reported their unexpected and untimely early menopause following their deployment were thought to fit into ‘normal’ epidemiological patterns. I have argued already in Chapter One that there is no such thing in regard to early menopause. Some soldiers were exposed to (organophosphate) pesticides during the Gulf War and toxicologists warn that the effect of these pesticides increases ten-fold when combined with nerve gas protection tablets. Without the availability of relevant documentation whether or not these women were exposed to pesticides or were taking nerve-protection tablets is conjecture. They were, however, subjected to a chemical cocktail of vaccines. Vaccines are highly noxious and contain a variety of substances (formaldehyde, aluminium phosphate, mercury, foreign proteins and viruses) that erode the immune system and change the immunological responses to disease (Scheibner 1988). Any assault on the immune system can cause an early menopause.

Although beneficence is intended through processes of industrialization such as the spraying of pesticides, inoculation by vaccines and the packing of foods in plastics, uncontrolled environmental manipulation has contributed to the incidence of early
menopause. This has occurred through uncritical sanction of scientific discourses and a lack of appreciation of the connection between the environment and women’s bodies.

**The spontaneous environment: beyond manipulation**

Not all of the environmental causes of early menopause are due to human interference. Present in the atmosphere are many infectious organisms that can affect the lives of women. Although individual women can be exposed simultaneously to the same infectious agents they will respond differently. Depending upon the organism some women may become very ill while others will barely notice any differences. Women who are exposed to an infectious agent but who do not become ill may nevertheless experience the infection on a ‘sub-clinical’ basis. That is, although the individual may not become ill the infectious agent has entered and may alter their body.

In medical terminology infective viruses, bacteria and fungi are antigens that are recognized by a person’s immune system as foreign or not belonging to that person. The presence of an antigen within a person’s body prompts a response by their immune system that will produce a protein substance called an antibody. Specific antibodies are produced in response to specific antigens. Memory cells are produced that recognize the antigen and prompt the correct antibody to neutralize the antigen or render it destructible by the immune system. In this way specific infections result in immunity through the creation of antibodies.

A specific environmental agent that has been identified as causing early menopause is the mumps virus (Verp 1983: 101-111). The mumps virus is spread easily by droplet infection and is common amongst children. It causes a high temperature and a general feeling of malaise. Mumps usually is identified by a characteristic swelling of the salivary glands in the cheeks. Medical books warn that in adult men mumps commonly is associated with painful inflammation of one or both testicles (Youngson 1992: 406). No mention is made of the fact that the mumps virus also can affect women’s ovaries and severe damage can cause an early menopause.

The mumps virus is thought to cause early menopause through inflammation of women’s ovaries. Damage to the sensitive ovarian tissue probably destroys women’s eggs directly although secondary effects of the inflammation are possible as well. It appears that women’s ovaries are most sensitive to damage by the mumps virus when a baby girl is in utero or during adolescence. Even a sub-clinical experience of mumps during adolescence can cause an early menopause (Jewelewicz and Schwartz 1986: 219-236). Researchers have identified a mother and her female foetus as both developing early menopause from the same episode of mumps (Verp 1986: 101-111). The mother developed early menopause following her mumps infection and her daughter, exposed to mumps as a thirty-nine week old fetus, never menstruated, had undeveloped ovaries and became early-menopausal as an adolescent. Women attending infertility clinics are more likely to report that they have had a previous mumps infection than women who are not being treated for infertility (Verp 1986). Yet medical scientists caution against over anxiety and state that early menopause is rare following an acute mumps infection (Verp 1986).

Despite varied rhetoric claiming concern over the changing environment no universal agreement or action has followed. This demonstration of disunited discourses that interpret the pollution of our planet parallels the confusion over the pollution of women’s bodies. Bodies that change out of context and compromise fertility through the destruction of women’s eggs can be viewed as a metaphor for the global risk of environmental toxicity and the consumption of natural resources within the modern world.
The uncertain social crucible

Not only are women’s bodies interpreted by various discourses but these discourses also influence different social behaviours. In the last section of this chapter I will show how perceptions of women’s bodies can modify social behaviour and cause women to have an early menopause. It has been proposed that naturalistic views of the body have influenced perceptions of the body, self-identity and society (Shilling 1993: 41). These theories of the control of the natural body over identity and culture assumed dominance during the eighteenth century and remain apparent today. In particular:

[T]he naturalistic approach continues to shape popular contemporary conceptions of the body and this is especially apparent in the view that gender inequalities are the direct result of women’s ‘weak’ and ‘unstable’ bodies. Shilling 1993: 41.

In this study the body is presented as a site of discursive interplay where women, culture and early menopause are merged. This interpretation does not view the body as an inanimate object detached and removed from its owner. It accepts that women are constructed through vacillating discourses and that their subjectivity is constituted within volatile discourses that cannot separate the whole from body, mind, spirit, environment, social structure and culture.

Nevertheless the concept of Cartesian duality with its distinct division between mind and body dominates the paradigms of science, including medical science. Consequently, early-menopausal women have been described through the status of their ovaries as if these are dislocated from the whole woman. Acceptance of this concept means that little attention is paid to what:

“… philosophers refer to as the ‘lived body’ as opposed to the objective body”. Turner 1992: 33.

Nor does this view take account of subjectivity. The notion of subjectivity, of conscious and unconscious thought, and of the relationship of the individual with the social acknowledges choice (Weedon 1989: 3). This means that dominant discourses can be challenged and complementary or alternate views embraced. Yet the endorsement of bodies as disconnected from their owners and as passive entities not only divorces body from mind but also isolates individuals from their cultural context. However, scientific or social theories which portray people either through ‘nature or nurture’, need not be mutually exclusive. A middle ground can be taken which acknowledges that a person is simultaneously a biological and a social being (Turner 1992: 17).

Moreover, these dimensions are fragile, alterable and interlaced. Thus, any understanding of subjectivity needs to be understood within concepts of ‘the body’. Nicholson (1999:57) articulates the view that the body need not disappear from feminist theory but that it becomes a variable rather than a constant. Or as Grosz (1994) states:

[T]he specificity of bodies must be understood in its historical rather than simply its biological concreteness. Indeed, there is no body as such: there
Fraser (1997) opens a debate between pragmatics and neo-Lacanian discourse theory that proposes the idea of the subject as fractured, having shifting identities and a non-essentialist basis. This works in with the idea that different subjectivities react to, and impose their own reality on the physical and social environment. Through this vacillating interconnection it is apparent that the bio-chemical and environmental reasons for an early menopause do not occur in isolation to ovaries which are detached from a woman. Moreover, there are cultural causes of early menopause. Often these are related to the idea that the body is a limitless and indestructible resource, which can be controlled and manipulated to suit the individual. Specific behaviours, which are condoned as normal within different social groups, can permanently alter people. Smoking, excess alcohol, drugs, poor nutrition, stress, childbirth and contraception can impact upon the bodies of women and cause an early menopause. These causes are largely ignored by the medical sciences as they are not consistent with the concept of a naturalistic and unchangeable body.

The social structure: influencing bodies

The ideology that divided individuals into body and mind has been used to legitimate separate and distinct disciplines. The sciences study the body; and the mind has been relegated to the humanities. Medical science has assumed a position of dominance and created the situation whereby only bio-chemical explanations of mental, spiritual or cultural events are accepted. Because of this certain conditions have been thought of as psychosomatic, or ‘only in the mind’, and have been dismissed as irrelevant. Thus, the medical sciences have treated all the problems of the body as bio-chemically based with little reference to social or psychological causes of wellness or illness (Turner 1992: 33).

Bodies can be shaped by the response of individuals to the social groups to which they belong. Not only is the external body reconstructed to represent the values of particular social groups, but the unseen internal body is influenced as well. Changes to the internal body are not identified easily as they lack visibility and also are dependent upon the social structure. The social structure, however, is not static but is a process which is formed and reformed. Individual responses can affect the social structure either by the dominant behaviour of one individual, or a number of individuals, or through the accumulated effect of numbers of people making similar choices (Babbie 1994: 59). This analysis proposes that a variety of social groups contribute to a whole social structure and that individuals can belong to, and move in and out of, more than one social group.

In the West women’s bodies can be viewed as representational sites of cultural values. They are constrained and trained to be acceptable within different social groups and can represent resistances to dominant discourses. Within contemporary society it has been proposed that women’s bodies are fashioned as commodities which are moulded to be as hetero-sexually desirable as possible. Emphasis is placed upon perception of youth, beauty and health (Lupton 1994: 36-37). This creation of a visibly fertile and heterosexually available body influences certain behaviours designed to represent the ideal female body. Currently this body is slim, carefree and autonomous, although aspirations of combining slenderness and vitality may endanger the fertility it is intended to portray. Women’s bodies are portrayed as an infinite and indestructible resource. This construction influences specific behaviours, which are intended to shape women’s
external and representational body. Unintentionally, these behaviours can impact upon the internal body of a woman and cause a culturally-imposed early menopause.

Up in smoke: the consumption of finite assets

Certain lifestyle choices that can cause an early menopause have been disregarded by dominant discourses. For instance for nearly fifty years studies have revealed that smoking cigarettes can cause an early menopause (Midgette and Baron 1990: 474; Schofield, Mishra and Dobson 1997)). This information is not offered to women. The tokenism of health education, such as the government warning that “smoking is a health hazard” attached to cigarette packets in Australia, is demonstrably ineffective. Young women are increasingly the largest group of smokers. And the number of women smokers has increased during the past thirty years (Australian Associated Press 1998). Recent legal action in the U.S.A. against the tobacco industry alleged that:

... major tobacco companies had conspired since the Fifties to defraud and mislead the American public and to hide information about the hazards of smoking. Harnden 1999: 20.

In Australia legal action against tobacco companies is being proposed as well but while there are huge economic profits to be made the tobacco industry will be difficult to topple. It will take a new order in discourses before long-term effects on individuals will no longer be dismissed as the result of their own ‘free will’. These ‘blame the victim’ strategies can be transferred to other life-style choices such as meat and alcohol consumption that support huge industries as well. Until the economic interests of global conglomerates are confronted, the real reasons for individual lifestyle ‘choices’ will not be addressed. Women will continue to be unaware that these practices can result in an early menopause.

For instance smoking cigarettes can cause an early menopause. Chemicals in cigarettes (polycyclic aromatic hydrocarbons) can kill the eggs in women’s ovaries and destroy their follicles (Midge-
te and Baron 1990: 474-480). Nicotine from cigarettes interferes with the delicate hormonal feedback system of the pituitary gland as well. This disturbance affects menstruation and may contribute to an early menopause. Additionally, the metabolism of sex hormones is altered and masculinization can contribute to an early menopause (Midgette and Baron 1990: 474-480; Torgerson et al 1994: 83-92; Schofield, Mishra and Dobson 1997). Smoking as a cause of early menopause is related to dose and duration but even without these variables being taken into account smokers over the age of forty-four years are reported as doubling their chance of having an early menopause.

Although smokers are reported as having menopause between one and five years earlier than average no studies have looked specifically at cohorts of younger women or children (Davis 1997: 155; Midgette and Baron 1990: 474-480). Smoking cigarettes is a common practice in some social groups although it is referred to as the choice of the individual. In the Western world many young women smoke despite the fact that smoking is reported as no longer socially acceptable. In Britain it is reported that twenty-seven per cent of people over the age of sixteen smoke (Murray 1997b: 6). This high percentage of young smokers is repeated in other Western countries and the increasing majority of cigarette smokers is young women (Gordon 1999; Australian Broadcasting Commission 1999). It appears that legislation to ban smoking from public venues and health education, for example the No Smoking Day in Britain (Evans Young 1995: 201-2), has succeeded only in shifting the habit of smoking from one social group to another.
Studies of smoking cigarettes concentrate on the individual. Physical and psychological addiction to nicotine is the reason medical studies give for smoking (Youngson 1992: 13). The concept of independent autonomy disguises the cultural influence of certain behaviours through interpreting these as entirely the choice of the individual. While ultimately individuals do make certain choices their social groups can influence these. For instance, families, particularly siblings, have been identified as the most prominent factor influencing children to start smoking (Murray 1997b: 6). Peer groups, too, assert a strong influence. Individual behaviour sends powerful messages to the social group and non-conformers are excluded. It is likely that if her social group condones it a woman will smoke and if it is condemned a woman will not smoke.

Smoking is intended to show sophistication, fun and worldliness (Evans-Young 1995: 201-2). Tobacco companies have created the impression through advertising that women who smoke represent the desires and values of particular social groups. For instance recent legal claims against tobacco companies have highlighted the role of advertising in attempting to entice young people to smoke cigarettes and in not drawing attention to the potential health risks involved. One lawyer suggested that if action went ahead the prosecution would:

... put up evidence to suggest that all the advertising which has taken place since 1960 that smoking is a sexy, glamorous, adult, cool thing to do, unattended by any health risk has been misleading and deceptive.
Gordon 1999.

Smoking, particularly in young women, is related to constructions of the body. Thin bodies are valued and as cigarettes are an appetite suppressant they may be used intentionally to remain slim. They also provide hand to mouth activity at socially prescribed times for eating, still helping to maintain a thin body. Cigarette advertising is directed specifically to the image of a young woman as refined, autonomous, carefree, hetero-sexually available, fertile and above all, thin (Gordon 1999). These young women are displayed as the ultimate ‘reproductive body’. Ironically, the action, which is intended to portray fertility, is destroying it.

**Designer bodies: construction of a conundrum**

Bodies are kept thin through dieting as well. Thinness is respected as a sign of self-discipline and restraint, while obesity is condemned through judgements of sloth and indulgence. When weight changes are desired usually this is not to improve health but to enhance body image. In other words, the control of body shape is social. Social circumstances, including psychological factors, influence what and how much people eat and this ultimately can alter the shape of their body. Although genes and the endocrine system play a part in body weight, social influences are powerful controllers of appetite. Poverty reduces entire populations to emaciation, whereas abundance creates a culture of obesity. In the Western world of plenty, resistance is admired and a thin body represents the selflessness of denial. This is consistent with the ancient concepts of ascetic behaviour where severe abstinence through the practice of self-discipline was revered. Fasting and dieting as forms of control of the body have traversed their origins as religious rituals to abstinence as the inverse of the abundance of consumption (Turner 1995: 161).

Thinness is a metaphor for resisting the excesses of consumerism: it projects an image of self-control, self-restriction and sexual androgeny. ... Abstinence is
seen as virtue. ... Thinness has, to an extent, replaced virginity as the desirable female quality. … In an age of plenty, with the accompanying moral fear of sloth and weakness, the strong-willed and able can apparently, like modern technology, overcome any imperfections and succeed. … [however] we have constructed the appearance of health and energy and hidden what lies beneath: the stress, anguish, pain and health risks of trying to achieve it.


Prolonged and excessive dieting can cause malnutrition and malnutrition is a cause of early menopause (Ginsberg 1991: 1288-1289; Grant 1994: 8). For instance zinc and magnesium directly contribute to the metabolism of everyday chemicals and their deficiency has been associated with an early menopause. A poor diet can cause an early menopause four years or more before it would have occurred otherwise (Evans Young 1995). Nutrients affect every hormonal interaction in the body and are essential in variety and quantity for the wellbeing of a woman’s menstrual cycle (Northrup 1995: 337).

Both obesity and excessive thinness affect menstruation, sometimes permanently. Nutritional deficiencies can cause a woman to stop ovulating and menstruating. Sometimes this can be associated with a vegetarian diet, which may not have adequate amounts of high quality protein. However, isolating one causative factor is too simplistic as, conversely, excess meat and alcohol consumption have been associated with early menopause. Food fashion and the quality of food need to be investigated as well. For instance, brown rice has five times more magnesium than white rice and “… the processed foods of this century have decreased our ability to properly detoxify twenty-first century chemicals” (Rogers 1995: 10). This observation is significant as magnesium is essential for hormone balance (Grant 1989).

Studies that have exposed the relationship between diet and reproductive health generally look for only one variable whereas individuals are exposed to a variety of social influences at the same time. Excessive exercise, vegetarianism or excess meat and alcohol consumption as well as the use of recreational or prescribed drugs may accompany these activities. Each of these social behaviours has been identified separately as being associated with an early menopause and an accumulation of them may have a compound effect on the bodies of women.

In an era obsessed by the appearance of good health women’s bodies have been created as commodities to be fashioned and displayed. Poor dietary habits are increasingly common as young women aspire to imitate the goddesses of the mass media. Dieting is endemic in young women and ninety percent of women diet at some stage of their lives (Evans Young 1995: 2). A slim body is the antithesis of the indulgence of consumerism and the external representation of inner control. Yet this slim body needs to appear healthy and fertile; it should not be an emaciated and infertile body. It is a designer body, the ultimate reproductive body. But the creation of an external body of female reproduction becomes a parody through the potential androgeny and infertility of the internal body.

**Stress, miasma of the new millenium: the psychological view point**

Populations once feared bacteria as the agents of disease. It has been contended that stress has become the new enemy of wellness. Stress certainly impacts upon the bodies of women as:
A traumatic experience may cause or appear to cause premature menopause. Prolonged stress or a crisis can cause a temporary hiatus in the production of certain hormones, cease production of eggs, and subsequently of oestrogen and progesterone. Periods stop and typical menopause symptoms appear. This is known as traumatic menopause.


Whereas stress can affect a woman’s menstruation temporarily, stress can cause a permanent disruption to menstruation and an early menopause as well. Stress is essential to normal living as it ensures basic survival through such things as feelings of hunger that motivate a person to find food and eat. But stress is multi-dimensional and can be negative as well as positive. Negative stress is a state of tension created by pressures or conflicting demands which defeat a person’s ability to cope adequately (Jary and Jary 1995: 659). This state changes as different people experience the same events variously. The induction of negative stress usually is described through life events as psychological, physical, chronic or acute. But it is not so much the event which causes stress or the individual’s response to their circumstances but their interaction.

The perception that menopause itself is a stressful event has been contested by many researchers. Some researchers have reported the occurrence of psychological symptoms attributed to menopause amongst women between the ages of thirty-five years and forty-five years. These psychological responses were thought to be due to life events, which occurred before the hormonal changes associated with menopause had started. Researchers concluded that stress experienced at midlife is no greater than stress experienced during other phases of life and that the interaction between stress and hormones can occur at any stage in a woman’s life (Ussher 1995: 120). However, reaction to the stress of life events can be so profound that it can cause an early menopause. Actual:

… nutritional deficiencies and immune changes [that can cause early menopause] can be precipitated by thoughts of grief, anxiety, anger, and depression via our own neurotransmitters. Rogers 1995: 30.

In addition, the reverse can occur. One researcher reported a respondent as saying that she had been:

‘… suffering with this menopause for twenty years (since the age of twenty-five) and it started [her] mental breakdown’. Ussher 1995: 106.

The interaction between stress and hormones is so compelling that their fusion causes multi-lateral responses. Anxiety and depression, which are common reactions to stressful situations, can disrupt a woman’s delicate hormone balance. Conversely, hormonal disturbances can cause depression and anxiety. This interconnection has been demonstrated specifically in regard to menopause where the severity of symptoms experienced has been related to stress (Ballinger and Walker 1987: 67).

Psychological explanations of the relationship between women’s bodies and stress contend that women have been unable to express feelings of anger and violence as these are not valued ‘feminine’ emotions. Women have learned to:
… express their unhappiness in a culturally acceptable way; that is as a syndrome which can be cured. Ussher 1995: 56-57.

‘Raging hormones’ have provided a version of women’s emotions that gain medical, legal and lay endorsement. This bio-chemical account of women’s experiences fits seamlessly into a consumer culture where specific syndromes can be identified and instant cures can be purchased. Pre-menstrual syndrome is a label, which has been used to account for any irregularity in a woman’s life, including the plea of diminished responsibility in a court of law. Progressively pre-menstrual syndrome has been transposed into the menopausal syndrome of emotional turmoil which now even has its own psychiatric diagnosis of ‘climacteric dysphoric disorder’ (Nechas and Foley 1994: 16). In other words the hormonal fluctuations of menopause have been pathologized and used to remove menopausal women from the economic sphere.

The possibility that stress can cause a physical response in women’s bodies, and vice versa, is a clear indication of the inadequacy of segregating women into body and mind, or other forms of reductionism. For instance the vacillation of governments looking for a single cause for the Gulf War Syndrome has turned now to stress as the cause (Brodie 1997: 8). But toxic environmental chemicals can change the way they affect an individual by exhausting neurological pathways and so cease to be handled in the original manner. Failure:

... to comprehend this basic bio-chemistry can make chemical sensitivity appear to be a psychiatric disease. Rogers 1995: 30.

Moreover, it is a convenient use of the theory of Cartesian duality to blame the mind of each individual for their own problems, thus removing governments from responsibility. An acknowledgement of the multi-dimensional interaction between individual women and their environment would reveal that all of these factors play their part.

**To birth or not to birth: the choice of the individual?**

After all women are conscious beings able to make decisions which directly influence their own bodies. The experiences of pregnancy and childbirth are considered by most women as an option they can either embrace or deny. This is thought to be a fairly recent choice in historical terms and is attributed to improved and available contraception for women. Control of women’s fertility is a contentious issue. It has long been the domain of religious and sexual politics, which have reflected the tensions and anxieties of the social structure. The complex issue of choice in birthing cannot be reduced to contraception alone. Political and religious control of reproduction along with consent or coercion for sex, conception, abortion, infanticide, pregnancy and birth all belong in an analysis of birth and its control. Nevertheless, women have been enclosed in a reproductive conundrum which has been interpreted by the disciplines of medicine, philosophy, anthropology, psychology, sociology and different feminisms. Neglected in this plethora are women’s experiences of pregnancy and birth, or their avoidance, which can result in an early menopause.

The fact that women can become pregnant and give birth impacts upon the lives of most women. Interpretations of this ability are immeasurable, from personal experiences to global implications. The ebb and flow of human needs and interests have influenced constructions of female fertility since the emergence of civilization. For a combination of cultural reasons many Western women nowadays have choices regarding control of their
own fertility. Having children, not having children, and preventing having children have all been associated with an early menopause.

In disadvantaged socio-economic groups it has been reported that the more children a woman has the more likely she is to have an early menopause. This has been associated with concurrent nutritional deficiencies indicating that the more children a poor woman has the less likely she is to be well-nourished herself (Madadevan et al 1982: 473-479). This association with early menopause is reversed in advantaged socio-economic groups as the more children wealthier women have, the later they have their menopause. Many studies have noted this discrepancy between different socio-economic groups (Torgerson et al 1994: 83-92).

In addition, multiple births have been associated with an early menopause and mothers of twins are reported to have menopause at least one year earlier than women who have single infants (Ginsberg 1991: 1288). The number of a woman’s ovarian follicles is influenced by the number of ovulatory cycles she has during her lifetime. An increase in ovulatory cycles decreases the number of ovarian follicles and experiencing over three hundred cycles in a lifetime is said to increase the incidence of an early menopause (Cramer et al 1995: 572). It has been estimated that two hundred years ago a woman had about thirty cycles during her lifetime. With fewer pregnancies and less time spent in lactation the average lifetime number of ovulatory cycles a modern woman with two children will experience is up to four hundred and fifty cycles (Read 1995: 7).

Women who have no children are reported as having an early menopause as well. The reason for this may be that incessant ovulation decreases the number of eggs more quickly than women who have several pregnancies and do not ovulate while they are pregnant or lactating. Similarly, when women have their last pregnancy before the age of twenty-eight years they may have an earlier menopause than women who have their last pregnancy at an older age (Ginsberg 1991).

Women who have painful periods might lose more eggs spontaneously and have an early menopause as well. Period pain is associated with ovulation and a uterine lining which releases more progesterone and chemicals that influence blood clotting and stimulate pain nerve endings (prostaglandins) (Read 1995: 7). Various circumstances have been associated with women who have an early menopause through a greater number of ovulatory cycles. These include the commencement of menstruation before the age of eleven years, a cycle length shorter than twenty-eight days during adolescence, the use of fewer contraceptives which stop ovulation, fewer pregnancies with live births or no pregnancies at all (Cramer et al 1995: 568-573).

Although some studies of women who use ‘the pill’ have shown that its use can delay menopause, others have shown that its use can cause an early menopause. As the oestrogen in ‘the pill’ works as a contraceptive by inhibiting ovulation, theoretically this should delay menopause as fewer eggs are used. But progestogen (synthetic progesterone) is added to oestrogen in varying types and quantities and it seems that this may have some effect on age at menopause. No studies have investigated this. Research into whether different progestogens vary in their ovulation-inhibiting capacity and therefore potential to influence age at menopause has been recommended (Cramer et al 1995: 572). There has been a reluctance to condemn ‘the pill’ as it is seen to have released women from a unilateral role of reproduction. However, the direct effect of oestrogen and progestogen on the pituitary gland stops ovulation and this can be permanent and cause early menopause. It is thought that ‘the pill’ may interfere with the cyclic functions of the pituitary gland, destabilize ovulation and potentially cause an early
menopause (Seaman1995: 117). Taking ‘the pill’ even can mask the signs of early menopause through the induction of a withdrawal bleed that imitates menstruation.

A less obvious connection between ‘the pill’ and early menopause is its association with endometriosis. The number of women diagnosed with endometriosis has exploded from twenty-one cases worldwide seventy years ago to five million cases to date in the U.S.A. alone. This growth of endometrial tissue outside a woman’s uterus can cause extreme pain and is one of the prime reasons hysterectomies are performed on young women (Sellman 1997: 30). Hysterectomy has been discussed already as the major cause of early menopause. Even though self-help books on endometriosis disclaim the pill as a cause of endometriosis (Hawkridge 1996: 36) research indicates the opposite. For instance some medical research has revealed that women who have taken ‘the pill’ are twice as likely to get endometriosis as women who have not taken ‘the pill’ (Grant 1994: 48). These oblique causes of early menopause do not appear in mainstream medical discourse.

The combination of factors connecting birth, or its avoidance, with early menopause emphasizes the contradictions surrounding the ability to reproduce. No absolute answers are available and each finding presented replicates the cultural location of different researchers. Women are left to wade through a myriad of choices which are made easier, or harder, depending upon their individual cultural context. However, it appears that conception choices can change the nature of the corporeal body and cause women to have an early menopause.

Conclusion

In this chapter I have examined some of the physical dimensions of the causes of early menopause. I have demonstrated that there are more causes of early menopause than those presented through the naturalistic model preferred by mainstream medical discourses. I have shown that early menopause is a fluid concept that is dependent upon its interpretation. By looking specifically at iatrogenic, environmental and cultural causes of early menopause I have suggested that in the main early menopause is the result of living in the modern Western world. In other words women’s corporeal bodies can be changed through their social location in history.

This particularly is apparent by the number of women who have an iatrogenically-caused early menopause. Research indicates that this is far more than the collective number of women who have an early menopause caused through genetic, environmental and lifestyle reasons (Northrup 1995). I have suggested that, in part, the fairly recent escalation in the number of women experiencing an early menopause is due to the dominance of medico-scientific discourses that construct women’s bodies as mechanistic and able to be manipulated without consequence. These positivist discourses disregard the changeability of the corporeal body through indifference to the changeability of the philosophical body.

In the first section I looked at medico-scientific discourses that have pathologized women as a unilateral reproductive body. I discussed how the concept of risk is used to control the uncontrollable and specifically, how this is articulated through gynaecological surgery. Risk that is identifiable only through scientific knowledge has been used to create both a demand and a market for the avoidance of this risk. Discourses of risk are applied to the unseen and unproven potential of women’s reproductive organs to become cancerous at a later date. Women are expected to understand and accept these definitions are considered irrational. This focus on risk is negative, and, unconcerned with attaining a positive outcome it is directed to
preventing its own definition of danger. It is a modern day implementation of the historical construction of women’s sexuality as a danger. In Chapter Five I will reconnect risk, sexuality and early menopause through the early-menopausal experiences of individual women.

In the second section of this chapter I reviewed a variety of environmental agents that can and do cause early menopause. I proposed that dominant discourses play down, refute or ignore this connection through acceptance of the construction of the body as naturalistic and unchangeable. In particular I focused upon women’s infertility as an inevitable consequence of early menopause. Although research into artificial conception is legally, institutionally and economically endorsed there is little investigation into why infertility occurs in the first place. In addition to the difficulty in identifying specific environmental agents as the cause of early menopause, a major obstacle to research is the dominance of the concept of the natural body. Thus, the connection between the individual infertility of women through early menopause and the infertility of the environment has been underplayed. Just as the fertility of the earth is threatened by an industrialized world the fertility of women is diminishing. In later chapters I will contextualize the experiences of individual women in relation to early menopause and infertility as both a product of environmental pollution and as a metaphor for consumerism.

In the last section of this chapter I looked at the location of women’s bodies within various discourses. In particular I suggested that concepts of identity and subjectivity influence individual and group behaviour and that some specific behaviours can change women’s bodies and cause an early menopause. I suggested that discourses that separate body from mind have prompted the concept that women are governed by their uncontrollable genetic inheritance. This biological determinism isolates women from their bodies and from their cultural context. Moreover, the construction of the bodies of women as naturalistic and universal endorses activities that can have irreversible consequences. Specifically there are a number of behaviours accepted as normal within Western cultures that can change the bodies of women permanently and cause an early menopause. These behaviours reflect the tensions and uncertainties of a changing world. In later chapters I will reunite the corporeal aspects of early menopause with ontological and embodied dimensions to expose these concepts as continuously interacting. I will suggest that not only does socio-historical location influence bodily changes but that these changes also modify women’s subjectivity. I will argue that women draw upon the experiences of their changing bodies to contribute to the changing bodies of discourse of early menopause.
DECONSTRUCTING EARLY MENOPAUSE

Chapter Three
Theoretical Considerations

... the crossover between feminist theory and poststructuralism has been especially vibrant and productive. The poststructuralist philosophical critique of the rational subject has resonated strongly with the feminist critique of rationality as an essentially masculine construct. Moreover, feminists have drawn extensively on the poststructuralist argument that rather than having a fixed core or essence, subjectivity is constructed through language and is, therefore, an open-ended, contradictory and culturally specific amalgam of different subject positions.


Introduction

In order to gain an expansive understanding of early menopause I needed to explore the socio-historical processes that contribute to its construction through diverse and, at times, discordant discourses. In this chapter I describe the theoretical considerations that helped me to make sense of early menopause as a socio-historical transaction. I commenced with an appreciation of generalized sociological and feminist theories. My intention was to locate early menopause within a theoretical background that could give meaning to the experiences of individual women.

Constructing a theoretical framework around early menopause was an on-going process. I became aware that articulating my findings could only be a representation of a particular moment in history filtered through my own constructions of the social milieu. As this juncture itself is produced socially and historically my research on early menopause needed to be understood as a variable enterprise.

I settled within a broad poststructuralist critique drawing upon feminist understandings as well. I found an interconnection between poststructuralist and feminist theories useful as this provided an interpretive framework in which I could deconstruct discourses of early menopause. More importantly, it opened the possibility for reconstruction through the changing discourses of a constantly reforming early menopause. In particular this theoretical background provided the sophistication for breaking free of binary sexuality and allowed for the dynamics of ‘sexual slippage’ (Matus 1995: 21-55). It made way for understandings of the body as “... open, permeable and subject to change” (Matus 1995: 47). Through this ontological perspective early menopause could be reconstructed as a diverse range of experiences within the mobility of gender.

Poststructuralism and feminism: deconstructing early menopause

To facilitate the process of developing a conceptual framework I needed to locate the theoretical bases preceding but spilling over into the broad theories of poststructuralism and feminism within history. For instance it is claimed that traditional and modern philosophies are severed by the Age of Enlightenment (Jary and Jary 1995: 11). This intellectual movement questioned traditional thought and social organization, seeing reason and human progress as determining social practices. Modernism, which
precedes postmodernism, supposedly breaks with this theory. Modernism features reflexiveness and a rejection of narrative structure; it explores ambiguity and uncertainty; and it emphasizes the individual through destructured subjectivity (Jary and Jary 1995: 420).

Postmodernism moves beyond this individualism to a world of change, movement and fragmentation. It claims that there are no absolute truths and rejects an overarching belief in scientific rationality. Empiricist theories of representation are questioned and there is “... an increased emphasis on the importance of the unconscious, on free-floating signs and images, and a plurality of viewpoints” (Jary and Jary 1995: 509). According to Leonard (1997) we should turn to postmodern theory in two senses:

... postmodernity as the period in which we are now living, the most recent stage in the development of late capitalism, and postmodernism as the critical challenge to the universal knowledge claims of modernity and its beliefs in reason and progress. Leonard 1997: 5.

While postmodernism is not synonymous with poststructuralism it has been suggested that poststructuralism is informed by postmodernism (Jary and Jary 1995: 509). Despite the similarities between poststructuralism and postmodernism some theorists suggest that it is misleading to align them (Kincheloe and McLaren 1998: 270). Similarly some feminist writers reject a connection between feminism and postmodernism/poststructuralism (McNay 1994: 6), while others concede an overlap (Leonard 1997; McNay 1994).

Poststructuralism reinterprets the theories of structuralism, which is a theory based upon a sociological analysis of the social structure (Weedon 1998: 22; Babbie 1994). Structuralism looks to the priority of structures over human actors; it concentrates its analysis on the structural features of language; and it assumes that social structures can be analyzed “... analogously with language and linguistics, ... as signifying systems” (Jary and Jary 1995: 660). Structuralism decentres individuals, who are no longer seen as subjects of history. Indeed subjects are accorded little or no agency at all. Structuralism, then, has been unable to resolve the fundamental sociological issue of agency and structure. Nevertheless, structuralism founded the impetus to combat the one-sidedness of individualism. It does not, however, provide a sophistication for breaking free of the dualism of agency and structure.

Some interpretations of poststructuralism allow this movement. Individuals are seen as culturally and historically specific, whose subjectivity is established and maintained through discursive practices (Leonard 1997: 34; Weedon 1998: 176). These discourses are transitory and thus subject positions change. Feminist writers have seen both the possibility of resistance to dominant discourses (Bordo 1993; Weedon 1998) and competition between discourses that can change positions of dominance (Hollway 1984). They maintain that various discourses jostle for control. The discourses of medical science, then, can be seen as constantly involved in stabilizing their dominance over constructions of ‘the body’. Flowing from discourse theory poststructuralism rejects metanarratives, or grand theories and accords privilege to the reader as the interpreter of texts and discourses. It is concerned with social interactions as inconclusive and is focused upon the role of the individual in transacting discourses (Fox 1993: 162-163).

Fraser (1997: 152) suggests that an understanding of discourse theory contributes to feminism by allowing expression to the interrelatedness, plurality and instability of
social identity, collective agency, cultural hegemony and social change. These distinct but overlapping concepts need to be understood in order to contextualize early menopause as a diverse individual experience but also as a phenomenon that can bring some women together as a transitory collective. Postmodern theory also provides an understanding of the socio-historical location of individual and collective social identities, and creates the possibility of change through shifting discourses.

The course of theoretical development itself is diffuse and constructed socio-historically through competing and contradictory discourses. For instance there are feminist critics of postmodern theory who:

... claim that the Western Enlightenment discourses of subjectivity, historical progress and emancipation are essential to feminism. They argue, among other things, that postmodernism, in contesting Enlightenment assumptions and values, ‘expresses the claims and needs’ of white privileged Western men who have had their Enlightenment and can afford to be critical (Di Stefano, 1990, p.86). Weedon 1998: 175.

Radical feminists have distanced themselves from postmodernism as well. They contend that:

[P]ost-modernism dislocates and fragments while claiming to create discursive spaces for a multitude of voices. But, they are so elitist and obscure in their language and this reliance on “French feminism” is spurious. Bell and Klein 1996: xx.

They argue further that the process of deconstruction used by postmodernists is not a victory for women but reinforces the status quo of patriarchy by removing any commonality among women (Spretnak 1996: 324). Moreover, radical feminism critiques postmodern feminism as a contradiction in terms. Thompson (1996) argues that “... while feminism is a politics, post-modern feminism renders its adherents incapable of political comment” (325).

Weedon (1998: 178) defends a location of feminism within postmodernism and poststructuralism. She maintains that:

[F]eminist objections to poststructuralism and postmoderism often rest on the assumption that to question the Western Enlightenment category of the subject is to undermine the possibility of subjeethood. A more positive and politically useful reading of poststructuralist theories of subjectivity would see it as socially constructed and contradictory rather than essential and unified. Weedon 1998: 176.

This point of view also is articulated by McNay (1994) and extended in her analysis of Foucault and Feminism. Foucault is represented widely as informing postmodern and poststructural theory. Even though there are various interpretations of postmoderism and poststructuralism they are linked by their identification with specific theorists. For instance both postmodernism and poststructuralism call upon the works of Foucault (Seibold 1998: 51). Feminist theories use Foucault as well. Despite this
commonality interpretations of Foucault are diverse and account is not always taken of Foucault’s reduction of the body to the discourses acting upon it. McNay (1994) finds this problematic. Foucault, she says, defines individuals as ‘docile’ bodies:

... which cannot explain many of the experiences of women in modern society and results in an impoverished and over-stable account of the formation of gender identity. The paradox that Foucault’s work presents for feminists is that, by placing so much emphasis on the body as a historically specific entity, he finishes by bypassing any notion of individuality and experience. Thus, whereas feminists have recognized the need to show that women are more than passive victims of domination through the rediscovery and revaluation of their experiences and history, Foucault’s understanding of individuals as docile bodies has the effect of pushing women back into this position of passivity and silence.

McNay 1994:

Thus, although poststructuralism generally is thought to consolidate a move away from grand theory and look more to local accounts for social analysis there appears to be some room for negotiation. By drawing upon the work of Derrida (1973/1976), poststructural theory appreciates the instability of language as a medium and the impossibility of any absolute truth. For instance, Derrida’s project of deconstruction reveals the ambivalence of all texts. It is consistent with Foucault’s (1965, 1973, 1975, 1980) theory of discourse and power that also helps to underpin poststructuralism (Jary and Jary 1995: 148, 241; Weedon 1989: 13).

My intention in relying upon poststructuralism is not to disunite women but to create an understanding of how women experience early menopause variously. By identifying the undecidability of meaning within the practices of discourse and enabling subjectivities to be multivocal rather than single and fixed I hope to show individuals as capable of “... ‘becoming’ through resistance to power/knowledge” (Fox 1993: 163). I do not view this aim as incompatible with feminism. Moreover, I propose that a theoretical overlap that includes aspects of feminism with poststructuralism not only recognizes dominance within discourses on early menopause but also allows for resistances to the nexus between ‘medical power and social knowledge’ (Turner 1991).

The concern of poststructuralism and feminism with movement within discourses allows possibilities of reconstruction. For instance, it allows for an appreciation of early menopause as a bodily experience as well as a:

... political surface on which is inscribed the discourses produced by the gaze of the expert. This ‘body without organs’ is the social body and as such is not simply passive under the gaze but also is a site of resistance.


Thus, it is possible to envisage an:

... intertextuality – the play of one text (book, film, body) upon, within or beside other texts. The inscribed body described ... collides with other textualities, which have the effect of ‘de-territorializing’ it momentarily, enabling transformation and ‘becoming’ other. ...

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In the play of text upon text, new possibilities are opened up, perhaps a new ‘plateau’ can be glimpsed. Fox 1993: 69, 108.

This ‘intertextuality’ can be applied to early menopause in order to open up further understandings. Dominant constructions of early menopause can be deconstructed through a theoretical understanding of the socio-historical production of all discourses. This momentary void allows for a reconstruction of early menopause. In addition it makes room for a rejection of dominant discourses. Different discourses can be heard including the transaction of discourses by women who have an early menopause.

As I have shown already, early menopause has been constructed through the single knowledge base of medical discourse. This powerful discourse has been produced socio-historically into a position of dominance and marginalizes other discourses (Lupton 1995: 5; Willis 1989: 36). Yet it is a rigid naturalistic discourse and presents only a partial interpretation of early menopause. A poststructural view would suggest that a sole and biological reductionist construction of early menopause is problematic. It insists upon a process of deconstruction to reveal the inconsistencies of all discourses. Further, it insists upon an affirmative deconstruction that makes way for other discourses.

[Derrida] suggests that this responsibility requires an examination of the very structures and conditions of discourse. In order to change the structure and conditions of discourse we need to go beyond a negative deconstruction. We need to engage in an affirmative deconstruction that first inverts traditional hierarchies but does not stop there. More than this – and this is what separates deconstruction from Enlightenment demystification – deconstruction unsettles the conditions of its own production; it undermines traditional concepts but creates spaces for new concepts by engaging in a parody of itself. By undermining itself, deconstruction exposes the ways in which our discourse needs its other. Derrida suggests that it is the double movement of deconstruction that opens on to the other and makes/marks the possibility of difference. Oliver 1995: 45.

Fraser (1997) suggests that a critical theory of recognition needs to be developed to understand current dilemmas. Using her thesis it is possible to concede that the discourses of early-menopausal women simultaneously are subsumed by the discourses of medical science and devalued through a gendered division that favours (male) ‘productive’ labour over (female) ‘reproductive’ labour’. The mobile sexuality of early-menopausal women and their so-called ‘non-reproductivity’ places pressure upon the binary opposition of sexual difference (Fraser 1997: 18-19). Thus a paradox emerges around the ‘sexual slippage’ (Matus 1995) of early menopause that destabilizes the biological delineation of sexual difference. Early menopause unsettles the “cultural-valuational differentiation” (Fraser 1997: 20) that is androcentric and devalues the ‘feminine’. Thus, women who have an early menopause are not recognized collectively and, as Fraser postulates, this non-recognition is a form of cultural inequality.

Here injustice is rooted in social patterns of representation, interpretation, and communication. ... nonrecognition (being rendered invisible by means of the authoritative representational,
communicative, and interpretative practices of one’s culture) … Fraser 1997: 14.

The cultural misrecognition and social devaluation of early menopause intertwine and reinforce each other. For instance, the discourses of medical science have been institutionalized to define cultural ‘norms’, and thus restrict the voices of women who have an early menopause. This critique must be posited within an understanding of the medical construction of sexuality through binary opposition. While social discourses may take for granted an original sexual difference within which there are ‘multiple intersecting differences’, medico-scientific discourses construct sexuality as opposed, fixed and separately valued. Thus, early menopause cannot be understood within a discourse that separates women from men through reproduction and places positive social value upon this difference. Movement within discourses exposes both the inconsistencies and interrelatedness of a dichotomy between the sexes.

The problem facing a poststructural and feminist critique of early menopause, then, is how to simultaneously address the gender injustice of androcentrism and the limited construction of early menopause. Fraser proposes more than an affirmative reconstruction, which she maintains leaves marginalized identities and group differentiations intact. She proposes transformative remedies that destabilize fixed sexual difference and allow for a fluidity of sexual identity. She uses homosexuality to illustrate her point.

Transformative remedies, by contrast, [to affirmative remedies] are currently associated with deconstruction. They would redress disrespect by transforming the underlying cultural-valuation structure. By destabilizing existing group identities and differentiations, these remedies would not only raise the self-esteem of members of currently disrespected groups; they would change everyone’s sense of self. …

The transformative aim is not to solidify a gay identity but to deconstruct the homo-hetero dichotomy so as to destabilize all fixed sexual identities. The point is not to dissolve all sexual difference in a single, universal human identity; it is rather, to sustain a sexual field of multiple, debinarized, fluid, ever-shifting differences. …

Whereas affirmative recognition remedies tend to promote existing group differentiations, transformative recognition remedies tend, in the long run, to destabilize them so as to make room for future regroupments. Fraser 1997: 24.

This leads into the diversity of feminisms that see sexual difference from various perspectives. While recognizing the subtlety within feminisms Fraser consolidates feminisms into three phases. These positions move from an equality feminism that sees sexual difference as an instrument of male dominance to a cultural feminism that sees sexual difference as essential to define women’s identity. Fraser sees these two perspectives through a political economy that claims unequal access to the distribution of goods and a cultural non-recognition of the value of ‘femininity’. Although women who have an early menopause are not an economically based group, they are culturally defined
because of their gender and age. They, therefore, fall into Fraser’s category of recognition and gender injustice of androcentrism.

Fraser maintains that feminisms of ‘gender difference’ and ‘differences among women’ separate these perspectives but that they need to be integrated in order to “... change culture and political economy in tandem” (Fraser 1997: 177). She suggests that a one-sided focus on cultural politics is a limitation that neglects social injustice. Like Leonard (1997), Fraser believes that these perspectives cannot be addressed adequately in isolation from each other. By aligning rather than opposing the politics of ‘redistribution and recognition’ the current third phase of feminism of ‘multiple intersecting differences’ can further develop. Fraser warns that while focusing upon recognition feminism does not eclipse redistribution. She looks for a *transformative* dimension that re-evaluates the old debates sympathetically. She says that we now:

... need to construct a new equality/difference debate, one oriented to multiple intersecting differences. We need, in other words, to reconnect the problematic of cultural difference with the problematic of social equality.

... we should develop an alternative version of antiessentialism, one that permits us to link an antiessentialist cultural politics of recognition with an egalitarian social politics of redistribution.

... we should develop an alternative version that permits us to make normative judgements about the value of different differences by interrogating their relation to inequality. Fraser1997: 187.

This debate of differences within difference is essential to an understanding of early menopause. The biological determinism used by the medical sciences to differentiate the social location of women and men through the physical body has been critiqued by the discourses of feminism. Biological distance between the sexes is contested as although this may unite women it concurrently disallows differences among women. Nicholson (1999: 65, 67) suggests that even theories that focus on cultural history and diversity still rely on a biological basis of sexual difference between the sexes. Thus, what is claimed to be a ‘feminism of difference’ is actually a ‘feminism of uniformity’. Early menopause exposes the impossibility of uniformity among women. It exposes the transience of sexual identity through bodily changes and most importantly allows for the oscillation of differences within difference. There is a residual bodily difference and even though menopausal women stop bleeding and experience changes due to gender or age they do not become men. They fall into Grosz’s (1994) concept of sexual difference that is:

... impossible to unify, impossible to separate from its various others and impossible to identify or seal off in clear cut-terms. Grosz 1994: 208.

Thus the construction of sexual difference as a binary conceptual system can be deconstructed. McNay (1998) positions this deconstruction within the context of feminist and postmodern debate:
[If] postmodern thought is seen to contribute to the critique of essentialism within feminism, then the other side of the debate is that a feminist perspective may contribute an awareness of issues connected with gender which, on the whole, is absent from most postmodern thought. The postmodern preoccupation with difference either bypasses the question of sexual difference altogether or, as Rosi Braidotti (1988) points out, renders sexual difference a metaphor of all difference, thus turning it into a general philosophical term which bears little relation to the concrete issues of gender or the historical presence of real-life women.


From this point of view I have attempted to deconstruct the naturalistic construction of early menopause. This process is concerned particularly with the pressure early menopause places upon the notion of sexual difference as biologically determined; the dominance of medical discourses that construct early menopause as ‘premature ovarian failure’; and the alienation of subjectivity from constructions of early menopause. It reveals the socio-historical processes that have constructed concepts of sexuality, fertility and subjectivity. I will suggest in later chapters that rather than being given or fixed these notions are fluid and changeable, and linked with many women’s experiences of having an early menopause. Later I will turn specifically to the discourses of early-menopausal women who articulate mutable and varied experiences of differences within sexual difference and demonstrate a range of ‘multiple intersecting differences’.

The conundrum of biologically-determined sexual difference

It has been argued in feminist theory that although philosophy has been concerned with ontological difference for centuries the concept of sexual difference has been neglected (Oliver 1995: 57). Yet, Oliver (1995) suggests that Irigaray (1993) sees sexual difference as ‘... the most pressing problem of our age’ (Oliver 1995: 57). She says that until we have sexual difference we cannot have ontological difference. She also suggests that for feminists this is a crucial debate as without some form of sexual difference it is difficult to locate the feminine (Oliver 1995: 56, 187-210). The medical construction of sexual difference, however, is problematic as it is constructed through a binary opposition. That is, men are constructed as the ‘norm’ and women as the ‘other’ (Shilling 1994:54; Grosz 1994). This sexual difference is constructed through discourses of biological determinism. Medical discourses construct sex as innate, immutable, identifiable at birth and interchangeable with gender. This binary notion of sexual difference needs to be deconstructed in order to make room for reconstruction through the ‘sexual slippage’ (Matus 1995) of early menopause.

Using a feminist dialogue Grosz (1994: 187) posits the argument that bodies have been polarized from the corporeal to the conceptual; the mind/body split of Cartesian duality. Feminists have critiqued the division between mind and body through an analogous relationship with sexual tensions. They contest that the rational (masculine) mind has been constructed as superior to the irrational (feminine) body (Matus 1995). This unease has been identified in some philosophical inquiry through the removal of sexual difference altogether. For example, Nietzsche is reported as denying the body of women as this ‘... body always reminds us of that first body, the maternal body, which sustained us; it reminds us of the maternal blood of which we were born’ (Oliver 1995: 65).
Grosz captures this anxiety as she goes on to argue that bodies are confined by a construction of nature:

... that is considered universal, innate, fundamentally nonhistorical, and capable of change only through the violent intervention of surgical, chemical, or physiological means, means which may alter details of the body but which leave its ontological status as inert and passive, as cultural ‘raw materials’, intact. The various theorists discussed and sometimes criticized here [Volatile Bodies] have helped make explicit the claim that the body, as much as the psyche or the subject, can be regarded as a cultural or historical product. They testify to the permeability or incompleteness of the notion of nature.


This critique exposes shortcomings within discourses of biological determinism that make no concession to the socio-historical production of the body or to its changeability. These discourses merge all women through a biology that exists only in opposition to men. Grosz comments further that this difference expresses social anxiety as that “... which is marginal is always located as a site of danger and vulnerability” (1994: 195). Within this context of binary opposition early menopause is problematic. Early menopause negates the biology of a ‘reproductive body’ through lack of menstrual periods and infertility. This means that within the discourses of sexed opposites based only upon reproductive capacity women who have an early menopause would be constructed as asexual. That is they would belong to neither sex. This lack of sexual distinction becomes a conundrum for biological discourses. Early menopause, then, only can be understood after the discourses of binary biology have been deconstructed and early menopause is reconstructed through discourses of the body as “... open, permeable and subject to change” (Matus 1995: 47).

Discourses of biological determinism that have been used to disconnect the sexes fail to account for the flexibility and inconstancy of the embodied experiences of early menopause. Moreover, they ignore the socio-historical production of the body. The construction of the sexes as incompatible opposites does not concede sexuality as mutable with subtle gendered variance let alone as an ambiguous, fragmented or changeable sexual identity. It proposes that there are two distinct and unalterable sexes. This rigidity between the sexes makes it impossible to concede the changing bodies of early-menopausal women. In response early menopause has been diminished and marginalized through its medical construction as an inconsequential anomaly of nature. This rejection protects the paradigms of science that divide the sexes through unalterable biology.

This form of sexual isolation is underpinned by the interpretation of bodies as naturalistic, universal and static (Shilling 1994). McNay (1994) suggests that the biological variation between the sexes has been heightened by its origins in social tensions. In this sense she suggests that sexual difference has been used as a metaphor of political separation. Moreover, she sees contemporary theoretical interpretations of sexual difference as not only coextensive but as conflicting in several respects (McNay 1994: 7). In other words she cautions that the deconstruction of biological sexual difference is not replaced by a unified reconstruction of sexual difference through postmodern and feminist discourses. Nevertheless, sociological discourses have contested that the reproductive capacity of women has been used to segregate the sexes as a “... dual principle of social
organization and domination” (Frank 1991: 41). In this way women’s bodies have been used as a site of conflict between different discourses.

Medico-scientific discourses that problematize women’s reproductive cycle transfer this anxiety to women’s life cycle through the changed fertility that occurs with an early menopause. The infertility women experience with an early menopause confronts the concept that all women have the same ‘reproductive body’. Women who have an early menopause defy not only a clear contrast between the sexes but also the discursive constructions that unite women through a fixed reproductive capacity.

It is specifically the construction of women as a ‘reproductive body’ that is threatened by the changing bodies and infertility of early menopause. Throughout history social anxiety has problematized “unproductive sexuality” (Turner 1991: 101) specifically women who do not reproduce. Moreover, medical discourses have attached value judgements to constructions of infertility.

Citing a variety of medical opinions, Leon Faucher’s *Manchester* in 1844 showed that factory women fail the most important test of womanhood: they are less fertile and less able to reproduce than normal (middle-class) women who lead well-regulated lives. One doctor declared that the fecundity of women diminished in proportion as they practiced early intercourse, especially when that intercourse was promiscuous. Another added that ‘the ill-regulated excitement which takes its source in a premature development of sexual propensities, tends to destroy the power of re-production’. Matus 1995: 65.

Movement within discourses provides a way to understand the inconsistencies and interrelatedness of this apparently dichotomous relationship between the sexes that devalues early-menopausal women as ‘non-reproductive’.

**One-sex, two-sex: subordination and exclusion**

Historical interpretations of sexual difference invite a contemporary critique that exposes embedded social conflict and discord. From before Medieval times to the turning of the twentieth century conflict between the sexes has remained unresolved. Up to and during the Renaissance the understanding of sex was restricted to one biology. Sex at birth was distinguished by observation. A male was confirmed by the presence of a penis and a female by its absence. It was assumed that a female penis was concealed internally. Graphic illustration and epistemological sources from the Renaissance era depict both female sex organs and male sex organs as analogous (Laqueur 1990: 4-5, 236). The only difference in this historical discourse was that male sex organs lay outside the body and female sex organs lay inside the body. This was attributed to the greater heat of the male body, a concept that was believed to be compatible with the natural social order. Thus, the male body was accorded superiority due to the nomination of supremacy to warm-blooded creatures over cold-blooded creatures.

Distinction of internal or external sexual organs designated a category for each individual, which bestowed specific social considerations (Laqueur 1990: 135). In this way gender was assigned. Sex was constructed as founded biologically whereas gender was ascribed culturally (Oakley 1972: 16). To be a man or a woman of the one-sex model was to hold a specific place in a society of gendered hierarchies. Although it was considered socially that there was one sex there were believed to be an infinite number of
genders. It was proposed that gendered divergence accounted for the concept of male and female bi-polarity that was active and passive, formed and unformed, and informing and formable (Laqueur 1990:135). Intrinsic to this hierarchcial relationship of the sexes was the idea that the female body was an inferior version of the male body. Laqueur warns of the dangers of viewing history through contemporary scientific language as neutral, and through the connection between gender and sex (1990: 124). Rather, Laqueur presents the Renaissance body as an expressive representational figure.

This web of metaphor does not simply mirror some set of beliefs about their bodies, though it does that as well. It has a life of its own which in some measure constitutes the connections between the body and the world. That is to say, the images through which bodies and pleasures were understood in the Renaissance are less a reflection of a particular level of scientific understanding, or even of a particular philosophical orientation, than they are the expression of a whole fabric or field of knowledge. Myriad discourses echo through the body.

Laqueur 1990: 118.

The Renaissance body as a social metaphor existed within a matrix which merged the boundaries “… between the natural and spiritual world and between the human body and the rest of creation” (Laqueur 1990: 120). Within this one-sex world gender adaptability was possible and sexual differences were considered as matters of degree rather than precise designations (Laqueur 1990: 122). Flexibility and the possibility of gendered change created anxiety as excessive contact between men and women was thought to bring about instability through the feminizing of these men. Conversely the fear of androgenic transformation constrained female activity to gentle physical and intellectual pursuits that did not transgress the bounds of gender, as “… inappropriate behaviors [sic] might really cause a change of sex” (Laqueur 1990: 126). This ancient fear of the ‘androgenic woman’ appears to be embedded in the contemporary unease created by the sexual uncertainty and bodily transformation of early menopause.

The intellectual, political and economic changes of the eighteenth, nineteenth and twentieth centuries confronted the one-sex model. The new liberalism that occurred following the Industrial Revolution modified the meaning of the relationship between men and women. The idea that there were two different sexes emerged and men and women were constructed as complementary opposites. The sexes were not regarded as comparable, nor were they considered equal. In this way the one-sex and two-sex models described by Laqueur (1990: 20) constructed a ‘natural’ order of cultural hierarchy and the sexual difference of biological determinism to validate inequalities between the sexes. Laqueur claims that these two models of sex have each been constructed to support the status quo of male dominance. He maintains that biological determinism has been used to establish both female inferiority and male and female opposition. Further, Laqueur (1990: 20) asserts that the transition from the one-sex model of bi-polarity to the two-sex model of sexual difference does not remove the tensions between the sexes but has been used to consolidate patriarchy.

Biological differences between male and female bodies came to be emphasized with the advance of the sciences. The discourses of science reinforced the construction of the difference between male and female bodies as the natural “… anatomy and physiology of incommensurability” (Laqueur 1990: 8). This connection between the discourses of science and the constraints of culture supported the idea of biologically disparate sexes and the inevitability of the social order (Laqueur 1990: 8).
Here the boundaries between male and female are primarily political; rhetorical rather than biological claims regarding sexual difference and sexual desire are primary. Laqueur 1990: 19.

In her anthropology of reproduction Martin (1993: 27-33) concurs with Laqueur. She also says that discourses of biological determinism supported the hierarchical social roles of men and women. Sexual differences, constructed as grounded in nature were held responsible for political differences between the freedom of men and the subordination of women. The concept of citizenship, as a status providing access to rights and powers, has been attained through the exclusion of women through sexual difference (Pateman in Vines 1993: 148; Abercrombie, Hill and Turner 1988: 33). Although women eventually were admitted some argue that this is as second-class citizens. Accordingly, the ideology of biologically-determined sexual difference has been considered a prop which is used by the discourses of essentialism to validate social inequalities. Laqueur (1990: 193) argues that it was not biology but the public and private confrontations over gender and power which produced the two-sex model. He maintains that:

[S]ex, in both the one-sex and two-sex worlds, is situational; it is explicable only within the context of battles over gender and power.

Laqueur 1990: 11.

In addition, Laqueur (1990: 6) asserts that the grounding of sexual difference in nature supported the politico-economic status of capitalism. A nineteenth century professor of biology nominated male cells as catabolic, or producers of energy. In economic terms they produced capital. By contrast, female cells were categorized as anabolic. That is they conserved energy. They were economically non-productive. These biological sexual differences reflected the cultural roles of men and women. Men were regarded as active controllers of society, the producers. Women were considered as passive, the consumers (Laqueur 1990: 6). Capitalist social values have favoured the productive and concede more power to groups who provide tangible evidence of productivity. Although women were able to produce progeny for society, male-dominated religious and medical groups seized the regulation of this capacity.

Early-menopausal women who are categorized through these economic analogies of consumption and production might be constructed as having consumed their natural resource of fertility. These arguments suggest that essentialist constructions of biologically-determined sexual difference are complicit with the gender injustice of androcentrism. Thus it appears that constructions of sexual difference through biological determinism can be approached through ontological discourse.

Oliver (1995: xii, 57) sets out an argument that attempts to open philosophy to sexual difference. She critiques a range of philosophical discourses, centring on Nietzsche, Freud and Derrida, to suggest that they each exclude active participation by the feminine. She argues that:

... Derrida’s attempts to open philosophy to the feminine not only do not succeed but also erase the possibility of sexual difference and reduce all sexuality to the masculine. ...

It would be one thing if Derrida’s deconstruction of the binaries man/woman or masculine/feminine opened onto an economy of diversity in which we are not trapped by only these two sexualities. If his deconstructive project made possible the multiple sexually marked
voices that he imagines in ‘Choreographics’, then it would provide hope for many feminists. But it does not. In spite of his attempts to replace the logic of castration, Derrida’s deconstruction remains within the logic of castration, in which everything is defined within terms of the masculine. Within this economy there is only one sex, never even two. Without at least two sexes we cannot imagine more. First, we must get beyond the one. Oliver 1995: xiv, xv.

Oliver (1995: 53-57) goes on to argue that feminist writers, such as Irigaray, Kristeva and Butler, have consistently exposed the exclusion of a feminine body from our culture. Only bodies that have cultural significance are represented and the feminine body is presented as the flip side, the ‘other’, of the masculine. Thus, it can be seen that the concept of biologically-determined sexual difference situates early-menopausal women in an intractable position. Their lack of menstruation and infertility confuse both the hierarchy of the one-sex model and the bi-polarity of the two-sex model. Thus medico-scientific discourses that have culturally marginalized early-menopausal women as ‘abnormal’ have also socially devalued them as ‘non-reproductive’.

Ovarian oppression: the creation of the hormonal body

Particularly pertinent to early menopause is the separation of the sexes through the scientific interpretation of women’s ovaries and their hormones. Until the construction of the one-sex model of sexual difference was reversed ovaries were not classified as unique to the female body. The emergence of the two-sex model described by Laqueur (1990) differentiated the sexes through biological distinction and gave the ovaries, for the first time, a name of their own. The position of primacy of the uterus was gradually relinquished to women’s ovaries. These organs came to represent the essence of femininity. In this way medical discourse constructed the concept that women existed only through their ovaries (Jose 1895, in Laqueur 1990: 149; and Chereau 1844, in Laqueur 1990: 175).

Biological investigation did not create the concept of the centrality of women’s ovaries. Rather, the biological significance of women’s ovaries was used to validate the distance between the sexes. Women’s ovaries were consolidated as symbols of female biological sexual difference despite the observation that women’s ovaries had both ‘male’ and ‘female’ dimensions. In this way the selectivity of scientific research supported a cultural preference of sexual difference. The construction of women’s ovaries as the core of ‘femininity’ was used to reinforce a split between the sexes.

Thus, medical discourse that constructs early menopause as ‘premature ovarian failure’ is problematic. Women who have an early menopause are reduced to their ovaries which are reported not only to have failed but also to have done so inopportune. In this way the medical construction of early menopause as an untimely collapse of women’s ovaries shifts the biological construction of sexual difference to a pathology of early-menopausal women. This ovarian oppression amalgamates and de-personalizes early-menopausal women. It also neutralizes early-menopausal women within an immobile construction of sexual difference.

The gradual shift of the medical gaze from a woman’s uterus to her ovaries licensed a clear distinction between the medical professions of gynaecology and obstetrics. Obstetrics had concentrated essentially on the uterus, whereas the “… the shift from the uterus to the ovaries provided the gynaecological profession with their own ‘paradigm-
specific’ organ” (Oudshoorn 1994: 19). During the developmental stage of scientific inquiry into women’s ovaries these organs were considered as regulators of the nervous system and hence their removal was believed to control socially-unacceptable female behaviour.

Ehrenreich and English (1976) describe the medical construction of the ‘virtuous’ female reproductive body. They suggest that not only were women’s ovaries held responsible for the physical, emotional and psychological aspects of women’s lives but mental or physical ill-health also was traced to women’s ovaries. In order to maintain reproductive and mental health, strict codes of gentle and ‘feminine’ behaviour were advocated. Excessive physical and mental exercise was thought to have deleterious effects upon the essential reproductive organs.

Thus a scientific justification was provided for the passive role that had previously been ordained by God. Davidson and Lader 1994: 7.

So-called ‘deviant’ female behaviour could now be treated by medical intervention (Laqueur 1990: 176). For instance, both women’s ovaries and clitoris were surgically removed to treat nymphomania (Ehrenreich and English 1976: 39; Greer 1992: 106). And in the twentieth century enormous doses of X-rays were used to render a woman’s ovaries inactive. These treatments caused an immediate early menopause. In addition, women reported miscellaneous symptoms such as “… giddiness, palpitations, delusions, nervousness, and general debility” (Greer 1992: 105). These symptoms nowadays are associated with a sudden iatrogenically-caused early menopause (Hufnagel 1989).

Ironically, the practice of the surgical removal of a woman’s healthy ovaries to control the so-called ‘failure of femininity’ made the physiological study of women’s ovaries possible. As a so-called symbol of femininity women’s ovaries are a paradox. On the one hand they are used to justify sexual difference yet removal of women’s ovaries:

… purports to create women who both are and are not more like men than they were before the procedure. The name itself, female castration, suggests the old view that the ovaries are female testicles, much like the male’s. But doctors were quick to deny that ovariotomy was anything like castration in its psychological and social effects.

Laqueur 1990: 176.

Nonetheless the removal of healthy ovaries stops menstruation and can change women’s secondary sexual characteristics. For instance, women who have their ovaries damaged or removed may have narrow hips, small breasts and strong facial hair. I will argue later that the destruction of woman’s ovaries can alter her construction of sexuality. In other words, as Grosz (1994) suggests, changes to the corporeal body can change self-identity and subjectivity.

Surgical removal or destruction of a woman’s ovaries was intended to dampen her sexual appetite, a characteristic which supported the more compliant and submissive cultural role expected of women. A paradox is evident even in the terminology, which refers to bilateral oophrectomy, or removal of both ovaries, as female ‘castration’. This terminology equates the female ovaries with the male testes and assumes that the latter is the generic state, or ‘true’ anatomical blueprint (Laqueur 1990: 176). Significantly, physical effects, such as the atrophy of a woman’s uterus, which follows removal of her ovaries, appeared to justify the problematization of women’s ovaries as the originators of all the ‘malfunctions’ of the female body. This intentional creation of early menopause
was disguised through sentiments of beneficence yet changes induced by this treatment placed the very concept of sexual difference under threat.

Previously isolated research centered upon the specific paradigm of the sex hormones as regulators of femininity and masculinity. Physiologists moved into the study of hormones, thus transferring female ‘disorders’ into the laboratory and spawning the developing science of endocrinology. While conflict had previously sat around the physiological and genetic models of sex determination, sex hormones were offered as the missing link. The double notion emerged of sex as both genetically-determined and hormonally-differentiated. The hormones of the ovaries and testes were nominated as sex specific and each was thought to be the antithesis of the other. This concurred with the social concept of sexual difference and the value of women as dependent upon their dissimilarity to men (Oudshoorn 1994: 19-23).

By seeking out the chemicals that were constructed as controlling sexual differentiation, sex endocrinologists were able to move the vision of gonadal sexual definition to the hormonal construction of a sexually-distinct body. Scientific claims that these definitions are neutral and objective collapse under scrutiny and reveal not only the internal confusion and contradictions of bio-chemical discourse but also the socio-historical construction of scientific ‘facts’ (Oudshoorn 1994).

The amalgamation of social tensions represented through the reduction and pathology of women as a reproductive body, the problematization of women’s ovaries and the creation of a hormonal body impact negatively upon constructions of early menopause. Alternate discourses of early menopause are marginalized by medico-scientific discourses. This discursive domination condemns early-menopausal women to social failure because it imposes upon them a redundant social status.

The move from the biological to the pathological construction of women through their ovaries has served to marginalize early-menopausal women. Medical discourses that construct early menopause as ‘premature ovarian failure’ imply that early menopause is an ill-timed biological disaster. This pathology is consistent with the social redundancy which confronts older menopausal women within Western societies. Pessimism pervades medical discourses of early menopause through the apparent loss of so-called ‘feminine’ characteristics, such as fertility, passivity and hetero-sexual availability. In this way early menopause confuses the two-sex model of bi-polarity through changing sexuality.

The medical identification of the ‘sex’ hormones was used to polarize the sexes further. Different hormones were said to be sex specific rather than belonging in various quantities to each individual (Furman 1995: 12-14). Moreover, the sexuality of women was related to the animal-mating period that was considered to be frenetic. The naming of the ‘female’ sex hormone, oestrogen, emerged. This term was based on the “Latin oestrus, meaning literally a gadfly and figuratively a frenzy” (Laqueur 1990: 219). The cyclic, and so-called uncontrollable, sexual passion of female animals was imposed negatively upon women and condemned them to the vagaries of an ‘oestrous cycle’. Social meaning was derived from the reproductive actions of animals which was translated directly to the social control of women.

The construction of women through the so-called female sex hormone, oestrogen, promoted the favourable cultural value of female hetero-sexual passion and availability. In this context the lowered rate of the production of the hormone oestrogen by early-menopausal women is considered to be problematic as it implies a loss of hetero-sexual interest and availability. In this way accepting only ‘evidence’ that favours the cultural context of the researchers creates scientific ‘fact’. In this case the construction of women
as opposite to men has been ‘validated’ through the selective recording of data that is indifferent to the hormonal variation between individuals.

During the past decade feminist, philosophical, anthropological and historical theorists have debunked the absolute biological origins for sexual difference and have substantiated the case for a cultural construction of difference between the sexes (Grosz 1994; Diprose 1994; Martin 1989; and Laqueur 1990). The degree of cultural influence remains an area of contention and feminist groups vacillate between theories of biological inferiority and social oppression as causal factors in the sexual rift (Vines 1993: 140).

It is argued here that the bodily processes of early menopause rest on an assortment of discourses. Medico-scientific discourses marginalize women who have an early menopause through the scientific definition of ‘premature ovarian failure’. This degradation of women’s ovaries and their hormones implies an individual failure of women’s bodies.

As post-menopausal women’s ovaries often continue to function, albeit in a different capacity, these discourses reflect the cultural condemnation of social redundancy associated with menopause. Moreover, the medico-scientific construction of ovarian hormones as specific to the female body and their presumed loss after early menopause brings into question acceptance of the body as a natural, biological and chemical construction. It challenges the idea of sexual difference. Furthermore, it brings into relief the notion of the impossibility of sexual unity. Rather than sexual difference Grosz (1994: 208) suggests there is only sexual identity.

Conclusion

In this chapter I have looked to different theoretical positions that help to locate early menopause within contemporary Western cultures. Using a union between poststructuralism and feminism I was able to expose the socio-historical construction and volatility of all discourses. In particular I suggested that the medico-scientific construction of absolute difference between the sexes both subordinates and excludes women who have an early menopause. I have drawn this debate together using Fraser’s (1997) theory of the interconnectedness of the concepts of social injustice and cultural misrecognition. I used a combined theoretical approach to unmask medical discourses that use biological-determinism to validate sexual opposition and suggested that these androcentric discourses construct early menopause as a failure of the female body. In this way the gendered pathology of ‘premature ovarian failure’ can be seen to devalue early-menopausal women. At the same time dominant medical discourses have marginalized the discourses of early-menopausal women rendering them culturally invisible.

Fraser (1997) draws attention to the distance between these two concepts but highlights the need to connect them through gender equality and identity. In other words she sees a social division and a cultural void that can only be redressed through combining both concepts. She proposes the use of a critical theory that can simultaneously support the equality of individuals within constructions of sexual difference, as well as identify and sustain variations among individuals. The use of such a critical theory can transform early menopause through the concurrence of social rebalance and cultural recognition.

To facilitate this process I have deconstructed medical discourses of sexual opposition and inequality. This makes way for a reconstruction of early menopause within a see-sawing sexual spectrum of differences between the sexes. It also allows the possibility of illuminating women who have an early menopause through an understanding of the fragmentation and oscillation of subjectivity. By listening to other discourses of early menopause the vacillation of subjectivity can be exposed. Through an
understanding of the individual as mercurial, both in a corporeal and ontological sense, the transience of differences *within* sexual difference can be disclosed.
Chapter Four
The Empirical Quest

In the context of menopause, biological reductionism – often referred to, inappropriately, as ‘medicalization’ – manifests itself as a conflation of lived experience and the dominant discourses of disease and illness. It thus represents an annulment of the subversive potential of the physical disruptions associated with menopause, a rejection of any possibility that they might give rise to challenges to the constraining influences of ideology and culture.


Introduction

The uncertainty and movement of knowledge means that there can be no final definition of early menopause. Poststructuralism and feminism, however, allow a process of reconstruction through listening to the discourses of women who experience an early menopause. An interpretation of these theories has guided the empirical research and methodology chosen for this study. I hoped to gain an understanding of the embodied experience of what it feels like to have an early menopause through qualitative research processes (Denzin and Lincoln 1998: 23).

I gathered the original material used in this study through in-depth interviews with fifty women who had experienced or were experiencing an early menopause. This inductive research activity was used to generate empirical data that could be interpreted within a number of different theoretical approaches. Employing a variety of methodological techniques provided a broad base to contextualize my research findings (Jary and Jary 1995: 698). Thus, an understanding of early menopause as an unfolding experience of embodiment could be achieved by including qualitative research within a diverse epistemological background.

The critical research process

In this chapter I explain the purpose and process of the methodology used to obtain the empirical data which directs this thesis. I wanted to find out what the experience of having an early menopause was like and what this meant. To do this I needed to go beyond collecting data. I needed to be involved in a process of critical research that saw that the meaning of experience depended upon the “... struggle over the interpretation and definition of that experience” (Kincheloe and McLaren 1998: 272). I wanted to interpret the discourses of women who had or were having an early menopause. I needed to do this within an understanding that:

... the way we analyze and interpret empirical data is conditioned by the way it is theoretically framed. It is also dependent upon the researcher’s own ideological assumptions. The empirical data derived from any study cannot be treated as simple irrefutable facts. They represent hidden assumptions – assumptions the critical researcher must dig out and expose. Kincheloe and McLaren 1998: 273.
It was apparent that the nature of my inquiry was best suited to a qualitative research process. Within this broad conceptual framework there is great mobility and an assortment of theoretical positions. These are steered by traditions of inconclusive debate and feature the inconsistencies of knowledge (Hamilton 1998: 115). Tracing its origins to the eighteenth-century philosopher Kant qualitative research is more than observation, it looks to a moral freedom where individuals are able to participate in shaping their own lives. Nietzsche articulated a move away from the inevitability of human progress and gradually descriptive data were used to illustrate the social and economic disruptions of industrialization (Hamilton 1998: 119). A web of qualitative theories continues to be woven around the ‘lived experience’ as a socio-historical production that sees the individual as free to “…respond to a multiplicity of circumstances” (Hamilton 1998: 121).

Broadly speaking sociology, and in particular medical sociology or the sociology of health and illness, incorporate these traditions. However, even within this discipline there are different and constantly evolving theoretical approaches. Sociology encompasses an assortment of competing and complementary paradigms. It is not a tightly inflexible discipline and, uniquely, remains open to ideas from other disciplines (Jary and Jary 1995). It does not have a single, universally accepted research tradition that sets it apart from the natural sciences (O’Connell Davidson and Layder 1994: 59). This:

... jostling of rival theoretical approaches and theories is an expression of the vitality of the sociological enterprise. In studying human beings – ourselves – theoretical variety rescues us from dogma. Human behaviour is complicated and many-sided, and it is very unlikely that a single theoretical perspective could cover all its aspects. Diversity in theoretical thinking provides a rich source of ideas that can be drawn on in research, and stimulates the imaginative capacities so essential to progress in sociological work. Giddens 1993: 729-30.

It has been argued that within the genesis of the sub-discipline of medical sociology this theoretical diversity was absent. It was claimed that there was a bilateral objective focus on the medical model and social medicine which displaced the “…subjective aspect of human experience” (Scrambler 1987: 6). Concern arose that from both historical and contemporary angles medical sociology:

... lost a crucial dimension from its thinking and methodologies and that this loss – of the subjective dimension – [left] it vulnerable to medical hegemony, its theories and technics contained within a perspective that alienates health and illness from the life history of the individual and of the society. Figlio 1987: 77.

The discourses of women who have experienced an early menopause provide a spectrum of enriched views that includes the individual within the social. Without this perspective a study of early menopause could unintentionally support a medical model that constructs illness and wellness as a form of biological determinism. In particular medical discourses have reduced women to a universal pathology and constructed menopause as an unavoidable disease and early menopause as an accident of nature.

More recently medical sociological theory has attempted to compensate for the positivism of medical discourses and methodologies that endeavor to represent
phenomena through qualitative accounts of embodied experiences have become prominent. Theories evolved that looked to individual experiences for locating the social body and that also provided a base from which to view the status of a group within a social structure. It was proposed that different forms of analysis need not oppose the individual and the social body. They each are part of a whole and can be woven together to form a matrix upon which to form an understanding of the human experience (Figlio 1987: 79).

Although the original data used in this thesis is qualitative it was necessary to review the quantitative data that contributes to the construction of early menopause. It has been suggested that the fusion of qualitative data with quantitative data reaps the strengths of both methodologies. These need not be mutually exclusive and sociologists have recognized the legitimacy in using a plurality of research methods or triangulation (Jary and Jary 1995; Giddens 1993: 698). Triangulation provides an expansive view of the same topic from several points of view. It involves using multiple methodologies and can highlight the various versions and multi-dimensions of the same phenomenon. Such research can provide the tools to explore this phenomenon from a number of different levels (O’Connell Davidson and Layder 1994: 53-5).

The sociological practice of combining qualitative and quantitative data is well established and many researchers buttress the findings of one method with data from the other. Each method has its own advantages and while neither can produce absolutely reliable or valid data both can provide useful insights into aspects of social life. It has been suggested that quantitative research provides a means of establishing the structural element in social life whereas qualitative research displays the processual (Haralambos and Holborn 1995: 856). Both methods, however, are interpretive in that the researcher inevitably imposes an interpretive gloss on the evidence in whatever form.

Affiliated with the expansion of sociological theories was an increasing tendency to view phenomena as socially produced rather than naturally given. These new perspectives emphasized the ways in which individuals constantly reinvent their own identity rather than simply being confronted by it. The Foucauldian view of social constructionism influenced many theorists. Particularly in the sociology of the body, the body itself was seen as “... a product of particular discursive practices rather than biology” (Jary and Jary 1995: 605). Health and illness came to be viewed as productions of social response rather than outcomes of nature.

As long ago as the nineteenth century Nietzsche challenged “... objectivity by revealing the power behind claims to knowledge, and by showing the impossibility, as well as the poverty, of a rationalist ethic” (Jary and Jary 1995: 450). The development of structuralism through theorists such as Saussure brought the general study of non-linguistic meanings, or semiology, into philosophical and sociological thought. In addition, Saussure argued that the meaning of words was created internally from the structures of language not from the objects described. He proposed that meaning is created by the differences between related concepts that are recognized by the rules of a language (Giddens 1993: 714). By turning its attention towards language and the processes of discourse medical sociology was better able to view the origin and maintenance of social life and subjectivity (Lupton 1995: 5). Fraser (1997: 152) clarifies the use of discourse theory for feminism. She suggests that discourse theory assists an understanding of the interrelated concepts of how:

... people’s social identities are fashioned and altered over time ... how, under conditions of inequality, social groups in the sense of collective
agents are formed and unformed. ... how the cultural hegemony of dominant groups in society is secured and contested. ... [and how] ... it can shed light on the prospects for emancipatory social change and political practice. 

Fraser 1997: 152.

These concepts are especially relevant in an analysis of early menopause as simultaneously culturally marginalized and socially devalued. Discourse theory provides a way of understanding the discrepancies between medical and lay discourses, as well as within these discourses. A study of discourse allows medical knowledge to be analyzed as:

... the result of negotiations about the meaning of phenomena in which the rules about theoretic consistency, experimental adequacy and dissemination of information are flexibly interpreted according to a varying agenda of interests. 


This argument must be extended to other knowledges as without a rounded interpretation of subjectivity the individual is portrayed as a passive body unable to act autonomously. The individual (female) is represented as victim to a rational (male) construction which renders the individual immobile and oppressed. Thus, prompting the question:

... where does the poststructuralist deconstruction of unified subjectivity into fragmented subject positions lead in terms of understanding of individuals as active agents capable of intervening in and transforming their social environment? 


By turning to the construction of subjectivity through language a mix of individual perspectives emerges. These divergent experiences need not remain isolated. Threads of commonality and contradiction that weave through the social structure can bring them together. Thus, the interplay between discourses emerges through an understanding of how the notion of the self is intrinsically bound to the cultural communities to which individuals belong. The shared meanings within cultures are represented through language. Thoughts, ideas and feelings are transmitted from individuals through sound, text and image. These discursive processes produce meaning, a way of understanding the world in which we live. They represent our cultural values and are instrumental in forming and “... maintaining social order and notions of reality” (Lupton 1995: 17).

For poststructuralist theory, the common factor in the analysis of social organization, social meanings, power and individual consciousness is language. Language is the place where actual and possible forms of social organization and their likely social and political consequences are defined and contested. Yet it is also the place where our sense of ourselves, our subjectivity, is constructed. The assumption that subjectivity is constructed implies that it is not innate, not genetically determined, but socially produced. Subjectivity is produced in a whole range of discursive practices – economic, social and political – the meanings of which are a constant site of struggle over power.
Language is not the expression of unique individuality; it constructs the individual’s subjectivity in ways which are socially specific. Moreover, for poststructuralism, subjectivity is neither unified nor fixed.


Subjectivity: fragmented and multiple

Using this poststructuralist approach for an understanding of early menopause calls for different discourses to be heard. In particular I suggest that women’s discourses of their embodied experiences of having an early menopause open up new discourses. These experiences are those of subjectivity; of each individual’s sense of herself. Sometimes thought to overlap the concepts of self and identity subjectivity relates to the individual. Whereas the self is constituted of society, subjectivity is constituted within discourse. Weedon (1998) proposes that in poststructuralism subjectivity moves away from the humanist concept of the individual as unique and fixed.

Against this irreducible humanist essence of subjectivity, poststructuralism proposes a subjectivity which is precarious, contradictory and in process, constantly being reconstituted in discourse each time we think or speak. Weedon 1998: 32.

I look particularly to how corporeal changes of early menopause effect changes “... in the structure and fabric of the self” (Diprose 1994: 117). In the state of constantly becoming subjectivity is formed and reformed within the experience of having an early menopause. This subjectivity is sexed and cannot be removed from the gendered dimensions of what is constituted as a female biology. In other words the physical event of the cessation or absence of menstrual periods is related to sex as a biological construction. I have discussed already that medical constructions of early menopause are embedded in the cultural preconceptions and presumptions of history. Yet the biological and hormonal interpretations of early menopause have been constructed as neutral and objective. “Biolog is somehow regarded as subject minus culture” (Grosz 1994: 191). Women negotiate these bio-medical discourses as they are instrumental in forming social knowledge. Moreover, divergent values placed upon the so-called biological determinism of sexual difference influence the experience of subjectivity.

For instance, early-menopausal women can experience the cessation of fertility negatively. Their subjectivity may be influenced by the cultural value placed upon women for their biological difference to men. This binary opposition relates specifically to the reproductive capacity of women and the social roles which are constructed around this. From women’s reproductive ability flows a whole constellation of discourses around fertility such as sexual availability, sexual attractiveness, sexual alertness, reproductive power, youth, supple and non-wrinkled bodies, firm and muscular bodies. According to Greer (1991) women fear not only the loss of reproductive potential but also the ‘social invisibility’ of loss of sexual attractiveness. This abyss can absorb early-menopausal women and some accept a negative social role, which is due partly to the biological base used to license the politics of sexual difference. Thus, women’s changing bodies can change their subjectivity. Pessimistic changes to the subjectivity of early-menopausal women can be constituted through the discourses of biological determinism. These reduce women to their reproductive potential as a single source of identity. When this capacity
ends or does not start the subjectivity of early-menopausal women may be formed around these discourses.

By deconstructing the notion of sexual difference feminist theorists like Grosz (1994) open possibilities of a multiplicity of sexual identities. Oliver (1995: 66) suggests that there is danger in removing sexual difference altogether. This, she says, would erase the feminine and return all sex to the masculine. Grosz’s answer to this is that meaning is tied to language and subjectivity.

Matus (1995) turns to history for a contemporary understanding of sex as mutable. She cites Victorian literature as representing instability within discourses of sexual difference. She suggests that scientific legitimation of sexual difference was entwined with theories of sexual fluidity. A construction “... useful in formulating ideas about differences among women of different classes and cultures” (Matus 1995: 21). She brings to light the difficulty of locating variables within dominant theories of categorization. Static models are rejected in favour of shifting meanings. In particular Matus exposes the history of discourses of sexuality that are useful in understanding constructions of early menopause.

The ideological use of the sexed body was indeed complex and diverse, rather than monolithic or conspiratorially misogynistic, but the development of ideas about difference was similarly complex and diverse, interwoven with disputes and debates about the basic similarity of the sexes. Matus 1995: 23.

Sexual difference appeared as a continuum where sexual differences were temporary. For instance, sexual difference appeared at puberty and later in life the sexes again merged. This sexual continuum could, however, be corrupted. The changed condition of women’s ovaries that might cause ‘sexual slippage’ became a discursive construction that displaced particular women within a cultural hierarchy.

I have been suggesting that ideas about sexual slippage and ambiguity were most ideologically useful in Victorian enterprises of ‘othering’ – the construction, particularly, of other classes, races and nationalities. In these discursive productions, the body’s responsiveness to change is an important ground on which the environment and social behaviour of other classes and cultures can be proven inferior. ...

Views about the prostitute’s body are particularly revealing of the way concepts of class and gender construct each other reciprocally. Especially before the 1850s, theories about the anatomical and physiological differences of prostitutes from other women function either as warnings of the dangers of a life of sin or to suggest that such a life is embarked on only by those whose bodies already deviate from the norm. Despite the fact that they appear to be the most sexual of women, prostitutes are really ‘unsexed’ and partly masculinised. Citing Parent Duchatelet’s work on prostitution, Thomas Laycock says that the characteristic ‘embonpoint of these women’ has been explained by the ‘use of mercury and the warm bath, inactivity of life, rich food etc.’. It is his view, however, that this fullness and plumpness, as well as the ‘harsh voice of prostitutes, has a sexual origin’. Excessiveness fatness
in young women, he notes, is ‘most usually associated with a morbid state of the ovaria’. It is well known that the removal, wasting of development of the testes or ovaries’ affects sexual appendages and voice. The same characteristic hoarse voice is found in prostitutes as in aged unmarried women. ‘It ought to be observed that this approximation to the voice of man is caused, probably, by some change in the ovaries, analogous to that of hybrid birds, prostitutes being, notoriously sterile’. Paradoxically, the most sexualised woman is, in fact, not fully a woman at all, her masculinisation detectable in her voice and the (alleged) fact that she is unable to bear children. ‘The ovaries of prostitutes’ concurred Tilt, ‘are seldom without some kind of morbid lesions’.

Matus 1995: 48-49.

These discourses emphasize how sexual identity is constructed through cultural discourse. Moreover, this particular example has implications for the subjectivity of early-menopausal women. As socio-historical transactions women’s experiences of early menopause similarly are constituted in discourse. Although discourses in which subjectivity is constructed are negotiated and renegotiated constantly they also are produced historically. Matus argues that these discourses of sexual instability and approximation continue to inform contemporary discourses.

I have noted already that feminist discourses have proposed that advocates of the social construction of the sexes have not challenged sufficiently the concept of the natural body. The biological argument used to define sexually distinct characteristics has been deconstructed by discourses that have exposed the socio-historical construction of the bio-sciences (Oudshoorn 1994; Laqueur 1990). The social embeddedness of medico-scientific discourses exposes how they have come to function as arbitrators “… in socio-political debates about women’s rights and abilities” (Oudshoorn 1994: 7). For instance, medico-scientific discourses present ‘physiological fact’, such as the passivity in women, to separate the sexes. Thus language mediates meanings of the body and of subjectivity. The dominance of medico-scientific language shapes cultural discourses and:

… scientific fact exists only by virtue of its social embeddedness. In this epistemological view, knowledge claims acquire the status of universal facts by virtue of the extent to which they become interwoven with the institutional settings and practices of scientists and their audiences.


Challenging the notion that the ‘facts’ of science are not objective observations but are culturally created Oudshoorn (1994: 4, 138-139) discloses the shortcomings of an uncontested acceptance of physiological explanations of the natural body. ‘Beyond the natural body’, she contests, lies the scientific construction of the hormonal body, which has imperceptibly evolved into a principal system of conceptualizing the body. Thus, scientific theory has achieved the position of natural facts due to strategies of ‘contextualization’ and ‘decontextualization’. Contexts are created through scientific language, which posits scientific knowledge and technologies as facts. The socio-historical context of the medical sciences is then concealed through claims of neutral objectivity. In particular, female hormones have been constructed through medical discourse to support a scientific inclination towards sexual differences on which social differences are constructed. Medical discourses about hormones have established a more extensive network around female hormones than male hormones. By locating the
embodiment of sex in chemicals medical discourses have constructed sex as an abstract quality, which can be measured and manipulated. The construction of this concept has eased the monopoly of early menopause into the discourses of the medical sciences. The subjectivity of early-menopausal women is negotiated within these discourses.

But subjectivity can change. This is a crucial concern for poststructuralist feminism that looks to reconstruction as a form of resistance. This feminism allows for numerous mercurial subjectivities (Flax 1993: 102; Seibold 1998: 61). It looks beyond “... subject centered agency to the plurality and agency of meaning” (Lather 1991: 120 in Seibold 1998: 61). I will look to a mobility of discourses that account for the individual woman who has an early menopause within the changing and contradictory constructions of sexuality, fertility and subjectivity. Thus the aim of this deconstruction is to break down the hierarchical opposition of the sexes in order to make room for multiplicities of understanding and thereby to make visible women who have an early menopause through reconstructed dialogue. Sexual difference would be seen, then, not through the binary opposition of biological determinism but as a sliding and mutable sexual difference that makes way for the mobile subjectivity of individuals.

Poststructural volatility: interacting individuals

Settling into a qualitative research process was not a logical progression. Theories abound and are constantly in a state of interpretation and reinterpretation. Researchers are influenced by theoretical development and I found that I was no exception. Denzin and Lincoln (1998: 410) quote Bruner to suggest that postmodern qualitative researchers are not removed from the text; are themselves socio-historically located; and take for granted the plurality, volatility and politics of discourse. I attempted to align myself within the research process aware that Denzin and Lincoln (1998) also warn of an over commitment to volumes of theoretical text that may not assist the practice of critical research.

The purpose of this study is to represent early menopause through the discourses of women and to contextualize these discourses within the constraints of social inequality between the sexes and the culture of identity. I have attempted to transact this argument through the discourses of women who, in a process of reconstruction, transform early menopause into an understanding of “multiple intersecting differences” (Fraser 1997: 175). To facilitate this process I needed to use a method that would recognize the multiplicity of women’s discourses on early menopause yet somehow allow me to view these discourses collectively.

I needed to find an acceptable understanding of early menopause that meant something to women. As discussed in Chapter One there is no agreement, even within medical discourse, on what constitutes an early menopause. The lower age limit of menopause is arbitrary and dependent upon cultural interpretations. Moreover, medical classification of early menopause vacillates between including or excluding various women based on indeterminate and unproved causes of their early menopause. Although attempts have been made to find a generic qualification for an early menopause this has evaded any sort of consensus.

It was apparent that so-called ‘natural’ menopause could provide some sort of benchmark by which to nominate what was ‘early’. There are fairly consistent interpretations across Western cultures that define age at menopause. They converge around the age of fifty years broadly nominating a ‘normal’ age range between forty-five and fifty-five years. However, the tendency to classify menopause as a finite biochemical event has been eroded by social interpretations. And even as a physical event menopause seems to be stretching to include a lengthy peri-menopausal period.
Underpinning this variety of menopausal constructions is a common concession to menopause as a turning point in women’s reproductive ability.

Intending that women’s discourses be heard from the outset I established what I hoped was an inclusive and elastic understanding of early menopause with which women could identify yet interpret or reinterpret in their own words. I suggested that early menopause occurred when a woman experienced her last menstrual period before the age of forty-five years; or when she attributed changes in her life to the menopause if she no longer menstruated; or by self-definition if a woman thought her menopause occurred early. Later I dropped any reference to age as I found this did not always influence women’s interpretations of early menopause. I also realized that the medical insistence that menopause can only be defined retrospectively was not consistent with women’s discourses. Most of the women interviewed referred to their early menopause as a process that occurred over varying periods, not as a single event marked by a ‘last period’. In addition I became increasingly aware throughout the research process that early menopause was not the only cultural identity of the women who participated. They had multiple identities and negotiated a multiplicity of circumstances. These were impossible to extricate from the women’s experiences of having an early menopause. Although having an early menopause consumed some women for others it was an inconsequential aspect of their lives.

I leaned towards grounded theory as a way to understand women’s experiences of early menopause and so contribute to an alternative interpretive view of this phenomenon (Boyd 1990: 80-81). Although no absolute or unequivocal data could emerge from this methodology it did provide a process for understanding the subjectivity of embodiment. Moreover, thematic analysis of this empirical data provided a framework that could be woven through existing epistemologies. The intention of obtaining qualitative research was to make sense of what it is like to live through a given experience. By defining illness and disease in terms of objective malfunction medical discourse ignores the phenomenological dimension of what this experience feels like (Turner 1991: 24). These interpretations provide rich and deep stories on the processes of embodiment rather than the construction of early menopause as a static, momentary and unified abstraction.

Participative observation and in-depth interviews are the primary procedures used in grounded theory research. Although I did not employ participant observation as a structured part of this study it became informally integrated into the research process. This occurred through my day to day observations in my capacity as a family planning nurse practitioner. I specifically became aware of early menopause as problematic through the experiences of a friend. Her reaction to having an early menopause was instrumental in the selection of my research topic and in directing the research approach. These choices expose my own cultural identity. It is accepted by most contemporary social researchers that there is no such thing as value-free sociology and that “... total objectivity is impossible because values inevitably enter every stage of the production of sociological knowledge” (Haralambos and Holborn 1995: 862).

I chose a single in-depth interview with each woman as the means of obtaining the primary empirical data used in this thesis. Some feminist researchers suggest that multiple interviews are more likely to be accurate than a single interview due to the added opportunity to ask further questions and get correct feedback (Reinharz 1992: 37). Although there was some appeal in this method, absolute validation is not considered possible within poststructural theory. Moreover the extra administration would have been difficult.
Interviews vary in form and can be structured or unstructured or fall somewhere between these two extremes. In-depth interviews fall away from the structured type of interview with set questions leading to finite categorizations. They are semi-structured and can be guided by broad topics or even specific questions but more or less follow the development of a normal conversation. Although I anticipated that particular themes might emerge it was rarely necessary to direct the respondent towards these topics. It has been argued that this non-directive method is the most effective type of interviewing (Haralambos and Holborn 1995: 839-840).

At first I was conscious of the same topics being covered in order to generate comparative data. I was hoping to use a grounded theory where themes would emerge to allow identification of similarities and differences among women. Despite this attempt at some form of structure I was aware that poststructural debate could not be conclusive and that the differences among women would generate “... discord rather than harmony” (Hamilton 1998: 115). Nevertheless, I have attempted a loose version of grounded theory research and thematic analysis in order to relate women’s discourses to existing literature (Boyd 1990: 82). I was aware that attempting to generate empirical data from in-depth interviews presents potential disadvantages.

For instance researchers have been accused of neutralizing themselves within a text as if they are invisible. Fine (1998) suggests that the interaction between the researcher and participants must be acknowledged. The researcher must reveal her own cultural identities and instead of trying to represent the researched “... listen, instead, to the plural voices of those Othered, as constructors and agents of knowledge” (Fine 1998: 142). This creates the opportunity for the fluid and contradictory identities of the researcher and participants to interact and hopefully to avoid an unequal relationship of oppression (Fine 1998: 135).

**Ethical issues: a critically-reflexive process**

Prior to commencing the research component of this study official approval was required by, and obtained from, Deakin University Ethics Committee (Project EC50/95). Unacceptable precedents of uncontrolled human research have indicated the potential for research to have detrimental effects upon individuals. As an essential component of the process of human study ethical considerations require constant attentiveness by the researcher. Universal ethics serve as a logical exercise that is concerned with morally acceptable behaviour and is organized to clarify familiar activities and judgements. These systematic ethics encompass various complex philosophical thoughts which are said to differ from common-sense morality (Johnstone 1989: 34). They include informed consent, confidentiality, emotional issues and invasion of privacy. Although I looked to these specifics initially I became aware of a feminist understanding of ethics that provided an awareness of embodied individual differences that could not be constrained by a universal ethics.

Nevertheless, I commenced by looking at the pragmatics of informed consent that has legal as well as moral implications. The legal implications of informed consent are the result of practical considerations regarding the giving of information and avoidance of injury. The moral implications of informed consent are generated from the assumption of respect for the independence of the respondent “... who has the right to make an autonomous choice” (Faden and Beauchamp 1986: 4). Both the legal and moral aspects of informed consent are inextricably linked. The analytical components of informed consent are recognized generally by moral philosophy as “... disclosure, voluntariness, competence and consent” (Johnstone 1989: 180).
The principle of informed consent suggests that researchers should inform potential research subjects about the nature and purpose of the study, should obtain their permission to be a subject of the research and assure them confidentiality.


These principles were employed for all respondents who participated in the research for this study. Both verbal explanation and written information were given regarding the purpose of the research and how the information would be obtained and used. Verbal consent was obtained, taped and transcribed following disclosure of the purpose of the research. The ability to withdraw from the project at any stage and to remove any information was offered clearly to all respondents. Respondents were given a Plain English Statement (Attachment 1) to read and keep prior to the interviews. Before each interview all respondents were asked if they understood that the findings from the interview may be used anonymously for research. At the time of the interview all respondents gave their consent for the data to be used in this way and none have withdrawn their consent since.

The demand for confidentiality arises from the broader moral principles of “...autonomy, non-maleficence, justice and the demand to keep one’s promises” (Johnstone 1989: 193). Unless approved by an individual participant all identifying material used in this thesis has been withheld. Tape recordings and transcripts have been cross-referenced to avoid accidental disclosure of personal details and all original data are secured in a locked safe.

Many of the women regarded discussion around their experiences of early menopause as personal. It is acknowledged that any information relating to personal issues may provoke unexpected emotional responses. These responses may not always be presumed to be negative. Many social researchers recognize the potentially cathartic effect of collaborative discourse, even in regard to emotionally charged issues. An ameliorating effect can be expected when an individual is allowed an opportunity to share personal information while participating in an interview process. Nevertheless an interview of this nature could trigger responses or memories which were emotionally painful. In the event that a respondent’s emotional responses to the interview caused distress a variety of methods to address this was available including professional woman-centred counselling (Roland 1995). It was intended that the individual would be able to make her own decision about what she considered to be the most appropriate manner to deal with feelings of distress. The dignity, integrity and autonomy of the individual was at all times given priority (Victorian Ministerial Women’s Health Working Party 1987).

Similar principles were observed in regard to invasion of privacy. The collaborative and democratic approach used during the research interviews was intended to allow each respondent to participate equally with the interviewer (Cash and Tucakovic 1993: 36). As the interviews were semi-structured the respondents were able to direct the situation and, in addition, were able to withdraw information at any time.

Contemporary social researchers have moved away from the rigidity of a universal ethics. Feminist researchers propose that trustworthiness is a more useful concept (Kincheloe and McLaren 1998: 281). They have acknowledged ethics as a complex and controversial process that overlaps questions of reflexivity and the political responsibilities of the researcher. Thus, refined considerations of qualitative research as a critically-reflexive process have emerged. Self-reflection is central to this process of interpretive inquiry. An interviewer needs to watch, listen, question, record and be
thoughtful. Moreover, subjectivity cannot be removed from the ethical. Oliver (1995) proposes that “... subjectivity itself is ethical in that it is always constituted through a relation with another” (xvii). It is therefore imperative that a qualitative researcher is aware constantly of her relationship with each participant and with the entire research process.

Feminists also claim that subjectivity is sexed and embodied:

... if universalist ethics regulates social exchange through which sexed identity and difference is produced and if this perpetuates injustice against women, then ethics needs to be understood as the problematic of the constitution of embodied, sexed identity. There are two parts of this problematic: how one’s embodied ethos is constituted by social discourses and practices (including ethics) and how one’s identity is constituted in relation to others. Diprose 1994: ix.

Oliver (1995) unravels this notion of the constitution of ethics through intersubjectivity. She looks forward from Irigaray’s ethics of sexual difference (Oliver 1995: 191) to the maternal body as constituting the first subjectivity. Oliver suggests that the relationship between the foetus and the maternal body is a harmonious process between human lives leading to subjectivity. Subjectivity, she says, is constituted through intersubjectivity and ethics is constituted through difference.

When the relationship between self and other becomes ambiguous, when identity is an exchange between self and other, only then can we begin to talk about ethics. Ethics requires a relationship between two that are neither identical nor autonomous. For if they are identical, there is no relationship and therefore no ethics. ... An ethical relationship takes place between two, by virtue of their difference, who are not self-possessed. On this model, we are not autonomous agents of Kantian ethics. Rather we are fundamentally and intrinsically dependent on each other for the generation and maintenance of our identities. We are not dependent on each other just on a conscious level but on an unconscious level as well. Brennan’s intersubjective theory of drives challenges any notion of autonomy on an ontological level. This is why, as Kristeva or Irigaray might say, we have to work on the level of the imaginary in order to change our very image of relationships. The intersubjective theory of the drives provides us with a new image of relationship, a more fluid and potentially reciprocal relationship, a relationship that engenders a new conception of ethics. Oliver 1995: 189.

These salient points seemed to have particular relevance for my research process. They demonstrate an inevitable but mobile relationship between intersubjectivity, difference and ethics. They indicate that ethical dimensions range from discursive constructions of knowledge to the interactions between the researcher and the researched. For instance:
Feminist nurse researchers have pointed out that additional ethical dilemmas arise when they are doing research in one’s own professional culture, where the researcher and professional roles may conflict. Olesen 1998: 314.

Thus, I constantly had to juggle with assessing if the interview process could cause harm or distress to the women who participated in this research. I became aware that some women became dependent upon my availability as a ‘sympathetic ear’. Although friendships developed I viewed these as an equal and voluntary interaction. I was conscious that a relationship beyond the interview process could be unequal. For instance, some women viewed me as having access to specialized (medical) knowledge that could assist them. Others viewed me as an interested confidant. Although the participants and I were both transients to the interview process I needed to consider the most appropriate way to remove myself. This generally occurred at the end of a single interview but I was conscious that some of the women might feel betrayed by a truncated relationship. I felt that this was a serious ethical issue that I was not always able to resolve. Many of the women had felt stranded by the medical profession and I wondered if I was repeating this desertion. I followed every interview by a phone call or letter to thank the women and give them the opportunity to express any feelings they had about the interview. I was also aware of my own need for professional distance and the potential harm of a relationship of dependence.

In addition to the problem of extrication some of the participants expressed views that could be interpreted as conflicting with the theoretical base I had chosen for my research. For instance, two or three women made derogatory remarks about ‘feminism’ yet obviously were willing to participate in more generic social research. And although I had chosen a collaborative approach for the interview process a number of women kept asking for direction or approval that they were saying the ‘right’ things. However, all in all my assessment of the interviews was that they were a very rewarding interactive process with a warm rapport.

**The interview process: strategy and interpretation**

All of the interviews for this thesis took place in London or from London via E-mail. Although I was living there for domestic reasons I found this location advantageous for meeting women who had had an early menopause. Initially I sought forty women who were willing to be interviewed who, by their own definition, had or were having an early menopause. Later, due to an overwhelming response, I expanded the number of women to fifty. More women than this came forward to participate but it would have taken me beyond the capacity of this study to have a greater number of women participating. Nevertheless this response indicated the necessity for an open approach to research as:

... it may not be possible or desirable to decide on the exact size and characteristics of the sample in advance of the research. The ‘emergent’ nature means that priorities may change as the research unfolds and the researcher begins to generate theory. Sampling must therefore be kept as flexible as possible to take account of the changing priorities of the research.

O’Connell Davidson and Layder 1994: 46.
Women heard of the project through a variety of sources. Information was made available through women's health clinics at Marie Stopes House, London (where I worked) and the menopause clinic at the Benenden Hospital, Kent (Attachment 2). An advertisement was placed in a central London newspaper, in the newsletter of the support group for early-menopausal women and on the Support Menopause page on the Internet (Attachment 3). Most of the women heard about the research through word of mouth and seventeen women, that is approximately one third of the women interviewed, were acquaintances or work colleagues. I found it extraordinary that women who had an early menopause surrounded me. It was impossible to speculate if this was chance or anecdotal evidence of the prevalence of early menopause. This non-random technique of volunteer sampling has been used widely in social research and I chose it specifically with the potential sensitivity of the topic in mind (O'Connell Davidson and Layder 1994: 95).

The inclusion of acquaintances and work colleagues as interviewees raised some ethical considerations. Although I did not actively recruit from this group of women the number who came forward offering to be interviewed suggested to me that early menopause was not only common but also that women thought it an important and under-researched topic. I hoped that my extensive experience of 'one-to-one' discussions in my role as a nurse practitioner in reproductive health favoured the practice of mutual trust and reflected my genuine interest in the experiences of women.

I was not introduced to all fifty women at one time. The first women to be interviewed had responded to my advertisement in a central London newspaper. To some extent these contacts snowballed as women informed friends of the project. I recruited only one woman from my own practice at Marie Stopes House. I decided not to pursue this strategy as it seemed to blur my roles as practitioner and researcher and I thought that this could potentially disadvantage participants through confusion. I had a good response from my advertisement placed on the Internet and found this method of interviewing unexpectedly rewarding. Interviews with women from the early menopause support group came later as this group was proceeding with its own evolution at about the same time as I was starting my research. Women who heard of the study by word of mouth came forward at various times throughout the interviewing period.

The women who came forward were from the United Kingdom, the United States of America, Australia and Canada. Any comment on sexual-preference was left entirely to the participants and none declared that she was lesbian. Different ethnic groups were represented (Caucasian, Asian and Negroid) but these were not considered in isolation as all of the women were living within the framework of Western cultures. Although one woman felt her Islamic background contributed to her experience and the cause of her early menopause her experiences have not been singled out on that basis. Rather I felt that her experience demonstrated the multiplicity of identities within subjectivity. Moreover, I felt that through her subjective experiences she represented the multi-cultural diversity of modern industrialized societies.

As an early menopause can be interpreted broadly participants varied in age from eleven to forty-eight years at onset of menopause. This process itself reflected the disparity between medical and lay understandings of what constituted an early menopause. Women did not negotiate their experiences on the basis of age; rather they interpreted their menopause as early within the boundaries of their subjectivity. For instance, one woman considered her menopause at forty-eight years early based her mother's menopausal age of fifty-six years. Her interpretation of early menopause was based on her own socio-cultural location.
In a conscious move away from the bio-medical model of a clinical setting, the interviews took place in a venue selected by each participant. This usually occurred at the home or work place of the participant or at my home. Occasionally a neutral location such as a park or a cafe was used but these were not particularly suitable venues. I took particular care to ensure privacy and to avoid interruptions. I asked each participant to read the Plain English Statement if they had not done so already and confirm verbally that they understood the purpose, intent and nature of the study. Following agreement by the participant I taped the interviews and later transcribed them. I used a cross-referenced numbering system so that any obvious identifying material was removed.

In writing up the interviews names or pseudonyms have been used as I found using a number removed the sense of each person from her story. In some instances I have retained women’s own names if they felt that was appropriate or their stories have been published elsewhere without a pseudonym. Some of the women chose their own pseudonym. I find it interesting that I can still ‘hear’ and ‘see’ each woman as I write up excerpts from their narratives for this paper. Some of the women who participated in this study remain in contact with me as their stories have never come to rest. Listening to the stories of these women has changed me as inevitably I became absorbed in the wide-ranging, and often poignant, responses of the women.

I invited each participant to tell me what it was like to experience an early menopause. This allowed each woman to participate freely in the interview process by selecting information that was most important to her rather than being directed by me to specific topics. The semi-structured form of the interview did, however, allow me to insert broad topics for discussion from time to time. For instance, I was conscious that “[A]ge at menopause has rarely been studied in relation to social factors of any kind” (du Toit 1990: 6). Given the paucity of literature on the embodied experience of an early menopause I did attempt some consistency with other social research. I was aware that socio-cultural studies of menopause lack comparative data and “... a major problem to date with comparative studies into menopause has been the absence of a standardized approach to collection of data” (Lock 1986[b]: 25 in du Toit 1990: 8). Some attempt has been made by socio-cultural researchers to rectify this omission.

The cross-cultural use of the same questions permit comparison of responses and explanations of differences. There are four questions which are reported by Lock that we used as well. Two of these are:

1. Do women worry about losing their minds during menopause?
2. Is a woman only half a woman and thus not a ‘real’ woman after menopause?

Initially I inserted these two questions into the interview process but I quickly dropped them as women thought the wording quite bizarre. Nevertheless women often referred to these issues without prompting. I have made no attempt to analyze women’s responses specifically in relation to other studies of menopause. This would not only expand the study beyond its current parameters but I came to realize could also jeopardize the spontaneity and lively variance amongst the women’s discourses. If women sought direction I sometimes returned to the original questions I had outlined. These broadly asked what having an early menopause was like; what changes were experienced; how women felt about these changes; if there were differences within relationships; if it was necessary to seek help; and how the women viewed their future. Some women asked for more specific questions (Attachment 4).
The interviews took from one to two hours. They generally were face-to-face although some took place via E-mail or as a written story sometimes following or followed by phone conversations. This interview was the first time many of the women had spoken extensively to anyone about their experiences. Although in some instances the interview occurred months or even years after initially finding out they were experiencing an early menopause women still recalled this vividly. The relief many women felt at being heard implicated the interview as an ameliorating experience and a form of self-awareness. Some women asked if they could have ongoing interviews on a quasi-counselling basis. As this was beyond my own expertise and an extension of the criteria set out by the Deakin University Ethics Committee I felt that this was inappropriate.

I did, however, make myself available to phone calls or informal meetings if women felt that they needed continuing contact. I had close contact with an accessible woman-centred counsellor who was interested in the study and willing to participate. Yet none of the women sought counselling as a result of the interview. Several women contacted me following the collection of the empirical data and a number said that they were grateful for the opportunity to talk about their experiences (Attachment 5). The interview process, however, did initiate friendships and continuing relationships through the shared interest of support groups or academic studies. All respondents received a written precis of the interviews for their comments. A number of women commented positively on this and I feel that the relationships initiated by the interview process for this study have not been truncated but continue in an open-ended fashion.

**Conclusion**

My interest in early menopause as a specific area of study was generated from my own cultural location as a family planning nurse practitioner. The experiences of a friend brought my attention to the lack of written material available about early menopause. This paucity of literature was puzzling due to anecdotal observations of the prevalence of this phenomenon. It seemed that what women were experiencing was not documented by social research and medical research was fragmented, reduced to specialties such as genetic studies and made no account of early menopause as an embodied experience. Women’s discourses of early menopause were missing. I hoped in some small measure to redress this imbalance. I used a qualitative research process to gather and interpret women’s discourses of early menopause. These have become the empirical data used in this thesis.

Although the findings from this study cannot be conclusive they do provide an understanding of early menopause from the point of view of the individual. Women’s interpretations of early menopause provide descriptions of this as varied and dynamic embodied experiences, whereas medical interpretations reduce early menopause to a single bio-chemical event. By embracing a plurality of methodologies an expansive view of early menopause emerges. Specifically an analysis of embodied experience and embodied practice shows how women are at once moulded by their cultural context and yet participate in its construction. This emphasizes the conjuncture of different interplays upon human bodies and removes the bifurcation of the organic and the lived body. It demonstrates the constitution and mobility of subjectivity through corporeal bodies. In later chapters I will suggest that the constructions of sexuality, infertility and subjectivity that emerge through the discourses of early-menopausal women around their changing bodies are metaphors of the risk, consumption and uncertainty of the changing Western world.
RECONSTRUCTING EARLY MENOPAUSE

Chapter Five

The Discourses of Women: Unique and Disjointed

There is no single discourse of menopause ... 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.

Komesaroff 1997: 56.

Introduction

In the third section of this thesis I present the findings from the interviews with women who had experienced or were experiencing an early menopause. The discourses of these women were fragmented and at times disparate, identifying the variation in embodied experiences. Within this array of differences, however, broad themes emerged that I was able to relate to continuing philosophical concerns. Anxieties around the major concepts of sexuality, fertility and subjectivity recurred throughout the women’s discourses. These topics were not an inevitable consequence of having an early menopause. They were woven through the inconsistent interpretations of individual experiences and were constituted within the dynamic discourses of each woman’s cultural context.

In this chapter I discuss how each woman’s experience of having an early menopause was unique and negotiated within a spectrum of discourses. Women interpreted their early menopause within dialogue that fluctuated and incorporated all aspects of their lives. Their experiences were not reduced to malfunctioning ovaries or hormones isolated from their lived bodies. A few of the women interviewed placed little significance upon their early menopause and said that it was a relief from menstrual periods and contraceptive concerns. However, most of the women I interviewed felt, at least initially, that their early menopause had a negative effect upon their lives. A significant number said that their early menopause was emotionally shattering. In particular adolescents and very young women were affronted by the irreversible changes brought about by early menopause. At a time when peers were progressing through a myriad of experiences they appeared almost to be defeated by concepts of being a menopausal woman. The medical construction of an early menopause focuses only upon this as a bio-chemical event but documenting and analyzing the discourses of early-menopausal women indicated early menopause as a vacillating and open-ended experience that was interpreted and reinterpreted within the inimitable and entire context of each woman’s life.

Profile of the interviewees: connecting the disparate

Fifty women participated in this study. All of the interviewees interpreted their changing bodies through discourses of early menopause. In other words all of the women who participated in this study defined themselves as having menopause before they had expected it to occur.

The most striking feature of the women as a group was their wide range in age at menopause. The women’s ages varied from eleven to forty-eight years old at the time they commenced menopause. Their experiences spanned thirty-seven years and in this
regard they contrasted markedly with the ten-year age span usually offered by medical
discourse as the ‘normal’ time frame in which to commence menopause.

Lack of concurrence with age and life stage expectations appeared to underlie
much of the uneasiness experienced by many of the women. Their disquiet seemed to be a
reflection of the social anxiety created by variants to the “... prescriptive timetable for the
ordering of major life events” (Neugarten, Moore and Lowe 1996: 24). In this instance
many women had identified the time for menopause as around the age of fifty or as
synonymous with what some termed middle or old age. Furthermore this life stage was
viewed negatively as a time of physical deterioration and reduced social value.

Some of the women, especially those who were adolescent or in their early
 twenties knew little or nothing of menopause. Knowledge specific to early menopause
was limited as well. Even women who had a family history of early menopause did not
expect that this would occur to them.

Not all of the women were sure why they had had an early menopause. Some
women appeared to have more than one possible causal factor and often causes were
speculative. Nine women had no idea why they had had an early menopause. Five women
had been told that their early menopause was genetic. Three of these women felt that
there were other factors involved. Two women had an auto-immune irregularity and one
woman had a history of mumps. Nine women had smoked over twenty cigarettes a day
since childhood or early adulthood. One woman had been exposed to industrial chemicals
for an extended period. Four women said that they had experienced prolonged periods of
stress prior to having an early menopause. Four women had used ‘the pill’ for extended
periods since adolescence.

Twenty-three women had had some form of gynaecological surgery. Only three of
these women had been warned that early menopause was a possible side effect of surgery.
Two women had both ovaries removed and were placed on hormone therapy. One of
these women had her ovaries removed at separate times and described her early
menopause as occurring before the removal of her second ovary and before she was told to
expect menopause. One woman had her early menopause following chemotherapy for
breast cancer.

Just over half of the women had children. Yet menopause as a marker for the non-
reproductive period of women’s lives was problematic for many of the women. Even
some of the women who had had children resented the lack of reproductive choice.

As a group the women were well educated. All but one woman had completed
secondary education and twenty-two were tertiary qualified or undergoing tertiary
education. Only four of the women were not currently in paid employment. One was
retired, two were supported by their spouse and one was a full-time mother. One woman
who was a full-time tertiary student at the time of the interview is now in paid
employment. As the women were self-selecting, that is they volunteered to be
interviewed, it is possible to imagine that, inadvertently, I had alerted a particular group to
the project through my recruiting strategies. Newspaper and Internet advertising as well
as recruiting by word of mouth obviously reached a select group of women. And of those
only well educated women came forward.

All of the women had had hetero-sexual relationships. Twenty-eight women were
in permanent relationships although several women commented that having an early
menopause placed pressure on that relationship. Three women said that having an early
menopause specifically caused the break-up of their relationship. Six other women said
that having an early menopause directly prevented them from having any permanent
relationship. Three said that they were no longer interested in having a sexual
relationship. And the remaining ten were not committed to a particular relationship. Many of the women described a diminished libido. The various cohorts responded to this differently indicating that sexuality is not necessarily related to libido per se but to the expectations of age and social norms. It appeared that diminished libido was more accepted by the older women but decreased libido in younger women was problematic as it was contrary to social norms.

Although in the main the younger women experienced more subtle menopausal symptoms than the older women, the overall effect on their lives was more dramatic. The differences in symptoms between different age groups could possibly be attributed to the various causes of early menopause. For instance the younger women were more likely to have an early menopause for social reasons such as excess smoking or genetic irregularities whereas the older women were more likely to have had an early menopause as an unintended consequence of gynaecological surgery. Early menopause caused by cigarette smoking, for instance, appeared to occur slowly over a period of years, whereas the menopausal symptoms following surgery appeared to be more sudden and severe. Yet the overall effect of early menopause was less negative for the older women than for the younger women. In this way the severity of menopausal symptoms was inversely proportional to the impact upon women’s sexuality and self-identity.

The experiences of most of the women differed from their expectations of age and social norms. Early menopause was constructed as abnormal and appeared as an expression of social anxiety. In other words early menopause is a social construction. Women whose experiences do not coincide with age and social norms are marginalized as untimely, and in this case as ‘early’. Yet, over time many women recreated their identities and were able to continuously redefine the status quo of menopause.

The following table presents a profile of the women through age groups.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age at onset of menopause</th>
<th>Age at interview</th>
<th>Probable Cause</th>
<th>Surgery</th>
<th>Children</th>
<th>I.V.F.</th>
<th>Sexuality</th>
<th>Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tanya</td>
<td>11 – 15</td>
<td>19</td>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td>Would have liked her own eggs frozen – but probably will try later using donor eggs</td>
<td>Says she is Not a ‘real Woman’</td>
</tr>
<tr>
<td>Susan</td>
<td>12</td>
<td>34</td>
<td>Unknown</td>
<td></td>
<td></td>
<td>1 x I.V.F.</td>
<td>1 x failed</td>
<td>Initially felt she had no right to to boyfriends Now has a successful marriage</td>
</tr>
<tr>
<td>Lara</td>
<td>13 – 14</td>
<td>24</td>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td>3 x failed</td>
<td>Boyfriend at eighteen</td>
</tr>
<tr>
<td>Carly</td>
<td>14</td>
<td>22</td>
<td>Unknown – told by doctor due to stress</td>
<td></td>
<td></td>
<td></td>
<td>Would like to try later</td>
<td>Not comfortable about sex A lot later than peers to have sex Has never let herself fall in love – needs to trust someone enough to tell them – hadn’t happened by the time of interview</td>
</tr>
<tr>
<td>Felicity</td>
<td>16</td>
<td>32</td>
<td>Genetic – feels her early menopause is related to illness and treatment of grandparents</td>
<td></td>
<td></td>
<td></td>
<td>Expects this is an option</td>
<td>Says that it affects every relationship for the worse – men find it so unnatural</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Age of Infertility</td>
<td>Infertility Reason</td>
<td>Psychological Impact</td>
<td>Medical Impact</td>
<td></td>
<td></td>
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<tr>
<td>Shireen</td>
<td>17</td>
<td>25</td>
<td>Genetic – sister had an early menopause – feels the cause is related to inter-marriage</td>
<td>Says she feels angry and aggressive about sexual relationships Shoked to find she had no ovaries Does not feel she is a ‘normal’ woman</td>
<td>Feeling of failure Afraid she is not suitable for marriage (related to Islamic religion) Frightened of spending her life alone Fear of exposure Fear of stigma attached to infertility Withdrawn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anna</td>
<td>17</td>
<td>26</td>
<td>Unknown</td>
<td>Says that sub-consciously she is looking for a partner with a child (her current partner has a child)</td>
<td>Feels she needs to discuss her situation with potential partners before becoming serious – this has ‘scared some people off’</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jeannie</td>
<td>17</td>
<td>37</td>
<td>Auto-immune irregularity Cigarettes Thyroid-ectomy</td>
<td>Too expensive and heartbreaking</td>
<td>‘Absolutely gutted’ at first – now sad but grateful for what she does have</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

95
<table>
<thead>
<tr>
<th>Name</th>
<th>Age at onset of meno-pause</th>
<th>Age at interview</th>
<th>Probable Cause</th>
<th>Surgery</th>
<th>Children</th>
<th>L.V.F.</th>
<th>Sexuality</th>
<th>Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liz</td>
<td>24</td>
<td>33</td>
<td>Chemical exposure Surgery #</td>
<td>Caesarian section</td>
<td>1</td>
<td>Has considered I.V.F. but aware of high failure rate and will not go ahead</td>
<td>Thought she would die early</td>
<td>Feels that women’s role is to reproduce – pleased she was able to have a child</td>
</tr>
<tr>
<td>Josie</td>
<td>25</td>
<td>39</td>
<td>Cigarettes</td>
<td></td>
<td></td>
<td></td>
<td>Felt no change</td>
<td>Early menopause didn’t bother her</td>
</tr>
<tr>
<td>Lisa</td>
<td>27</td>
<td>30</td>
<td>Surgery &quot;The Pill&quot; * Cigarettes</td>
<td>Hysterectomy Bi-lateral oophrectomy for endometriosis – ovaries removed at separate times – early menopause after first ovary removed</td>
<td>1</td>
<td>Sex drive completely gone – although she still feels ‘womanly’</td>
<td>Miserable</td>
<td>Afraid her marriage will end due to her lack of libido</td>
</tr>
<tr>
<td>Angie</td>
<td>27</td>
<td>32</td>
<td>Surgery #</td>
<td>Hysterectomy</td>
<td>2</td>
<td></td>
<td>Feelings ‘numbed’</td>
<td>Enthusiasm for life diminished</td>
</tr>
<tr>
<td>Robyn</td>
<td>27</td>
<td>40</td>
<td>Surgery #</td>
<td>Hysterectomy</td>
<td>2</td>
<td>Feels ‘feminine but not sexy’</td>
<td>Feels old and resentful about what has happened to her body</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Age at onset of meno-pause</td>
<td>Age at interview</td>
<td>Probable Cause</td>
<td>Surgery</td>
<td>Children</td>
<td>I.V.F.</td>
<td>Sexuality</td>
<td>Identity</td>
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<tr>
<td>Dianne</td>
<td>34</td>
<td>34</td>
<td>Mumps</td>
<td>Hysterectomy</td>
<td>2</td>
<td></td>
<td>doesn’t know if she is a ‘woman or not’</td>
<td>‘Gob-smacked’</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cigarettes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Very upset</td>
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<td></td>
<td></td>
<td></td>
<td>‘The Pill’*</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Stress</td>
<td></td>
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<tr>
<td>Renee</td>
<td>35</td>
<td>40</td>
<td>Surgery #</td>
<td>Tubal ligation</td>
<td>2</td>
<td></td>
<td>accepted that she was different</td>
<td>quite pleased it ‘was all over with’</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>good being over 40 now</td>
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<tr>
<td>Carole</td>
<td>35</td>
<td>43</td>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td>shocked but not particularly concerned as she doesn’t want any children</td>
<td></td>
</tr>
<tr>
<td>Aisling</td>
<td>35</td>
<td>45</td>
<td>Surgery #</td>
<td>Tubal ligation</td>
<td>2</td>
<td></td>
<td>doesn’t feel ‘feminine’</td>
<td>not too concerned</td>
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<td></td>
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<tr>
<td>Terri</td>
<td>35</td>
<td>41</td>
<td>?Surgery #</td>
<td>Removal of ovarian cyst and uterine fibroid</td>
<td>1</td>
<td></td>
<td>doesn’t feel ‘in love’ with husband – married because she thought she should</td>
<td>emotionally compromised</td>
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<td></td>
<td></td>
<td>depressed</td>
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<td></td>
<td></td>
<td></td>
<td>difficult to live a ‘normal’ adult life</td>
</tr>
<tr>
<td>Jackie</td>
<td>35 –36</td>
<td>50</td>
<td>Surgery #</td>
<td>Tubal ligation</td>
<td>2</td>
<td></td>
<td>changed by surgery – doesn’t feel ‘feminine’ any more</td>
<td>confused at first – now resolved as has reached ‘normal’ menopausal age</td>
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<td></td>
</tr>
<tr>
<td>Hilary</td>
<td>35 –36</td>
<td>44</td>
<td>Auto-immune irregularity</td>
<td></td>
<td>2 (twins)</td>
<td></td>
<td>felt early meno-pause was a denial of her femininity and ‘womanness’</td>
<td>distressed</td>
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<td></td>
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<td></td>
<td>reduced interest in sex</td>
<td>angry</td>
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<td></td>
<td></td>
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<td>unexpected</td>
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<td>too young</td>
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<td></td>
<td>not ready</td>
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<td></td>
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<td>different person</td>
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<td></td>
<td></td>
<td>loss of self-confidence and self-esteem</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>has become</td>
</tr>
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97
<table>
<thead>
<tr>
<th>Name</th>
<th>Age at onset of meno-pause</th>
<th>Age at interview</th>
<th>Probable Cause</th>
<th>Surgery</th>
<th>Children</th>
<th>I.V.F.</th>
<th>Sexuality</th>
<th>Identity</th>
<th>Optimistic about future – time for her to grow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dianne</td>
<td>34</td>
<td>34</td>
<td>Mumps, Cigarettes, &quot;The Pill&quot;*, Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Doesn’t know if she is a ‘woman or not’ ‘Gob-smacked’ Very upset</td>
</tr>
<tr>
<td>Renee</td>
<td>35</td>
<td>40</td>
<td>Surgery #</td>
<td>Hysterectomy</td>
<td>2</td>
<td></td>
<td></td>
<td>Accepted that she was different</td>
<td>Quite pleased it ‘was all over with’ Good being over 40 now</td>
</tr>
<tr>
<td>Carole</td>
<td>35</td>
<td>43</td>
<td>Unknown</td>
<td></td>
<td>3 x abortions</td>
<td></td>
<td></td>
<td>Shocked but not particularly concerned as she doesn’t want any children</td>
<td></td>
</tr>
<tr>
<td>Aisling</td>
<td>35</td>
<td>45</td>
<td>Surgery #</td>
<td>Tubal ligation</td>
<td>2</td>
<td></td>
<td></td>
<td>Doesn’t feel ‘feminine’</td>
<td>Not too concerned</td>
</tr>
<tr>
<td>Terri</td>
<td>35</td>
<td>41</td>
<td>Surgery #</td>
<td>Removal of ovarian cyst and uterine fibroid</td>
<td>1</td>
<td></td>
<td></td>
<td>Doesn’t feel ‘in love’ with husband – married because she thought she should</td>
<td>Emotionally compromised Depressed Difficult to live a ‘normal’ adult life Menopause means old age and not ready but has to move on</td>
</tr>
<tr>
<td>Jackie</td>
<td>35</td>
<td>50</td>
<td>Surgery #</td>
<td>Hysterectomy</td>
<td>2</td>
<td></td>
<td></td>
<td>Changed by surgery – doesn’t feel ‘feminine’ any more</td>
<td>Confused at first – now resolved as has reached ‘normal’ menopausal age</td>
</tr>
</tbody>
</table>
| Hilary | 35 – 36                    | 44              | Auto-immune irregularity |          | 2 (twins) |       |           | Felt early menopause was a denial of her femininity and ‘womanness’ Reduced interest in sex | Distressed Angry Unexpected Too young Not ready Different person Loss of self-confidence and self-
<table>
<thead>
<tr>
<th>Name</th>
<th>Age Range</th>
<th>Surgery/Drugs</th>
<th>Procedure</th>
<th>Abortions/Failures</th>
<th>Feelings/Thoughts</th>
</tr>
</thead>
</table>
| Lily   | 36 – 42   | Surgery #     | Tubal ligation | 4 + 3 abortions   | More feminine and sexual
|        |           |               |            |                    | Frightened – thought she was a freak but later didn’t care
|        |           |               |            |                    | Pleased she had children early
| Verrian| 36 – 44   | ‘The Pill’*   |           | 1                  | Loss of sexual confidence as her partner views menopause negatively
|        |           |               |            |                    | Welcomed the menopause as it freed her from heavy and painful menstruation
|        |           |               |            |                    | Didn’t like fertility removed as a choice
|        |           |               |            |                    | Has not told her partner
| Pat    | 36 – 53   | Surgery #     | Tubal ligation | 3                  | H.R.T. made her feel better about her sexuality but ‘that’s not everything’ and she stopped taking H.R.T.
|        |           |               |            |                    | Felt cheated as her youth
|        |           |               |            |                    | Too young
| Caroline| 36 – 38 | Surgery       | Hysterectomy and bi-lateral oophorectomy for endometriosis | Uses H.R.T. for libido and sexual activity | Un-controllably, ridiculously guilty
|        |           |               |            |                    | Felt a freak
|        |           |               |            |                    | Shocked Too young
| Sarah  | 35 – 41   | Unknown       |            | 2 x abortions 2 x failed | Feels more masculine
|        |           |               |            |                    | Sexually ‘aggressive’
|        |           |               |            |                    | Shocked
|        |           |               |            |                    | Too young
| Peta   | 38 – 45   | Drugs Alcohol Cigarettes | 1 x abortion | Lost interest in sex Guilty – punishment for abortion
|        |           |               |            |                    | Angry as doctor didn’t believe she was menopausal
|        |           |               |            |                    | Disappointed and upset she ‘will never be a mother’ – made her question her identity
|        |           |               |            |                    | Doesn’t feel sexual any more
|        |           |               |            |                    | Loss of identity as a woman – recreating
<p>| Fran   | 38 – 38   | Cigarettes    |            |                    |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Menopause</th>
<th>Procedure</th>
<th>Outcome</th>
<th>Identity</th>
<th>Reason for Menopause</th>
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<tr>
<td>Elaine</td>
<td>38</td>
<td>50</td>
<td>Tubal ligation</td>
<td>3</td>
<td>Unchanged</td>
<td>Unexpected but not surprised</td>
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<td>Positive attitude to menopause</td>
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<tr>
<td>Linda</td>
<td>38</td>
<td>50</td>
<td>Cigarettes</td>
<td></td>
<td>‘Went off sex completely’</td>
<td>Too young</td>
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<td></td>
<td>H.R.T. no good as it’s not ‘just a bodily thing’</td>
<td>Felt she had failed as a woman</td>
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<tr>
<td>Oona</td>
<td>39</td>
<td>50</td>
<td>Surgery #</td>
<td>Hysterectomy</td>
<td>2</td>
<td>Feels good about her sexuality – partly because of H.R.T.</td>
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<td>Embarrassed</td>
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<tr>
<td>Stephanie</td>
<td>39</td>
<td>43</td>
<td>? Stress</td>
<td>3 x failed</td>
<td>Libido diminished</td>
<td>Shocked</td>
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<td></td>
<td>Feels asexual</td>
<td>Devastated</td>
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<td></td>
<td>Completely changed her self-identity from confident and outgoing to sad, reclusive and an absolute feeling of failure</td>
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<td>Bronte</td>
<td>39</td>
<td>41</td>
<td>Genetic – mother had menopause at 40</td>
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<td>Totally unexpected – a crisis</td>
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<td></td>
<td>Felt a curiosity</td>
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<tr>
<td>Julie</td>
<td>39</td>
<td>54</td>
<td>Unknown</td>
<td>2 (twins)</td>
<td>Changed – less interested in presenting a ‘typical feminine image’</td>
<td>Surprised</td>
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<td></td>
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<td>Felt too young</td>
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<tr>
<td>Simone</td>
<td>39 – 40</td>
<td>54</td>
<td>Surgery #</td>
<td>Hysterectomy</td>
<td>3 + 1 adopted</td>
<td>Loss of interest in sex yet feels her ‘femininity’ is important</td>
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<td>Loss of sexual confidence – partner’s fidelity as issue</td>
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<td>H.R.T. to improve libido</td>
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<td>Too young</td>
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<td>Frustrated</td>
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<td>Not prepared to be ‘old’</td>
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<tr>
<td>Melanie</td>
<td>39 – 40</td>
<td>46</td>
<td>‘The Pill’*</td>
<td></td>
<td>1 x abortion</td>
<td>Blamed her abortion</td>
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<tr>
<td>Name</td>
<td>Age at onset of menopause</td>
<td>Age at interview</td>
<td>Probable cause</td>
<td>Surgery</td>
<td>Children</td>
<td>I.V.F.</td>
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<tr>
<td>Rebecca</td>
<td>40</td>
<td>48</td>
<td>Surgery #</td>
<td>Hysterectomy plus unilateral oophorectomy</td>
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<tr>
<td>Jenny</td>
<td>40</td>
<td>42</td>
<td>Surgery #</td>
<td>Hysterectomy</td>
<td>Partner has children</td>
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<td>Nicole</td>
<td>40</td>
<td>42</td>
<td>Surgery #</td>
<td>Hysterectomy</td>
<td>3</td>
<td>‘Should have been a boy’</td>
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<td>Julia</td>
<td>40 – 41</td>
<td>50</td>
<td>Surgery #</td>
<td>Tubal ligation</td>
<td>1 x abortion</td>
<td>Feels completely different</td>
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<tr>
<td>Karen</td>
<td>40</td>
<td>41</td>
<td>Unknown – late menses</td>
<td></td>
<td>3 x failed</td>
<td>Changed – doesn’t feel as ‘feminine’</td>
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<td>Joanna</td>
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<td>Unknown</td>
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<td>Pam</td>
<td>41</td>
<td>50</td>
<td>Chemo-therapy</td>
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<td>2 x adopted</td>
<td>Sexual confidence eroded at first</td>
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<td>Description</td>
<td>Adoption</td>
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<tr>
<td>Beth</td>
<td>42</td>
<td>56</td>
<td>? I.V.F. ? Drugs ? Stress</td>
<td>2 x adopted</td>
<td>3 x failed</td>
<td>Changed Less ‘feminine’</td>
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<tr>
<td>Jean</td>
<td>42</td>
<td>50</td>
<td>3 (twins + singleton)</td>
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<tr>
<td>Martine</td>
<td>42</td>
<td>54</td>
<td>Surgery # Tubal ligation</td>
<td>3</td>
<td></td>
<td>Libido diminished but still feels sexual</td>
</tr>
<tr>
<td>Dana</td>
<td>42</td>
<td>45</td>
<td>Surgery # Caesarian section</td>
<td>2 + 3 miscarriages</td>
<td></td>
<td>Changed but ‘not due to menopause’</td>
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<tr>
<td>Lauris</td>
<td>43</td>
<td>49</td>
<td>Surgery # Hysterectomy</td>
<td>2</td>
<td></td>
<td>Loss of libido Feels ‘feminine but not sexual’</td>
</tr>
<tr>
<td>Anne</td>
<td>43</td>
<td>54</td>
<td>Genetic – strong family history of twins Hysterectomy</td>
<td>2</td>
<td></td>
<td>Diminished libido</td>
</tr>
<tr>
<td>Meg</td>
<td>45</td>
<td>50</td>
<td>Surgery # Tubal ligation</td>
<td>2</td>
<td></td>
<td>Feels more sexual than when younger</td>
</tr>
<tr>
<td>Marie</td>
<td>48</td>
<td>56</td>
<td>Cigarettes</td>
<td></td>
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<td>Less sexual</td>
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# Early menopause an unintended and often unexpected consequence of surgery
* Combined oral contraceptive – especially long-term and commenced during adolescence
Cultural pluralism: the world of the individual

The cultural definitions and values that are available to individuals made it possible for each of the women who participated in this study to interpret their own experience of having an early menopause (Turner 1991: 213). These understandings not only differed from medical understandings, they also differed between individuals. Moreover, each woman’s construction of her own experience was dynamic with varying intensity and meanings. It was apparent that viewing these women as an homogenous group was too simplistic as each woman had her own fluctuating values and understandings. This multiplicity can be explained through the concept of cultural pluralism that recognizes cultural diversities and makes it possible to regard personal interpretations of an experience as representative of each individual’s cultural context (Wildavsky 1989: 58). By examining the fabric of individual experience early menopause could be seen as an aspect of social action. Early menopause did not occur in a vacuum but was dependent upon the translation, preference and meaning given to it by each woman. Moreover, the cultural values of these meanings were not static. Women vacillated over various meanings and these meanings sometimes changed over time. The medical definition of early menopause as an ‘objective’ bio-chemical malfunction ignores this phenomenology of the body and fails to recognize women’s experiences of early menopause as conscious perceptions. More importantly, it fails to recognize the mobility of the experience of early menopause as the women constantly negotiated and renegotiated a range of contradictory, conflicting and changeable discourses.

Despite the dominance and authority of medical discourses over the research, teaching and practice relating to early menopause, the majority of the women interviewed rejected, at least partially, medical interpretations of their experiences. Twenty women did not pursue medical clarification of their early menopause nor did they seek medical treatment. Even though the other women did seek medical sanction of their circumstance sixteen of these women rejected strict medical classifications of early menopause. And all of the women who were on hormone ‘replacement therapy’ (H.R.T.) had an uneasy relationship with this as an ongoing treatment. This highlights the inadequacies of medical discourses that will only search for and find bio-chemical explanations and ‘treatments’ for illness. Moreover, the medical classification of early menopause as a disease did not correlate with the women’s more philosophical perceptions of their circumstances.

Modern medicine, treating the body as a sort of machine, regards illness and disease as malfunctions of the body’s mechanics. All ‘real’ diseases have specific causal mechanisms which can be ultimately identified and treated. Such an approach rules out the centrality and importance of experience, feeling, emotion and interpretation of the phenomenology of sickness and disease. Turner 1987: 214.

Women interpreted their early menopause through a labyrinth of discourses that continued to change. Most of the women had some level of awareness of medical discourses and recognized the ‘symptoms’ of menopause. Yet it was not these changes per se that concerned early-menopausal women; it was what having an early menopause meant to each of them as individuals and as members of the social group women that had the greatest influence. The following lengthy excerpts from the interviews of different women show the assortment and vacillation of the meanings of early menopause. I have
used unabridged sections of conversation so that the reader may find their own interpretation of these women’s stories. Occasionally I have used italics to indicate my own weighting for what I feel is an important part of the narrative. I have marked these in order to differentiate them from the emphases of the women, which I have put in upper-case lettering. The first story, from Hilary shows how she has contextualized early menopause within a range of different aspects of her life.

H: I’m one of triplets, my other triplets being one a boy and the other being a girl. I’m forty-four next April and had menopause when I was thirty-five. It started first as thyroid trouble. I’d had it in my teens and developed thyrotoxicosis. I went to Hammersmith Hospital but they couldn’t control it and decided to do a thyroidectomy when I was twenty-four. It was suggested to me prior to my thinking about having children. That was my prime reason for having a thyroidectomy. It went successfully and I was alright.

I became pregnant but miscarried, but about two years after the thyroidectomy I had twins myself. But by the time I was thirty-five I was quite poorly. I had started to get a little bit chubby and a little bit depressed and hot sweats and just generally not myself. I hadn’t gone on any thyroxin but apparently now thyroidectomies are quite common and they put people on thyroxin in case they develop myxodema which is exactly what happened to me.

All of this had happened over a period of a few years. I became increasingly depressed. And fatigue - I’ve never felt so tired and irritable. Scanty periods. Lack of interest. I mean I still kept going but really not me at all. I actually didn’t go to anybody for quite some time. I was about thirty-five when I did eventually go. I initially didn’t connect it with thyroid trouble. I’m a nurse myself and nobody had even suggested to me that after a thyroidectomy there was a large possibility of me being myxoedematus [having an under-active thyroid gland]. So many years had passed anyway that I thought, ‘Oh well’. Even if I had been told that I probably would have forgotten.

I got really quite poorly and decided to go to my G.P. He referred me to a specialist who put me on thyroxin and I immediately felt one hundred percent better. But I was still getting quite a lot of hot sweats through the night, still mood swings, still sensitive, temperamental, a bit depressed and no periods by then. Although I had more energy because my thyroid was getting sorted, nevertheless, I was still tired. I told this to the endocrinologist and he did some blood tests and suggested that I go on H.R.T.

S: Did he say why?

H: That he suspected that I had gone into an early menopause because of the complication to my thyroid. I had used the pill for a few years early on but after that we used condoms so my cycle had been natural.
Up to the age of about thirty-five I had never had any trouble with my menstrual cycle. I had normal periods. Even as a kid when I was thyrotoxic I had normal, regular periods because I remember them asking me that at Hammersmith. I didn’t have any problems at all. For some reason my menstrual cycle was never really an issue. It only became problematic with menopause. For my endocrinologist it was, ‘This is what the blood tests say and you’re lucky you can go on H.R.T.’.

I did do that. I went on H.R.T. because I’d heard it was a good program to be on and it certainly did help the night sweats and the moods. I did feel I got neglected in the lack of support that just wasn’t available about going on H.R.T. What I know about H.R.T. I found out for myself. There was nothing there. Also the lack of emotional support and sensitivity from the endocrinologist bothered me [my italics]. He was just disinterested. I did ask if there was somebody I could talk to about H.R.T. - a support group or something. And he said, ‘Oh, yes, there’s probably one at your G.Ps’. He didn’t want to hear. He’d done his job. He’d sorted out my thyroid and thought, ‘Well, we’ll give her this’, and that was it. And I was paying for it! Although of course he’s a well-respected endocrinologist and probably good in that field but that’s it.

S: Do you remember how you felt when he told you were menopausal?

H: Well, I was distressed. I was angry. I was angry at him for being unsupportive. And angry because I was too young for this. It was unexpected. I wasn’t ready for this. I was too young. It was like a denial of everything I had taken so very much for granted, which was part of my femininity and part of my ‘womaness’. Yes, I was angry. Without question it was my fertility as well. It was just part of my life over and I wasn’t ready for that. And I’m still not ready. I’m still young [my emphasis]. Although I recognise intellectually what’s happening with my body I’m not ready for that yet. My choices of having any more children have obviously gone and whether I would have had more or not is immaterial, my choices aren’t there. Even although I’m forty-four now I still feel that. In some ways it has its bonuses [my italics]. You’re free from the anxiety of becoming pregnant and what to do if I hadn’t wanted to. That’s the bonus I suppose.

S: Have you stayed on HRT?

H: Yes, I have been on that for some time. I have actually stopped from my own choice. I think for me it was a matter of, ‘Well, I have to take these medications and I don’t want to so I’m going to stop them and see what happens’. It’s a matter of control really over your own body.
S: Did you decide that because of information you received or was it intuitive?

H: It was intuitive. I was unhappy with being on it for so long and I really wanted to know if the H.R.T. had really kick started for some reason, you know my body into functioning into some sort of normal way. So I thought I’d give it a whirl and I went off it for three months and I started getting all the symptoms back again and I really didn’t feel that on balance that it was worth coming off it. I did that twice over a six-year period and on balance I feel better on it than I do off it although a part of me still resists having to take medication [my italics].

My main concern was breast cancer which obviously remains a concern. And obviously thrombosis. Other concerns like weight gain I’m not happy about that but it’s not a prime worry. I think breast cancer is a worry. Of course you hear conflicting reports and you read this and then you read that and you make your choice. If experts can’t agree where does that leave you? In the middle of nowhere [my italics]. But women are very good at taking responsibility for themselves. They have to do it. I don’t know any other way around that.

Another reason I stayed on H.R.T. is that Guys Hospital contacted me to do an osteoporotic scan as part of a research program and I did that. I think the bone density was fine, although they did suggest perhaps if I’d stayed on H.R.T. it perhaps would be better.

I do weight bearing exercise but I have a back condition and in the last two years I’ve done less. I do play badminton twice a week and I swim and used to do what I call ‘keep fat’ because it used to keep me fit but never thin. Because of this back condition I’m very reluctant to do that now. It frustrates me because it makes me feel older than what I actually am. So it all feeds in to this feeling of menopause and getting older or ‘past it’ as they say [my italics].

S: How do you view yourself?

H: Well, I can say that physically my body has changed in the past two years. The physical changes I feel and I don’t like it. But on saying that I recognise that this is part of the cycle [my italics]. I’d like to get into a keep fit program. I want to keep relatively fit and well, and to look after myself. I probably look after myself a lot more than when I was younger. I want to eat well, to try and rest and do relaxation exercises because I am a highly-strung anxious person. I want to get plenty of fresh air and have hobbies.

S: Do you view your future optimistically?
H: I try to but I work at it. *Everything is happening at the same time* [my italics]. My children are getting older. They are only fifteen but doing O levels [Year Ten] and I’m thinking that soon they’ll be off. And my husband travels abroad an awful lot and he’s off and I thought, ‘Well, where does that leave me’? You know I focused on bringing up the children all this time and really living in quite an embryotic state. To my horror actually, and it is only on reflection that I can say that because at the time I didn’t recognise that. Now I realise that there is a bigger wider world out there and this is my last chance I’ve got to go for it [starting a university course].

It’s exciting and challenging and frightening and I try and balance out those things. Sometimes it’s more frightening, sometimes it’s less. Sometimes it’s more challenging. Sometimes it’s wonderful. I think I view my future relatively optimistically.

S: There are a lot of women returning to education. Perhaps it’s for self-fulfilment.

H: That’s my hypotheses. Mature students, something over the age of forty – I have to do a dividing line you see – primarily do a degree for personal satisfaction as opposed to reasons of job function. There are other factors – getting away from the children.

That is something I should talk about. My memory is really menopausal. It is shocking. I have noticed a steady deterioration of my memory.

S: Has this whole thing affected any of your relationships, for instance with your children or husband?

H: Just sexual. *I don’t feel sexual as I used to.* My libido has definitely dropped. *Maybe some of it is self-identity.* You know, *‘Where am I in all of this’? Part of my life is over with* [my emphasis]. I have to say that the last two years have been very traumatic. We’ve had about ten deaths in the family so all of that has fed in. *You can’t separate it really* [my italics]. All that grieving and stress.

*I think women have so many changes in their lives* [my italics]. They make so many adaptations. I think the menopause comes as quite a shock. I hadn’t even thought about it. I had known about it but *I hadn’t expected it so early* [my italics]. To me it was far, far away. My sister [triplet] is well. She hasn’t got thyroid trouble and she isn’t menopausal. She’s got twins. My mother didn’t have early menopause. She was about fifty. I can’t remember.

*I am all of these things.* I’m not just someone with a thyroid condition or premature menopause. *I think the medical profession*
does have a priority of just dealing with the condition and not with the person as a whole person [my emphasis]. I think it’s improving but my doctor isn’t. It was a priority at that particular time. I felt poorly but, nevertheless, he could have been a bit more supportive. Even if he didn’t provide it himself but just acknowledge it.

S: Do you have anyone to talk to about it now?

H: I talked to my husband about it. Although he’s very caring he doesn’t really understand. My reduced interest in sex has caused some conflict and in fact has been a bit of a battleground. But things are settling down. We have a relatively good balance now. But without question it did influence the relationship because he was as unprepared for it as I was. It has taken quite some time to get the relationship back on a good level. It would have helped if I’d had someone to talk to when I had it diagnosed. Initially I was so pleased that I was feeling so much better that I pushed it to one side really. Part of that was me - I didn’t want to face it either. It was only as time went on I started to think, ‘Well, this is it really’ [my italics].

My husband was quite pleased because he didn’t want any more children. I don’t know if I would have had any more children but it was a question of when, and if I would like, but that choice was taken away from me and I feel upset about that. Certainly I would have considered having more children if they were going to be twins. My mother’s sister had twins as well.

I didn’t actually talk to my friends about it. I don’t know if I thought that they really wouldn’t understand or that I really didn’t want to admit it. It was all part of the denial I suppose. I’m not sure. I think the denial was part of the grieving process. You know, ‘This is it. Now all over’. It’s odd really because I never talked about my fertility, I just took it all very much for granted [my italics]. I never had any problems getting pregnant although I did have a miscarriage. I had always taken it very much for granted so it was a big shock when it actually happened. I didn’t initially talk to friends about it. I do now. I don’t know what’s changed. I think it’s because I was perhaps more upset about it. I didn’t want to let on that it was happening to me. Eventually when I came to terms with it I was able to talk about it. It took some years with all the other things that were happening as well. But I do have two lovely healthy children.

I didn’t actually think about myself but now it’s time for me to grow. Parenting was fulfilling but watching your children grow up you realise that you’re not a child any more. I was uninformed I didn’t really know what was going on around them. I was so focused.

Certainly my husband would never bring up talking about the menopause unless I did. It isn’t a subject I imagine is discussed with
men. My children probably would have known more about menopause than my husband would have. It’s more open now. It’s discussed more openly now. My son certainly knows the word because he used it when he was about five instead of some other word and he used it quite inappropriately. It was really quite funny.

You don’t know who you are. This is a different person [my italics]. This is obviously not you. Well, it’s part of you but it’s not the ‘you’ that you know of. It’s not the ‘you’ that people love and know and are familiar with. It is a part of you but it is so unexpected in every way [my italics].

Why does menopause not affect some women yet it does affect some others profoundly? It’s like a personality change. I lost my self-confidence and self-esteem. I thought, ‘Who is this person’? I was confused by my body [my italics]. It was frightening and in my acute stage it was quite stressful. My husband was away a lot so I didn’t get much support from him, but he was as confused as I was. One minute I was alright and the next minute I was ranting. He was probably thinking, ‘Who is this person’? But when I went on the H.R.T. I was settled. I’m not happy on it still. I’ve taken medication most of my life and I do resist it [my italics]. Sometimes I don’t take a tablet.

Hilary.

Hilary’s self-reflection involved complex and mobile pluralities. She negotiated medical discourse around her thyroid condition, early menopause and H.R.T. But she rejected aspects of medical discourse and was concerned about the side effects of H.R.T. The changes within her sexuality, fertility and subjectivity were woven into changes within her relationships with her husband, children and her ‘self-fulfillment’ through continuing education. Her cultural context is quite different from Carly’s who was an adolescent when she started menopause. She related her story almost as a soliloquy as she paced the room during the interview. She said it was the first time that she had spoken to anyone about how it felt to have an early menopause.

C: I started my periods when I was eleven. I was on a school trip so it was a rather bizarre thing to happen. I had to tell one of the teachers and I was embarrassed. Then they were very, very regular from the first period. Then the Christmas when I was aged fourteen I had my last period. January came and I didn’t have a period. And I thought, ‘Oh, well’. I wasn’t pregnant because I was only fourteen. But then the next month after that my father was diagnosed with terminal cancer. I didn’t get a period but it was pushed aside and my Dad died in April. My mother spoke to doctors who said it was stress. I said, ‘I didn’t have one in January and I didn’t know then unless I’m extremely psychic and had a premonition’.

It wasn’t until the October and by then I was fifteen that Mum said, ‘Right you’re going to see a doctor to see if something’s wrong’. He referred me to a specialist at Norwich Hospital where I went to see a
gynaecologist. He took a mountain of blood tests. I always remember because no one can ever find my veins. The first time they said they can’t find anything wrong. Then the next time I went back he said, ‘Well, it’s very unusual you’ve gone through menopause. This might mean that you won’t have children. Does that upset you’? I was only fifteen years old!!!! I sat there and thought, ‘Oh, yeah. I don’t know’. He was horrible. I’ll never go back there. So I left and thought, ‘Why is this happening to me’? It worried my Mum as well. It must have been such a strain. She was worried why it happened and that it was her fault.

I practically blocked it out. I went on to the pill. The specialist said, ‘You’ll be on the pill for the next forty or fifty years’. ‘O.K.’, I thought, ‘this is great. I’m fifteen and on the pill. If word gets out – you know I live in a small town’. So anyway I went back to school and as I’d been in hospital they wanted to know what was wrong with me. So I told three people, which probably means the whole school knows, but no one has mentioned it since. So whether they all thought I was lying I don’t know. Even though they’re my best friends I just never talk about it. They don’t know how to approach me. I’ve never mentioned it since. It was the same when Dad died – all in the same year.

I’ve got two older sisters. They still live at home with my mother. They know everything that’s been going on but I’ve been so secretive I didn’t want to talk about it. I just ignored it for years. I’d never heard of anyone else [my italics]. Admittedly I didn’t go to my G.P. and ask her but I don’t like her. I’ve got a thing about doctors – I don’t like them. If she was that good a doctor – it’s only a small town and a small practice – she could have done a bit of background work herself to help me. After all I go every year to see her and every six months to see the nurse to get the prescription. I think I’ve put on weight.

So it’s been eight years and I’ve had to cope alone. That’s when I thought, ‘Go out and do something yourself’. I was shocked when I found out and also I was embarrassed as a teenager [my italics]. I went through horrendous mood swings. I remember before it was diagnosed I was horrible. I said horrible things to my parents – both of them. I look back now and think, ‘Oh, my God, I hope that’s because of my hormones not just me – I’m a horrible person [my italics]. I was extremely embarrassed. I remember that. I was embarrassed because it’s not normal [my italics]. I do get upset now. I think if you’re feeling depressed or low you feel totally sorry for yourself and have a good cry. And then O.K. well, there you go it’s part of me now [my italics]. When I was fourteen I remember the doctor said there is a chance you could have children. You might come off the pill and it might start. And he said, ‘Don’t hope for it and don’t think it’s going to happen but it could happen’. But I’ve
been on the pill so long now I wouldn’t know. But I know it’s not going to happen and I’ve come to terms with it. I think that’s what brought me through those early years.

I did go through it before my mother. She’s going through it now – hot flushes and so on. There is no sign in my sisters. It’s not normal [my italics] but it’s not life threatening. It’s awkward. You can’t see it so people don’t know [my italics] and it’s a hard thing to talk about. I sympathize with my mother now she’s going through it.

I don’t feel very comfortable about sex [my emphasis]. I was a lot later than my friends but I just said, ‘Sure, I do it’. It has taken me eight years to talk about it. I spent so many years with it as my own problem. I mean my family are there but I’m still on my own and I don’t discuss it with anyone. It’s always there. It never goes away. In most situations it comes out especially in relationships. I’m just like anyone else. I go out and enjoy myself and I’m pretty much like all the other twenty-two year olds I grew up with but I think I’m on a different level to them. I’m more cynical about life. I think that might be why. I think going through the menopause and my father dying has sort of notched me up. I’m rather too mature for my age. Now I seem to be the one everyone comes to with their problems. I’ve become the agony aunt for all my friends but I very rarely talk to anyone else about what’s happened to me. They don’t ask.

I think my mother had problems when it happened. I think she blamed herself and it used to make her cry because she didn’t know what to do to help me. It’s hard when I go back home and my friends have children. I’d consider anything to have a baby. I.V.F. or adopting. I’d like to help someone else. But that depends on the relationship. I don’t want ten I.V.F. children or anything like that. If I have I.V.F. and multiple children I’ll know what it’s like because I nannied for triplets. People must think it odd that I look after other people’s children when I can’t have my own. They might think I want to kidnap them.

I have no self-confidence about my own self [my italics]. I have wondered why it happened. I went through a stage when I thought it was me that triggered it off or wondering if I hadn’t done something would it have happened. I couldn’t recall anything specific. I thought things like had I not used tampons or things like that. But when you’re fourteen years old you don’t really know and you’re too embarrassed to ask. I used to be so shy. All in all it has given me confidence to go out and do things myself. I went off so young travelling and nannying. I feel like I’m doing something positive with my life. My job gives me confidence [my italics].

But it’s a fact. I’ve got a body like a fifty year-old and I can’t have children [my italics]. Saying that you can’t actually have a family –
that’s all I was told. Just that. I didn’t get any back up. I must have been in his office about five minutes when he told me – and that’s it – nothing. My mother hates that doctor for telling me how he did. I think that’s why it all got shut in. I just don’t talk.

*I am different to everybody else* [my italics]. I’m not anything special. I’m just different to the average twenty-two year old and I was different to the average fifteen year-old. I’m less wild and more mature. There was a show on tele the other night about teenage mothers and one girl said how good it was. Of course it is. Because what other people think about she’s already got. I can’t have children. That’s it. And she’s done it. I do have my off days. I don’t feel cheated but I will try for I.V.F. when the time comes. *Thirty seems the age for the fertility bit* [my emphasis].

Now I’ve come to terms with it I think, ‘That’s me. That’s part of the person I am. I wouldn’t be me if this hadn’t happened. I’d be some other person’ [my emphasis]. Although I’ve just come to terms with it – because it’s been part of my life for so long – while it’s always there – eight years is a long time to go without a period. The doctor I go to is no comfort. I’d rather go to someone else [my italics] but she’s the specialist you know. When my periods stopped it took me nine months to go to the doctors. I had hot flushes and everything but the doctors just say, “Maybe you’re pregnant’. Although I hadn’t had a period since January I believed it was stress. It can happen and reverse. But deep down I knew it wasn’t because I was like clockwork form the age of eleven. I can’t believe how horrendous I was. *I hope people know that it wasn’t my fault* [my italics].

Carly.

All of the women interviewed interpreted their changing bodies through their own cultural discourses. Some women were aware that these changes indicted they were having an early menopause; other women initially were completely unaware that they were experiencing an early menopause.

**Muted discourses: creating a cultural void**

Many of the changes associated with menopause have been constructed through medical discourse as belonging to age-related menopause and have been attributed to the anxieties of midlife. Young women experienced many of the same changes reported by older women; it was the interpretation and significance placed upon these that differed. This variance indicates that as well as the physical changes women experience there are social, psychological and spiritual aspects of early menopause that need to be contextualized. In other words early menopause is incorporated and intertwined with all aspects of the life of each woman within her own cultural context. Older menopausal women are said to experience both negative and positive symptoms in relation to their life stage (Daly 1997: 161). Whereas the menopausal experiences of the younger women who were interviewed for this study frequently were disbelieved, diminished or ignored.

None of the women interviewed expected to have an early menopause. Teenagers and very young women rarely connected their experiences to a change associated with much older women. Other women interpreted the changes they were experiencing as
early menopause although this was not always immediate. Lack of anticipation made having early menopause difficult to identify and to contextualize. For instance many of the women felt cheated of their youth. They were confused by the construction of menopause as synonymous with middle age. Many of the women experienced menopause before their mothers or older sisters and all experienced menopause before their peers. In other words the medical construction of menopause as chronologically pre-determined was not supported by the experiences of the women who participated in this study. Martine, who was medically-trained commented:

I was only forty-two so I thought it couldn’t possibly be menopause then. I had amenorrhoea right out of the blue. No bleed, no abnormalities or irregularities. It just stopped. I had mood swings. I had always had regular periods almost to the day and hour so I thought it was impossible. ...

It couldn’t be menopause. I was too young. It didn’t fit in with my expectations. I was too young to be at this stage. I visualized myself as an old woman. Martine.

Martine’s comments are representative of many of the women interviewed. Most of the women were surprised to have an early menopause because they had not heard of it before. Yet, by virtue of their own experiences women rejected the medical construction of menopause as age-related. In addition they rejected the medical construction of early menopause as a genetic fault. In most cases there was no ‘family history’ of early menopause and even when there was, women were reluctant to accept that a family predisposition meant that an early menopause would inevitably befall them. Two of the women, Elaine and Bronte, had mothers who had had an early menopause, yet neither of these women expected that this would happen to them. Felicity, however, used the etiology of heredity to shift responsibility to the ‘weakness’ of previous generations (Helman 1988: 118).

When I was diagnosed as having a premature menopause I was told it was genetic. But my mother hasn’t even had her menopause yet and she is fifty-two. I’m twenty-six now and had menopause at sixteen. I believe that it was because of my grandparents on my father’s side. My grandfather was treated with chemotherapy for cancer [before the birth of her father] and my grandmother was always ill. Felicity.

It is impossible to speculate on the feasibility of this suggestion. What is significant is that Felicity did not accept the medical construction of her condition as natural or inevitable. She looked for other reasons to explain the possibility of a genetic mutation which might have caused her to have an early menopause.

Another woman, Shireen, rejected the genetic origins of her early menopause as biologically-determined. She speculated on the biological impact of cultural practices on her body. Her story exemplifies the fragility of the discursive construction of genes as fixed and unalterable.
Consequently my family and I had to deal with my condition. My older sister recognized my symptoms in herself which led the specialist to believe there may be a genetic link. This thought is reinforced as my parents are first cousins. As the families have intermarried any children are more prone to hereditary conditions. I am at the end of the family chain and I am the one who has suffered the effects of intermarriage.

Shireen.

These examples indicate that the women did not view their bodies as static or unchangeable. They had intuitive understanding of their bodies as a fluid connection with the past, present and future. Yet the complexities of such issues, and perhaps the inelasticity of prevailing paradigms, made it difficult initially for many of the women to contextualize early menopause. Most of the women were unprepared to accept the role they thought of as belonging to a menopausal woman. They did not associate menopause with youth or even middle age. Most of the women reported that they considered menopause as indistinguishable from old age and this was viewed as a time of restricted choices and a decaying body.

I thought that menopause was for old ladies. Recently I’ve been feeling old and I’m not happy about that. My joints have been aching and I get confused and weepy. It makes working very difficult. I have an image of myself as old and it’s not good.

Simone.

Reflection of the Western negative social value of the aged seemed to account for the reluctance of many of the women to move into the life-stage of the ‘obsolete self’ (Esposito 1987 in Day 1991: 39). The specific invisibility of the older woman in Western societies is based not only on different access to traditional markers of success such as wealth, power, economic security and social prestige (Day 1991: 45) but it is placed upon concepts of femininity, such as physical appearance and fertility. Although infertile, early-menopausal women did not want to accept the social devaluation that is thrust onto older women.

It appears that the difficulty women had in contextualizing their experiences arose from the cultural misrecognition that obscures early menopause. As discussed previously this form of marginalization results from the domination of medical discourses around constructions of the body. Young women’s reports of menopausal symptoms were inconsistent with discourses of chronological certainty and often were dismissed. Without women’s discourses being represented there is a paucity of knowledge around early menopause. This circular deficiency creates and compounds the cultural misrecognition that has precluded women’s experiences of early menopause from discursive construction. Most of the women were unaware that other women had early menopause. This isolation further marginalized women’s discourses and reinforced the cultural non-recognition of early menopause.

No one has ever heard of anyone having menopause as young as me before [at fourteen years old]. So whether or not there is someone in a similar predicament to me or not who knows.

Lara.
This dislocation between women’s experiences and medical discourses underpins the cultural non-recognition of early menopause. Nearly all of the women seemed to negotiate medical discourses of the ‘natural body’ but most found that they were unable to contextualize their experiences within this paradigm. Women’s experiences of early menopause were constituted within multiple and varied cultural discourses. Some women found that their own cultural context gave visibility to early menopause.

My first experience of wondering if I was going through the menopause was the tailing off of my periods when I was about thirty-eight. There seemed to be a reduction and then I got hot flushes. *When my periods just started fading away and I experienced hot flushes then I guessed this must be it* [my italics]. I think I was quite lucky as although some of them were quite bad I could cool off in the fresh air. They didn’t really last all that long and I think that I had a very easy menopause.

Menopause didn’t bother me. I knew what it was. I heard of one woman who went quite peculiar and had to go on H.R.T. I just thought, ‘Here we go’ and just got on with it really. I didn’t go to lectures on it or anything like that. I just think that it’s another part of my life that I’ve got to deal with. It’s really mind over matter, but you have to get on with it.

I was brought up here [in London] but within a very Irish community and a close family. I remember my mother saying when she had a hot flush and my sister as well. She was much worse than me and she had to go on tablets for a while. But hers have abated now. I didn’t have lubrication so I had to resort to K.Y. [lubricating jelly]. You can take H.R.T. for that sort of thing but I’m not interested.

I always had a close relationship with women. In our community the men sit in one room and the women in another. It was all quite open and everything was spoken about. My mother has been quite a big influence. We discussed sex. It’s never been anything that’s hidden. It’s knowing that you’re going to go through these things that’s important. I knew what menopause was. My sister used to talk about it. We used to have a jolly good laugh together on the phone. She did have H.R.T. prescribed but I’m not actually sure if she ever used it or not. She had them there as an insurance sort of thing.

*I didn’t ever go to the doctor* [my italics]. I would have considered it if I thought I was going to get worse. I’m not totally adverse to H.R.T. If I thought I was going to go loopy or anything, I’d take anything. I’d do anything. If I thought I was going to get any dreadful side effects that were attributed directly to the menopause then I’d go and see if I needed it. But I thought if I can get on without any medication then I’ll try and live with it. I didn’t get depressed and think I was loosing my head or anything. *I still view myself as feminine. I didn’t think I was no longer a female* [my italics].
I probably should read about long term health but I’m not that interested. I walk when I can and I like being in the fresh air. When I was twenty-five my best friend died from cystic fibrosis and we have had a lot of friends and relatives die young so we have had a lot of stress that way. There have been a lot of things and I have become a grief counsellor. I don’t know if any of that is related. I am not a crier so it’s possible that I don’t deal with these things. So maybe that’s stress keeping it all inside. I do cope though. I love music and I think I use that. If stress is a contributing factor then that could account for the menopause for me. After our daughter was born I was sterilized because we really didn’t want any more children. I don’t know if there is any connection between sterilization and menopause. I’d be quite interested to know. I menstruated after that for a couple of years and then I started the menopause.

Elaine.

Pam’s experience of early menopause was positive as well. She suggested that her early menopause was beneficial as she felt that it helped to control her breast cancer.

The chemotherapy threw me into instant and complete menopause within four months of commencement of the drugs. My theory is that this side effect of chemo, rather than the chemo itself was a life-saving event. I will explain this.

Menopause meant that I produced less of my own natural oestrogen. A good thing for a hormone-receptive cancer.

Pam.

Pam goes on to explain her doctor’s point of view and her further treatment with tamoxifen. However, she returns to her interpretation of early menopause as helping to cure her of a life-threatening cancer. In other words, Pam was happy to have an early menopause as it helped her avoid a physical threat to her body.

Although in most instances women had not heard of early menopause before their own experiences some of the women realized intuitively that they were having an early menopause. They were able to articulate this through their own cultural discourses. Despite the cultural non-recognition of early menopause that had been constructed through the dominance of medical discourses women were able to reconstruct narratives around their own experiences. Thus women’s changing cultural discourses gives early menopause visibility.

The legitimizing process: the shortfall of the medical consultation

Many of the women I interviewed sought an explanation from their doctors for the changes they were experiencing. Sometimes it took months or even years before their early menopause was recognized. Women experienced changes to their menstruation, had sudden hot sweats, were unable to become pregnant, had mood swings or just felt different. A significant number of the women interviewed became aware that they were going through an early menopause by an intuitive understanding of their own body. Sometimes mothers or sisters of the women suggested that these changes might be due to an early menopause. Unless they were concerned because of severe symptoms, infertility,
or long-term side effects, or needed to label this change the women did not seek medical advice.

This finding might help explain the enormous variation in estimates of the number of women who have an early menopause. If women do not seek outside help, and specifically medical verification of their circumstance, they may be excluded from epidemiological data. One woman, Josie, told how she had tried to participate in hospital-based medical research on early menopause but was rejected as the researchers did not believe that she had experienced menopause at such an early age. She was twenty-five and based her identification of early menopause on her lack of periods, infertility and feeling as if she was walking on air with loss of balance. She said:

... no one was interested in me until I started to feel unwell. Then I had the blood tests that showed I was in the menopause.
Josie.

In other words Josie’s own intuitive knowledge contradicted medical opinion until her belief could be demonstrated using scientific ‘evidence’. Terri told me how she had difficulty convincing her doctor that she was having an early menopause as well.

I’ve been feeling like this for at least five years, I’m thirty-two now. I had hot flushes and sweated at night. I became suspicious that this was the beginning of menopause. I thought it was a bit early although I have had a hysterectomy that left the ovaries. My doctor didn’t think it was anything and swept my suggestions of menopause aside for years. When I demanded a test it turned out I was right.
Terri.

Some doctors, however, did accept women’s stories or even alerted the women that they were early-menopausal. These doctors were able to identify the bio-chemistry of menopause before midlife but seemed unable to relate this knowledge to each woman as an individual. Significantly few of the women reported satisfaction with the medical consultation. It appeared that this was due to the inequality between medical discourses and women’s discourses on early menopause. Some of the women sought explanations for their experiences as they were uncertain they were experiencing an early menopause until this was confirmed by medical tests. This usually was obtained through a medical diagnosis although this was not always an easy process. Bronte had an early menopause when she was thirty-nine years old and pursued a medical diagnosis even though her mother had had an early menopause at a similar age. Yet she subsequently expressed dissatisfaction with the medical process and a resistance to medical discourses.

I feel that too high a faith is placed in modern medicine, the medical establishment and technology for diagnosis of problems. I went through a lot of unnecessary tests and suffering trying to diagnose something that older, wiser women would have recognized much sooner had I been in a community where women shared information. Modern women have lost a lot of wisdom that used to be shared within communities and generationally about their own bodies and lives. What bothered me most about the entire experience was the difficulty of diagnosis and the lack of
Information about early menopause.

Bronte.

Medical endorsement was not always forthcoming and many women were told that they were not the right age to have menopause. In seeking medical confirmation of their early menopause many of the women found that their doctor disregarded their discourses and intuitive knowledge. Despite this apparent lack of overlap in knowledges some of the women sought medical definition of their early menopause. This search for medical sanction seemed driven by the need to remove the cultural void. It appeared that for these women their own experience of an early menopause was dependent upon external knowledge and scientific definition (Beck 1993: 53).

I was relieved to find out what it was and to put a name to it. It made it easier for me to understand and to justify how I felt to my husband.

Julia.

It could be construed that these women were participating in a labelling process whereby they could choose to play the sick role (Turner 1987). But none of the women thought of themselves as sick and most rejected the medical categorization of ‘premature ovarian failure’ as an illness even though the meaning and experience of having an early menopause was often problematic.

Some of the women found that their doctors were helpful and understanding although it is significant that many of the women reported their medical consultations as less than satisfactory. A number of women reported that their doctor completely disregarded their story or laughed telling them that menopause was impossible at their age. Women told of repeated trips to their medical practitioners before full account was taken of their story. Even teenagers who had no periods for years told of this experience. When a diagnosis was made a number of women described being told this in a dismissive manner and found their doctors unhelpful, particularly in regard to the effect early menopause had on their entire lives.

When I went back for the results of my blood test the doctor told me I was just starting menopause even though I was only thirty-four. She said, ‘You’re having an early menopause’ and then went on to another topic. End of story.

I was gutted. Her attitude was that I should just get on with it. I found that very hard and came out of there feeling very upset.

Dianne.

Several of the women commented on cultural and ethnic differences between themselves and their medical practitioners. Cultural differences seemed to be more problematic than gender differences. Different cultural contexts between some of the women and their doctors seemed to exacerbate the disparities between lay and medical discourses. Occasionally these were related to ethnic divergences and included attitudes towards menstruation.

I want to change my doctor because I feel as if my doctor is strange when I’ve got my period [withdrawal bleed from hormone replacement therapy]. He’s [from another country] and I feel as if
he’s funny around me when I’ve got my period. That’s the last thing I want to feel, that sort of thing. Peta.

Not all of the women had experiences like these. Some found great sensitivity and support from their general and specialist medical practitioners (Nicole, Kate and Aisling). Nevertheless, the diagnosis was a crucial stage for women. Many of the women found it difficult to absorb the implication that early menopause is an irreversible condition and that they would be unlikely to have their own children or more children if they were already mothers.

It appeared that it was difficult to break this news as well. Women’s stories indicated that few of their doctors were skilled in this area. Insensitive handling at this stage seemed to damage a woman’s ability to cope with her circumstance and the degree of empathy shown by others appeared to influence the degree of her reconciliation. Some of the women were dismayed by having an early menopause and felt stranded as if their condition had stopped at diagnosis.

I feel as if my whole world has ended. Everything – motherhood, being a proper wife – has been taken away. I can’t concentrate on anything. I can’t find any H.R.T. to suit me and I feel as if my doctor has wiped me off. Stephanie.

As part of the medical diagnostic process many of the women were examined gynaecologically. Some of the women found this invasive; and others who had no examination thought that their doctors were negligent.

I’ve had no exam. I mean nothing. The doctor doesn’t touch me. She sits at the computer. Martine.

Some of the younger women who were examined vaginally said that they had not had this experience previously. They reported feeling stripped of dignity and power. This intrusion into women’s bodies can be construed as a form of violation that represents medical control and domination over female reproductivity. Various stages of the gynaecological examination have been identified where the medical practitioner and the woman each act out a series of roles. It is proposed that a woman ‘patient’ passes in and out of a ‘non-person’ role which removes “... potential ambiguities and embarrassment for both parties” (Giddens 1993: 103-4).

None of the women interviewed commented that indignity and embarrassment were removed from the gynaecological examination. Furthermore, the entire medical setting was often inappropriate, sometimes sited in a hospital or a menopause clinic for older women. When Shireen experienced menopause as a seventeen-year old she said:

[D]uring the time when I was diagnosed I was so angry. The nurses assumed I was pregnant and looked down on me and treated me badly. Then I had to attend a clinic with older women. It was all really unpleasant. Shireen.

As a teenager, Lara, found the lack of confidentiality of the medical experience embarrassing.
When I was about thirteen or fourteen years old my periods stopped for no apparent reason. After a few months I sort of forgot about them, but at the same time I started experiencing hot flushes at school, followed by a very red face. This could happen at least six or seven times a day no matter what I was doing. It started to get very embarrassing, especially when someone noticed my face going the color of beetroot.

It wasn’t until my friends and I were sitting at the pub one night (not that I should have been at the pub at that age) that the subject of periods came up in the conversation and I suddenly thought, ‘Oh God, I’d forgotten about those’.

I didn’t think of going to see a doctor as I thought he would probably say it was normal for a girl’s periods to be irregular for the first few years.

It must have been about a year after my periods had stopped and the flushes had started that I thought I’d better go and see my doctor about it. I couldn’t tell Mum about periods. It was all rather embarrassing at that age, so I asked her to make an appointment for me because I had a sore throat.

She gave me a lift to the surgery and in I went. I explained to the doctor what had happened and he said (as I thought he would) that it was quite normal for a girl’s period to stop. He took a blood test and told me to come back to the surgery the next morning for an examination.

So out I went to the car trying to hide the cotton wool on my arm from my Mum who still thought it was my throat I was bothered with. At that point the doctor came outside. I nearly died of embarrassment when Mum asked him what he thought was wrong with me. He just started rattling on about periods and things. Mum’s face!!! I had no option then but to tell her why I was there. Lara.

The medical encounter frequently was problematic for women. This seemed to be the result of differences between the expectations of women and the expectations of their doctors. Although the women consulted doctors in order to obtain medical substantiation of their experiences they wanted more than this from the consultation. They wanted an acknowledgement that having an early menopause affected all areas of their lives. In addition they hoped for some guidance on how to incorporate this information into their lives. Some women had specific questions.

I wanted to know how having menopause then would affect me. Did it mean that my body was old inside; did I have to go on H.R.T. forever; could people see my secret? These questions flashed through my mind
but they were never uttered. Instead he wrote me a script for H.R.T. and I left the surgery.

These unresolved questions indicate a discursive clash. Researchers have noted the historic structure of the medical consultation where the doctor is trained to recognize specific signs and symptoms. From these, a diagnosis of illness is made and a specific treatment recommended. The apothecarial origin of general medical practice ritualizes the conclusion of the consultation with the giving of a script (Coleman 1994: 61). This convention is further controlled by the doctor’s need to manage the constraints of time and money (Lupton 1995: 105-130). The quandary for the medical practitioner ends with diagnosis; for the woman it often is the beginning.

Dissatisfaction with the medical consultation was a recurring theme that demonstrated the mismatch between women’s expectations and the format of the medical consultation. Women became frustrated, angry or disappointed when medical practitioners disbelieved their stories; failed to empathize with their feelings; were abrupt, dismissive or patronizing; used exclusive terminologies; or provided no information or opportunity for women to express themselves.

This discontent indicated a disparity between medical and lay understandings that was particularly evident during the consultation when women received confirmation of their early menopause. It was apparent that women had different expectations of the medical consultation from their medical practitioners. They wanted medical information but they wanted understandable information delivered with empathy, clear terminology and an opportunity to express their feelings.

Nearly all of the women resisted the medical construction of early menopause in some way. Many women questioned the unyielding medical classifications of their condition. Rarely did women express their early menopause as the failure of their ovaries. Each woman interpreted her experiences within the context of her entire life. Most of the women who were taking H.R.T. took themselves off this medication at some stage. They usually made this decision by themselves without the knowledge of their doctor. Some went on and off H.R.T. for years as their resolve to go ‘drug free’ vacillated depending upon how they felt or on how persuasive their doctors were. Younger women, in particular expressed concern at the length of time that they were expected to stay on H.R.T. when there have been no studies done on the long-term use of H.R.T. Many women felt compromised by the expectation that they should remain on this medication when very little information on the adverse side effects of H.R.T. was available.

But I was only sixteen. Psychologically it was huge. I felt self-pity because I was different. I just wanted to have a period. I wanted to be like my friends. I had to be secretive about being on H.R.T. I didn’t tell anyone. I’m not very good at keeping secrets so you can see how it affected me.

The tablets made me very sick. I got headaches so I went onto the patches. In fact I think I was one of the first people to use patches. We were guinea pigs. There were thirty of us and I was about seventeen and the youngest. I have been unhappy with the different H.R.Ts. They have been O.K. for the first few months then I get side effects like continuous bleeding. It is very difficult. I haven’t found any doctor or H.R.T. I’m happy with. Now I have the most awful
recurring cystitis. It’s really, really bad and I blame the H.R.T for that. You can’t be on medication for that long without some side effects. But where do I go from here?

One doctor I saw wanted me to have a hysterectomy. He said, ‘What’s the point of having what you’ve got when you’re never going to have children’. He was quite brutal. It’s very difficult because they’ve discovered something they think works and now they’re trying to promote it [H.R.T.]. But what about the side effects? Health doesn’t work like that. You can’t use people like that. I’ve offered myself as a guinea pig. It concerns me because you have to do something. But how can you really understand.

Felicity.

Although many of the women expressed a preference for greater equality within the medical consultation some women found that they were unable to confront their doctors directly about this. A number of the women complained about the medical encounter and resented the attitude of their doctors. Even though they felt disadvantaged by the inadequacies of the medical consultation some women felt unable to challenge the status quo. Lauris was ignored when she told her doctor of her menopausal symptoms within days of her hysterectomy.

So he did a hysterectomy and I recovered very quickly. But within ten days of having the surgery I started getting hot flushes. I wondered was this surgical shock or what is it? I eventually became quite conscious of what one would expect with menopause. It came on so suddenly it had to be related. I’m now sure that’s what happened and I’m sure I’m going through menopause [at the age of forty-three].

When I mentioned it to the doctor he didn’t seem to listen. He said things like, ‘You’ll miss your periods like a hole in the head’. That sort of thing. It was so inappropriate. I liked having periods. Even though for the past few years they had been extremely draining, to me it was part of the female fertility cycle. I thought his comments were extremely patronizing.

Menopause was earlier than I expected and it came on so suddenly. ... But when I went for my check-up after surgery the gynaecologist didn’t acknowledge that I was having menopausal symptoms nor did he say that this was a common side effect. He said, ‘I’ve never met an unhappy customer. I don’t need to see you again; you’re fine’.

But I thought, ‘How do you know that people are happy customers if you never have to see them again?’ At first I didn’t realize it was menopause but I thought it was something to do with my oestrogen. I just felt hot and uncomfortable and then it went away, and then it happened again a bit later. ... I did think it might be a temporary thing but it’s not. It was really later that I felt an inner change. It has definitely affected me. I’m very much in tune with my body and I
don’t need to go and have a blood test or any confirmation. I haven’t even discussed it with my G.P.

Sometimes I feel like marching into the gynaecologist’s office and telling him. Or perhaps I should write him a letter. Even though I am concerned that he must speak to other women like that I have not done anything about it. I saw him by chance recently and it made me angry all over again.

Lauris.

Further compounding discontent with the medical consultation was lack of continuity between practitioners. Many of the women reported that they saw different practitioners at different times due to the set up in the medical practice they attended. Some saw different doctors during different stages of diagnosis or ongoing medical treatment and felt that there was no overlap in knowledge paradigms. Many felt that they were lost to a dissection of the body. Disjointed medical practice was exacerbated by the isolation of different specialties. Melanie wrote her story for her support group and speculated that her early menopause was caused by treatment for cancer. She said that:

[T]he problem seems to be that there is no-one between the fields of gynaecology and oncology: doctors know either about gynaecology or cancer, but not both. Melanie 1997.

Many of the women found medical discourses unrepresentative of their experiences. In order to make sense of their condition many of the women sought an alternate information source that was more reflective of the woman’s own cultural context. In other words women’s experiences of an early menopause was constituted within their own cultural discourses. Few of the women gained the information they sought from professional services. Some found solace through friends or relatives, and those who were able turned to a support group. In the main women gathered sparse information where they could and interpreted this within their own understandings. Nearly all of the women expressed disappointment with the bulk of literature on menopause stating that it just did not relate to their situation.

The desolation of exclusion: discourses of abnormality

Many of the women who had an early menopause felt alone. When they first became aware of their own early menopause few of the women had any idea that other women have this experience. Their doctors told many of the women that they were ‘rare’ and ‘abnormal’. This enforced alienation was pervasive and the diagnosis of an early menopause often was kept secret from family members, friends or even partners. Many women preferred to look for resolution where they could be anonymous. Sometimes this was through a support group although specific support groups for early-menopausal women are not readily available. So far there are only four known formal support groups worldwide although these affiliations are finding escalating membership (Daisy Chain 1998). Susan, Carly, Carole, Liz, Felicity and Shireen were all founding members of Daisy Chain a support group for early-menopausal women. This group was started about four years ago when some of the women met by chance at an I.V.F. clinic. Membership has snowballed and they now even have their own web site (www.daisychain.org).
Some of the other women were reaching out for understanding and compassion through cyberspace by communicating on the Internet. Bronte, Dana, Terri, Lisa, Karen, Sarah and Kate all responded to my ad placed on the Internet and that is how we did their interviews. Informal groups seem to be successful in meeting women’s need to exchange information as well. Josie, Verrian, Simone, Dianne and Meg all met informally with other women who had had an early menopause. Lara had written an open letter to a women’s magazine seeking help. Carly and Susan appeared in a television documentary that they had initiated to raise awareness of early menopause in order to help other young women. And Carly had participated in a feature for a teenage magazine as well. These women did not seek support through the medical system. Indeed, menopause clinics, especially if they were hospital-based, found younger women reluctant to attend (Royal North Shore Hospital: 1997; Marie Stopes House 1996). In other words women rejected the dominance of medical discourses on early menopause and were in the process of reconstructing early menopause through their own dialogue.

This sense of isolation is generated from the departure of early menopause from what medical discourses describe as ‘normal’. The bio-chemical construction of early menopause as singular creates this as a deviant event and marginalizes early-menopausal women from their peers. Emma experienced hot flushes and mood swings when she was fifteen years old and had her early menopause confirmed when she was seventeen by a gynaecologist. He told her that she was a very rare case. Two years later she said this still angered her. She wrote in the Daisy Chain newsletter:

[T]o be alienated like that, to be told you’re not normal. It’s every teenager’s nightmare to be told you’re not normal. ... I slipped into such a deep depression that I can’t remember my nineteenth birthday.

Emma 1997: 22.

Many the women who were interviewed noted how definitions of abnormality estranged them from their social groups of family, peers and friends. In particular teenagers found their experience of early menopause dislocating.

I didn’t get any help for years and years. I was fourteen when my periods stopped and the doctors didn’t know why. When they finally diagnosed a premature menopause I was nearly eighteen. They said I was not normal and I have been devastated ever since. *I don’t feel abnormal* [my italics] but I live in a small town and don’t want anyone to know. Mum has to pick up my prescription [H.R.T.] at the chemist because I’m too embarrassed to go.

Carly.

These vignettes indicate a conundrum where women are simultaneously reliant upon medical discourse to define what is ‘normal’ and what is ‘abnormal’ and yet reject these definitions as inconsistent with their own interpretations. Women find this disconnection between medical definitions of abnormality and their own experiences disconcerting. Thus, at the interactive level between women’s lived experiences and medical discourses there is conflict and unease.

Beck’s (1993) thesis of risk and reflexive modernity accounts for early menopause as a widespread and maleficent consequence of the scientific era. Conversely it explains the paucity of knowledge around early menopause through its construction as rare and naturalistic. Beck proposes that the processes of technology can be hazardous and
threaten individual health. This individualization of risk moves from the centrality of industrial society and acknowledges the autonomy of agency within the constraints of modified industrialization.

Risk is unseen, futuristic and defined by science. Discourses of science are required to determine risk as it is supposed that what is caused by science can only be defined by science. The use of expert knowledge to define risk is used equally to define non-risk and:

... one comes up against the law that so long as risks are not recognized scientifically, they do not exist – at least not legally, medically, technologically, or socially, and thus they are not prevented, treated or compensated for. Beck 1993: 71.

Although women’s experiences indicated that early menopause was not a rare and naturalistic fault this is hidden in scientific discourses that have failed to account for the discourses of women. By allowing only scientific discourses to define health and illness early menopause is lost to scientific definitions as a non-risk. The naturalistic construction of early menopause is unchallenged by dominant discourses and early menopause has not entered the discourses of risk. This exclusion contributes to a cultural non-recognition of early menopause.

Cultural recognition: rejecting medical discourses

This discursive omission was apparent when many of the women who did seek medical verification for their early menopause found that their doctors were unaware that women could experience menopause at a young age. Medical discourses that marginalize other discourses, especially those that are ‘non-scientific’, and fail to take account of embodied experiences have diminished the frequent occurrence of early menopause. Thus medical discourses that construct menopause through to pre-determined life-stages and early menopause as a freak of nature are unprepared for young women’s reports of menopausal symptoms. The young women I interviewed frequently found that their doctors disregarded their stories as they did not fit the chronology of biological determinism. The women repeatedly reported that they were told they were too young to be having menopause.

It was an enforced menopause because of having a hysterectomy. I was thirty-five. I didn’t realize I would have menopause then. It [her hysterectomy] was for C.I.N. III [pre-cancer]. I had had two cone biopsies and you’re only allowed two cone biopsies. By the third one you have to have a hysterectomy. I had no option. And I’d had very, very heavy haemorrhaging before I had the biopsies because that’s part and parcel of the symptoms. I didn’t really want the operation but the doctor told me I had to have it.

I had the operation in August, by the October I was back saying, ‘I’m in the change. I’ve got hot flushes’. The doctor said, ‘That’s
impossible. You’re left with your ovaries. This can’t be. You’re too young. Go away and come back in a year’s time’. I got told, ‘There’s no way. Obviously it will take some time because you’ve still got your ovaries’. I said, ‘No, I want H.R.T.’. I was very determined. I said, ‘I’ve got the change and I’m not prepared to put up with this. I don’t like it’. I was dealing with a G.P. you see. It’s different to the Well Woman Clinic. Anyway he said yes because there was no alternative.

So, I had the test and it showed I was in the change. But I already knew. Then I had a bone density scan and H.R.T. At first it didn’t suit. Then I tried the patches. Now after five years I’ve stopped taking H.R.T. because I just can’t bear the weight problem. I put so much weight on I’ve just given it up for a short time. Renee.

When Renee’s experiences following her hysterectomy differed from the medical information she had received she rejected this knowledge in favour of her own intuitive understandings. Her experience of early menopause was a conglomeration of changes which she gave meaning to and constituted within her own cultural discourses. She negotiated medical discourses around her experiences and incorporated them within her own understandings.

Jenny also constituted early menopause within her own cultural discourses.

*I think that my body's changing* [my emphasis]. The most typical symptom is that I’m very emotional and moody. I feel like bursting into tears. All the typical things that you hear about menopause. I linked that into the changes I have noticed in my body. I get really, really tired. I get physically tired as well as mentally tired. My joints get sore and all the things that older people talk about. I linked it in to menopause because I thought that there had to be something that was changing. It seemed right for some reason or another.

I had a hysterectomy on my fortieth birthday. I was told at the time that there was a very small chance that I might go through an early menopause but that it was unlikely and uncommon [my italics]. I had it [the hysterectomy] because of a medical diagnosis of fibroids and endometriosis. I felt really good for eighteen months afterwards. I don’t remember when I started getting emotional. I just passed it off as being tired. I continued to get a bit of fluid retention. I don’t think I get that anymore. The prospect of going through menopause was not something that I really considered until I thought there must be some reason why I’m this emotional all the time.

I seemed to be sensitive all the time and I seem to get emotional about things that I don’t think are right whether they are right or not. I don’t seem able to work my way through things the way I used to be able to. I feel sometimes that I can’t concentrate as well. I don’t know the word for it – but I’m not always there. Things are happening around me and I know that they are happening around me but I seem to be on
this other planet. I’m just not in the situation and that’s very unsettling. I don’t know why I linked it into menopause, but I just did.

*It has affected how I feel about myself* [my italics]. My new job has given me a lot of extra confidence but because of this [menopause] I’ve actually lost confidence. When things get a little bit out of control, or I think they are, I panic a bit. I try and grab everything together because I feel as if I’m not in control of things. I hate it. There have been instances where I haven’t been tuned into things. I wouldn’t know what I’ve said let alone what anyone else has said so it’s hard to go out and meet people which is what my job is all about. I’m quite an intelligent person and I think, ‘Why can’t I have a normal conversation without forgetting everything’? I guess this is why I linked it to the menopause because I was worried I was going nuts. I had a friend who did have a nervous breakdown when she was young and I can remember saying to John that I hope this isn’t happening to me. And I get so tired. I have to have an afternoon sleep sometimes.

The other thing that’s worrying about it is that I have no reason to be moody or depressed. I have a good relationship, a wonderful life and, a good job. Everything is going well. So why am I moody? So you start to blame yourself because there is nothing else you can blame. It makes it easier to have something else to blame other than myself. It’s good to put a label on it and to think that there’s an end to it eventually. Maybe a couple of years. John said, ‘Will it be over in six months’? and I said, ‘I don’t think so’.

*I thought it was menopause as I tried to piece all these things together – even though it’s earlier than I expected* [my italics]. Hearing all the stories about it I knew that’s what it was. I worked with a lot of older women when I was in my twenties and if one wasn’t having a hot flush another was. And they talked about not concentrating and I’ve read articles about it. *I came to this conclusion myself. I don’t need to go to a doctor* [my emphasis].

I don’t feel anything about menopause really. It’s just something that happens to people. I don’t want to be sick with it. I want to be in control. I think that you can help your body. I have read that some women have problems with menopause but I also know that many don’t. It’s all happened so quickly I have to adjust to it. I did think that my menopause would be normal though. I don’t mind the thought of getting old but I don’t want to be old and stiff and sore. I could think of nothing worse. Some old ladies look wonderful. They’re calm, they’re placid, they’re in touch with themselves, they know what they are about. They might have knobbly hands but that’s O.K. If I can get old like that I don’t mind. Jenny.

Like Jenny and Renee a number of the women rejected the medical construction of early menopause. Some women did not go a doctor at all (Rosalie, Peta, Marie, Fran,
Elaine, Melanie, Joanna, Julia, Pat, Jenny, Meg and Anne). Others did see a doctor but were unhappy with the encounter and cast aside the medical construction of their circumstance (Lily, Josie, Verrian, Simone, Renee, Beth, Dianne, Stephanie, Hilary, Linda, Julie, Martine, Lauris, Bronte, Dana, Lisa, Karen, Terri and Robyn). Other women, particularly adolescents or very young women, continued to see a doctor but expressed dissatisfaction with the need to do this (Carly, Sarah, Shireen, Felicity, Liz, Carole, Kate, Rebecca, Pam and Lara). That is the majority of the women interviewed negotiated medical discourses but constituted their early menopause within their own cultural understandings. Many of the women rejected the medical construction of early menopause as an innate malfunction and contextualized their experiences within the concept of changing bodies. They did not accept scientific knowledge as impenetrable and sought other discourses to break down the barriers of scientific myopia. They modified the relationship between medical discourses and social knowledge by refusing to accept scientific authority as infallible. Thus these women were using their own cultural discourses as a process to reconstruct early menopause.

Conclusion

While many women accepted aspects of medical discourses on early menopause, their experiences were not constrained by them. Each woman’s story was unique and constituted within the diverse narratives of her own cultural context. None of the women had expected to have an early menopause. Yet when it did occur many of the women were able to contextualize this through their own intuitive understandings. Those who sought medical verification found that this took a long time and few of the women were satisfied with the medical process. There was a strong rejection of medical discourse, apparently due to the inconsistencies between the realities of the scientific world and the realities of women. Thus Beck’s (1993) thesis about the impenetrable nature of medical science cannot be wholly supported. Although the medical profession controls the clinical practice, research and training related to early menopause, women challenged this position of power by rejecting the medical diagnosis of disease. In the main the women did not accept medical knowledge as value-neutral. Nor did they accept the personal authority of the doctor.

There was conflict at the level of the medical consultation due to the inconsistencies between the discourses of women and medical science. The denial of medical science to place early menopause as a modern risk meant that in most instances it was unrecognized, at least in the first instance. Thus early-menopausal women were determined by medical discourse as ‘abnormal’, a label women found disturbing and alienating. They preferred to define early menopause through their own intuitive understandings of their changing bodies. They did not find that medical discourses were able to contextualize early menopause adequately and turned to the discourses of other women and the realm of everyday understandings.

The discourses of these women challenged the status quo of medico-scientific discourses of early menopause. They constituted early menopause within discourses that are multidimensional and fluid. Specifically they constructed early menopause as a social interaction and not as a natural female fault. Women’s discourses of early menopause can be presented as a microcosm, a reflection of the rapid changes within the contemporary Western world. These discourses suggest that women’s bodies are changing as a consequence of the technological age and are so interwoven with concepts of fertility, sexuality and subjectivity that these form and are formed by early menopause.
In the following chapters I will locate these themes within the mobility of women’s discourses, ideologies and culture. Firstly, I will juxtapose women’s discourses of their changing sexuality with the pandemic of early menopause brought about by the medical management of the so-called risk of women’s sexuality. Secondly, I will reveal a connection between women’s discourses of fertility and the ‘the commodified body’ (Lupton 1995: 36). And, thirdly, I will explore women’s interpretations of their changing bodies through the dynamic processes of the construction of subjectivity.
Chapter Six

Sexuality and Risk

As a concept, sexuality is incapable of ready containment: it refuses to stay within its predesignated regions, for it seeps across boundaries into areas that are apparently not its own.


Introduction

Sexuality has various meanings. In this chapter I will show how the experience of early menopause changed many women’s constructions of their sexuality. Nearly all of the women I interviewed reported that their sexuality was compromised by early menopause. This occurred through changing sexual desire, sexual response, sexual interest, sexual activity and sexual identity. Most of the women stated that these were altered to some extent. Although this confused and distressed some women, a significant number did not view their shifting sexuality negatively. It appeared that these women were able to reconstruct their sexuality through a movement of diverse discourses.

Several of the women felt that their infertility negated their ‘female’ sexuality. It seemed that sexuality that was not bound to reproductivity was problematic for these women. Others were able to move beyond this reduction and reconstruct their sexuality through their own individuality. Some women reconstructed their sexual identity, sliding in and out of a stretchable spectrum of heterosexuality, androgyny and asexuality. Their diverse and mobile sexual identities accentuated the mismatch between the bipolar construction of sexuality as immutable and the variable experiences of individual women. A number of the women said that they felt that they were not ‘true’ women and described a gradation of gender that incorporated their sexual identity as a shifting concept. In other words these early-menopausal women constituted new and mobile sexual identities through their own discourses of an array of changing sexual dimensions.

Sexuality, social anxiety and reproduction

Over the centuries women’s sexuality has been shrouded in conflict, confusion and containment. It has been constructed through discourses of sexual opposition and committed to concepts of fertility, femininity and heterosexuality. At the same time it has been created as dangerous through its relationship with reproduction. Reproduction is a major social issue that has been valued for its role in providing immortality for human beings as a species (Foucault 1984: 121, 125). The social anxiety around reproduction has been transacted through strictly regulated codes of sexual practice that were developed supposedly with the intention of ensuring healthy offspring (Foucault 1984: 122).

Throughout human history women’s bodies have been treated as especially threatening to the moral and social stability of society [Suleiman 1986]. In particular, female sexuality has been the target of religious and magical practices which have mobilized to restrain women and to provide a surveillance of female reproductive capacity.

Medical and religious social regulation of reproduction has been handed down from “medieval monastic practice” (Turner 1991: 20). This uneasiness over women’s sexuality remains evident today through medical and religious surveillance of the reproductive capacity of women. Social anxiety has been wound into a spiral of institutionalized control and consolidated by the problematization of women’s sexuality through pathology and risk (Beck 1993). Female sexuality that is unrelated to reproduction augments this negativity and underpins women’s confusion when they have an early menopause. The non-reproductive female body has been condemned historically and:

... unproductive sexuality had always been regarded as deviant within the orthodox traditions of Christianity and Judaism.


This construction of non-reproductive women as deviant is apparent within the moral realms of contemporary religion and medicine. For instance contraception is a complex social issue. It is mediated by the church through ambiguous and contradictory discourses, and controlled by the institution of medicine as an arbitrator of moral values. The church condemns abortion as a sin against the unborn, while medicine undertakes ‘safe abortion’ only if the sanity or future fertility of a pregnant woman is endangered. Infertile women are offered spiritual salvation through the church and physical deliverance through the, usually unsuccessful, mechanics of medical technology.

Most of the early-menopausal women I interviewed found that intertwining sexuality with reproduction was inconsistent with their experiences. Only one of the women had a live birth through I.V.F. following her early menopause. Susan, who became menopausal as a teenager, described how her construction of sexuality and its interconnection with reproduction had been produced by cultural and medical discourses. She goes on to explain how she was able to deconstruct this sexuality away from reproduction through the discursive reconstruction of her own experiences and then back to reproduction through her changing body. Susan’s experiences led her to commence the first formal support group for women with an early menopause and versions of her experiences appear in other publications (Hawkridge 1999: 164; Tomlinson 1997: 31; Update 1996).

I felt I had no right to boyfriends and was concerned that any sexual experience with me would be in some way abnormal, so I preferred to avoid any sort of relationship with boys. My upbringing and lack of periods had combined to persuade me that I would be abnormal in personal relationships too, and sexuality was something I had no right to because of my medical condition. On the outside I was outgoing, even flamboyant, yet I shied away from boys, afraid of initiating something that would expose me as a physical ‘fraud’.

I don’t exactly understand what I was afraid of. I only knew that, on some level, I’d read enough about the menopause to feel I had not developed adequately for physical relations. When I met Keith I found someone determined to pursue me, who found me very physically attractive and told me so. I let him believe the packs of
H.R.T. were contraceptives and eventually, after many months of platonic relationship, I took the plunge!

It was almost a shock to find that, to him, I was a normal full-blooded twenty year-old. I had half expected confirmation of my freakishness. After some months I came clean about the little pills. I explained that I didn’t need contraception and my ovaries didn’t work. It was all very low-key. The next surprise was that it made no difference at all. We have been married now ten years.

Having an early menopause left me feeling that I didn’t count; I felt invisible at doctors surgeries, where a doctor would read all my notes and more than once ask what I used for contraception; several times I have resisted the temptation to ask, if my case was indeed so rare and unheard of, why wasn’t anyone taking an interest in me? All this was long before the issue of infertility came up for me. I was and still am angry that a condition that is so distressing is still the subject of abject ignorance, even occasionally, at specialist level. In a country where antenatal care is excellent, one has to wonder why it is hard to get an understanding of premature menopause, and good follow up care.

When I was twenty-six a G.P. asked me if I’d thought about I.V.F. with donor eggs. I hadn’t, because I thought my womb was too small, I said. The next time I saw her she had made enquiries on my behalf. “You can’t put a baby in there” were her unforgettable words. Seven years, and several thousand pounds later, I was able to contradict this statement. Susan.

Although Susan’s experience of having a baby after early menopause was unusual her feelings about her sexuality were not. A number of the women found sexual activity that was unrelated to reproduction problematic. Lauris appeared to relate sexual activity with the capacity for reproduction if not reproduction itself.

I even wonder why we have sex anymore. He had a vasectomy before all this happened and now I’ve had my menopause it just seems a waste of time. Lauris.

Simone’s consternation about the connection between sexuality and reproduction extended to her sexual identity and sexual desire. Moreover, she constructed her sexuality as problematic through risk.

My feelings about not being a total woman were very real in my mind. I had to come to terms with the loss of fertility. I wanted another little boy but at least I had my other children. What did bother me was my loss of sexuality. At the moment I really don’t feel very female at all. I just don’t have any feelings. I’ve lost my libido - it’s pretty devastating. I have lost my confidence as a ‘female’ female. And I don’t feel attractive to my husband anymore.
I was really embarrassed once when he said to his brother that we don’t bother [having sex] anymore because I always have a headache or a tummy ache or something. I thought he doesn’t understand how I feel. I had a total feeling of inadequacy. I was very confused and not able to cope. I became very jealous if he spent time with other women. I couldn’t come to terms with my lack of confidence in myself as a woman. It really did have a dramatic effect on the way I felt. Later I had to give up work because I couldn’t think clearly. I was worried I had brain cancer or something like that.

Simone.

Felicity, who experienced early menopause when she was sixteen years old, expressed the incongruity between discourses that related sexuality directly to reproduction and her sexual ambivalence. She viewed herself as a woman but not within the discourses that confined her to a personal ability to reproduce. She was able to transfer the issue of her infertility away from her sexuality. Her conflict was not with her own construction of sexuality but with the disparity between her sexual identity and the construction of her sexuality through the discourses of others.

I have come to wonder who I am. Obviously I’m not a ‘true’ woman but I still feel female. I have only had periods since I’ve been on H.R.T. and I can never have my own baby. I do dream that one day I might be able to have a baby by I.V.F. but I don’t know if that will be possible.

I haven’t told my boyfriend about my menopause. I feel he would find it so unnatural. We use condoms but we don’t need to - except for A.I.D.S. I mean we don’t need to for contraception. But how can I tell him that I’m not a proper woman. I’m not who he thinks I am and I’m not who anybody thinks I am really. It’s a secret deep inside me that can’t escape.

Felicity.

Felicity went on to explain her struggle with wanting to appear like other women yet acknowledging to herself a difference that she felt would be too alien for others to comprehend. She said she was unable to talk to her friends about her early menopause and although she wanted to tell her partner she felt inhibited by his anticipated response. For instance she admitted that her use of condoms was a charade intended to confirm her boyfriend’s expectations that she was fertile not a protection against sexually transmitted diseases for which they had both tested negative. As she was unable to conceive she did not need contraception but omitted to tell her partner this. This was not an intentional deceit about contraception but implied the deeper issue of a conflict with sexually-specific expectations. She knew her boyfriend would assume she was fertile and she explained that if she told him of her early menopause and consequent infertility this would threaten his idea of her sexuality. In other words her concern was the anomaly between her sexuality and the sexuality others expected of her. She found that she was unable to resolve this issue.

Meg, however, was able to shift her sexual interest away from reproduction thus reconstructing her sexual identity through changing discourses.
Once you’re not reproductive you’re not considered a woman. But I don’t feel that way about myself. I’m very sexual. More so than when I was younger. I think the sexual act is reflective of the differences between men and women. Sex for men is quick and immediate and for women it is slower and deeper. Meg.

I have drawn upon the experiences of Lauris, Simone and Felicity to demonstrate how discourses that connect sexuality with reproduction can be problematic for some early-menopausal women. Another nine of the women had similar stories. Susan and Meg, however, show that women can resist these discourses. They were able to reconstruct their sexuality away from reproduction. Their discursive constructions of their experiences of early menopause indicated an ambivalent relationship between sexuality and reproduction. Twelve other women repeated this transience in sexual identity. This indicated that while some early-menopausal women found the construction that binds sexuality to reproduction initially problematic they were able to reconstruct their own sexuality within more flexible discourses.

**Sins of the flesh: punishment and absolution**

The historical relationship between sexuality and sin was apparent within the narratives of many early-menopausal women. Social anxieties originating from the desire for control over life itself have been constituted within religious and medical discourses that are specific to sexuality, health and risk (Foucault 1984: 125). Certain sexual activities, especially those that deviate from medically-defined norms, have been interpreted as being intrinsically harmful to bodily organs. Thus a relationship between medically unsanctioned sexual activity and pathological disease has developed (Foucault 1984: 16, 97, 98). These ancient concerns appeared in women’s expressions about their experiences. For instance three of the women blamed their early menopause on having an abortion. Sarah viewed her unwanted pregnancy as the result of unauthorized sex and her early menopause as her punishment for having an abortion.

I can’t tell you how angry it made me feel. That damned abortion. The guilt of all women piled onto my shoulders. It’s not as if I even cared for the father. And it was definitely the wrong time for me. But it’s returned to me time and time again since I’ve been infertile.

Of course I’ve blamed it all on the abortion - a punishment for wicked women. If only I’d known. I had one when I was at uni. too. The heartache is enormous but most of all I feel guilty. Sarah.

Sarah’s response seems directly entwined with religious and medical control of sexuality through sin. Although interest in sexual restraint and the relationship between sexuality and evil preceded Christianity it was this doctrine that formally defined the connection between sexuality, sin and death (Foucault 1984: 14). The ‘sins of the flesh’ provided a definition of behaviour, including sexual behaviour, which could be used as a basis for control and restriction of lifestyle by creating a manageable social order (Turner 1991: 20-24). Peta also thought that her early menopause was her ‘punishment’ for having an abortion.
When this grieving came up I grieved for that baby that I had terminated. That’s the first time that I did. It was the first time that I had had any real feelings about it. I thought, ‘That’s my punishment. Now I’ve got menopause because of this termination.’ It wasn’t logical but that’s what was going through my head – that sort of stuff – and general sadness. Peta.

Carole related her sexuality to the non-reproduction of abortion. For instance when she had an early menopause in her thirties shortly after an abortion (a suction curette) she felt sure that:

… it did something to my body. I just never felt the same after that abortion. I had had two previously and felt O.K. but that last one just knocked me. And then to top it all off I got all these menopausal symptoms. Hot flushes, the works. I can tell you I was really stunned when I worked out it was menopause. I knew something was wrong but it took me ages to work it out. I had been to my G.P. and he just said, ‘Don’t worry, this sort of thing is quite common’. Well, I ask you, is it? I mean after a few months I didn’t even have any periods. Ironic isn’t it. I’d put all that effort into not having a baby and now I can’t anyway.

It’s made me feel quite different about myself. I’m not even that interested in sex any more to be truthful. In fact I really couldn’t care if I never had sex again. It has really affected my relationship. I have sex because he wants it but it doesn’t do anything for me. It’s not that glorious thing that it used to be. I just don’t feel the same. I even wonder if I’ll stay in this relationship. Carole.

Another four women discussed abortions they had had at some stage prior to having an early menopause. All were reflective about this to some extent although they had not interpreted their abortions through sin and pathology as had Sarah, Peta and Carole. For instance, Lily said:

… oh yes, and there was an abortion after I had Darren. I had to have a termination because Darren had German measles and my ex-husband carried a genetic deformity and they said because I didn’t have the antibodies in my blood they wouldn’t take the risk. As soon as I found out I was pregnant they took it away. It was like a D. and C. Lily.

Lily interpreted her abortion through the sanction of medical terminology. Her abortion was for the ‘good health’ of herself and the baby and therefore did not appear to be connected to her sexuality or her early menopause as a ‘punishment’ for ‘wrong-doing’. Unsanctioned sexuality, however, came up in Beth’s story about her early menopause. She sought counselling as a consequence of the infertility related to her early menopause.
B: I found therapy almost immediately an enormous help. Just to get the focus right and to get my balance between emotional and rational together. Mainly it was the fact of not mourning my own infertility. I needed to go through that. But I also needed to deal with things from my own childhood. This feeling of lack of worth and failing and feeling that it was always my fault that things were wrong. It was to do with things in my childhood – my relationship with my father – and the fact that I had been sexually abused when I was four.

It’s ridiculous that a professional working in the area should get to forty to realize that this was what actually happened to her when she was four. Because the guy had never actually penetrated me - he used to masturbate on me and masturbate me - I never thought that it was actually – it’s ridiculous isn’t it? I was surprised that I hadn’t actually twigged that this was sexual abuse.

S: How did you feel at the time?

B: What I remember most was curiosity that this happened, that this man could do this. I was frightened of him. He was a guest in our house. My parents were often out. We had a babysitter but she was frightened of this man. And what he did was come and get me out of bed at night and the babysitter would pretend to be asleep and not notice that he was taking me out of the room. And then he would take me to where he said to watch for where my parents would come. He was damn well watching to see that he wasn’t jolly well going to be caught. Then he would stand me on a chair and make me masturbate him until he came. The he’d stroke me – which I liked as well as being revolted by. I was very confused. He used to say that you mustn’t tell your mother because she’d be very angry if she knew you were up so late. And I never did tell her until I came to do this counselling.

And incidents happened - then we went to Australia and there were two boy cousins on the farm playing doctors and nurses - and they hadn’t seen a little girl’s genitals before - and they used to be doctors and look at my genitals and shove little leaves and things up – and one broke inside me and I had to tell my mother because it was hurting me. And she took me to the local hospital where they did a speculum examination. I was only five and it was agony. If course I was the naughty girl. I don’t think my mother thought that but I’m sure the mother of these two little boys thought that I was a little Jezebel leading her innocent boys on and of course this speculum examination was like a punishment. And I had terrible pain because of this.

Then when I was about eight and on a sporting trip for school a couple of boys asked me up to their bedrooms and they would masturbate in front of me. Why did it happen to me? Why did they invite me up
there? They just wanted me to be a spectator. I knew what was going to happen – almost as if it was inevitable.

S: Were you asking ‘why me’ when you were eight or is it now?
B: Well, I wondered why didn’t some of the other girls get invited up. Why was it me? I still don’t know. Was it something about me? An awareness or was it something that made people think I had a sexual curiosity. What was it about the child that made that happen? I thought I was being naughty. I probably shouldn’t be there. It was probably more exciting. Again I didn’t tell my mother. In some ways I wasn’t quite sure what my role was, because on previous occasions I’d been part of what happened.

S: Did this have any effect when you had your own sexual relations?
B: I was very late – possibly as a result of that. I was twenty-six when I went along with a sexual relationship. ... It was a disaster. ... He was using me. All this came out when I had the counselling for my early menopause. I had put these incidents away. I was amazed. The thing is I could talk about it but I put it into a compartment that wasn’t attached to any emotion. Because I’d got those things in a little compartment I didn’t see it as child abuse. It came out in little fits and starts. But I came to acknowledge it and come to terms with it. And made connections with a lot of my behaviour patterns. My ability to keep secrets and also my ability to put uncomfortable things into unemotional compartments and shut them off from myself. So I was able to endure a lot without feeling it. So all that came out with my menopause. The naughty little girl still being punished. I don’t have much of a sexual relationship with Tom - and then there’s the infertility.

Beth’s interpretation of a complex array of experiences, only partly represented here, contributed to the construction of her sexual identity. Her discourses of early menopause appeared almost as a culmination of multifarious happenings that Beth contextualized through her sexual image. Thus, Beth’s connection between her sexuality and early menopause was complex, negative and self-denigrating. However, with counselling she said that she was able to acknowledge the incidents from her childhood and recontextualize the constructions of her sexuality and early menopause. Although Beth still felt sadness she thought she was able to move on from the culpability she has assumed from the manipulation of her sexuality.

I have used the stories of Sarah, Peta, Carole and Beth to exemplify the strength of the historical connection between female sexuality and sin and to show how women can interpret this association through bodily ‘failure and pathology’. These women had interpreted their so-called ‘unsanctioned’ sexual activity directly with having an early menopause. Beth, however, shows how women’s discourses can change and they are able to reinterpret their early menopause by negating the ‘sins of the flesh’ through renewed discourse.

**Sexuality under the knife: disposable organs**
Other women interpreted the so-called dangers of sexuality through their body. This corporeal site was used to express the mortal dangers of sexuality. Some of the women had internalized the construction of their reproductive organs, particularly their uterus and ovaries, as unnecessary, useless or diseased and in need of removal. In this way a few women unintentionally participated in the censure of their sexuality, for instance by accepting surgical removal of their healthy reproductive organs as beneficial. It has been argued that “...the most ardent supporters of hysterectomy among women are those who identify the womb as sinful or dirty or wicked” (Simkin 1996: 33). The discursive construction of the redundancy and pathology of women’s reproductive organs is well-documented (Hufnagel 1989: 47). This condemnation is reported to have originated in misogyny and as a form of social control (Greer 1991: 218-9).

A number of the women described their compromised sexuality after having an early menopause caused by surgery. Often this sexuality was centered upon a woman’s uterus. A paradox appeared where some of the women described their own uterus as diseased and life-threatening, condoned its removal and yet mourned its loss physically, emotionally and spiritually through the changes to their sexuality.

It wasn’t until years later that I could visualize the emptiness left by my uterus. I came to have a feeling of my ovaries as desperate and angry, then sad and dying. And my womanhood, my sexuality, my uterus had all been taken and there was nothing left. I grieved and I understood the pain I had felt was not just a physical pain but my inner being, my spirit if you like, crying for my damaged body.

Robyn.

The changes in sexuality that women report following gynaecological surgery have been portrayed as having a psychological origin (Williams 1987). For instance a prominent gynaecologist who seeks media attention to promote the advantages of removing women’s healthy reproductive organs maintains that women only want to keep their organs for emotional reasons. He suggested to the British Medical Society that women’s healthy ovaries should be removed indiscriminately at hysterectomy and women given H.R.T. carte blanche. This, he says, is because he has:

... no doubt that that oestrogen [H.R.T.] is safer than ovaries [my italics]. ... However, if the patient doesn’t want it [her healthy ovaries removed] – who cares for psychological, sentimental, illogical or irrational [my italics] reasons - then don’t do it. Studd 1994.

As a “… well known ovarian predator” (McKay Hart 1994) this surgeon has been influential in the construction of medical discourse. Yet, as long ago as the early eighties the prevailing theory of the psychogenesis of women’s loss of sexual desire after hysterectomy was debunked. Women were freed from the expectation that their ‘emotional attitudes’ determined their sexual interest (Zussman et al 1981).

The construction that a woman is foolish if she grieves for her lost organs let alone her sexuality, fertility or feelings of womanhood continues to affect medical dialogue and lay constructions as well (Simkin 1996: 33). Yet many of the women interviewed mourned this loss; even women who had suffered excessive menstrual pain and bleeding that had been relieved by hysterectomy.
I’ve had the most dreadful gynae. history from the age of about fifteen when I used to have the most DREADFUL period pains. At eighteen my mother took me to see her gynaecologist and I went to hospital and had my first operation for ovarian cysts. From there on I cannot tell you the amount of D. and Cs I’ve had because of dreadful, painful periods about every two and to three weeks and seven days of feeling ghastly. ...

[Some years later] I had a smear test done and it was negative and we were going away in November and I had a complete check up and that time they found cancerous cells at a microscopic stage. So my gynaecologist said, ‘You come in January and we’ll do a hysterectomy’. I was thirty-two and they whipped me in. He kept the ovaries in and took the womb away and he said everything should be alright now. ... I must say I recovered very quickly but I had no periods and my whole life changed.

To start with I had no more problems. I was healthy and fit and I felt so good. It seemed like it was the best thing that ever happened to me. I didn’t regret it. I thought, ‘Why must we women suffer when they can keep the ovaries in and have the wretched womb taken away’? But it was less than two years later that I discovered that I couldn’t walk as quickly as I used to because I was leaking from the bladder. I was incontinent! I was so EMBARRASSED. I was putting on weight. I couldn’t walk fast. I couldn’t do anything [Oona had been playing squash and generally quite active prior to her hysterectomy]. I was very tired and feeling I couldn’t get through the day. I was sleeping wherever I sat. Because that operation literally drained me, sapped me of all my energy. I was getting terrible black periods. My joints were hurting. I felt terrible pain in my joints.

It passed through my mind that it was menopause. But then I kept thinking, ‘No, I’m too young. This cannot be right. I was too embarrassed to go to my doctor and say, ‘Look I think I’m going through the menopause’. I was only thirty-five and if I was out with my friends I would excuse myself and go out and drink gallons of cold water. At the most ridiculous moments, when you least expect it, you go into this awful sweat. I was throwing my clothes off. I was so hot, and the next thing I’d be cold. I didn’t do anything about it. I always took matters into my own hands, trying to solve things and I kept thinking, ‘We’ll see’. I never take medicines. I never go to the doctor for useless things and I tend to ignore things till it’s too late. I’d just carry on.

But eventually I had to go because of the incontinence. So I had a bladder repair and I had to go on H.R.T. They said they put me on it because of that operation. They said it would help me a bit. It goes back to when I had the hysterectomy. I used to get hot flushes and terrible headaches. When I went on the H.R.T. I was told it will make
you feel sexy. I think that’s a lot of nonsense. It did make me feel better but I didn’t want to run off to bed with the first – you know. It’s such a lot of nonsense. I think it’s how your mind interprets things. I never, ever was a frivolous person before. I must have been moral I think – or it’s the way you are. But I did feel different after the hysterectomy. Not as sexual. It made me feel sad. Part of my life had changed and it’s never come back. I guess that’s what happens when you take that part of you that is a woman away. Oona.

The medical construction of the psychological origin of loss of sexual interest and enjoyment following hysterectomy is based on the assumption that women’s ovaries, cervix and uterus have little physical or hormonal connection with her libido or sexual enjoyment. It has been assumed that if physical factors alone were responsible for these changes then all women would experience them. These arguments have been refuted and in addition to any psychological assault, biological and chemical reasons for decreased libido and sexual satisfaction after hysterectomy have been acknowledged (Hufnagel 1989: 85-90). Discourses of lost libido and sexual enjoyment after hysterectomy now have been extended beyond the simple approach of looking at psychological causes. There is some acceptance that a woman’s uterine hormones and the physical response of her uterus and cervix during orgasm can affect the sexual pleasure of some women.

Your uterus serves as a receptor site for estrogen [sic] and progesterone and works as a feedback mechanism with the pituitary gland. The loss of your uterus disrupts the production and circulation of these hormones. In fact, one recent study shows that the uterus manufactures and releases estrogen [sic], just as the ovaries do. Hufnagel 1989: 85.

This assault has motivated some hysterectomized women in the United Kingdom to ‘Campaign Against Hystrectomy and Unnecessary Operations on Women’ and to bring gynaecological procedures under statutory control. The founder of this charity maintains that “… sex is the main casualty of hysterectomy” (Simkin 1996: 25). She goes on to say:

Female sexual response then is dependent upon the presence of the cervix and the vagina – the very organs which gynaecologists tell us we will not miss if they are removed. Female orgasm is not an optional extra for most women – indeed, it is what is most sought after in sex. Without orgasm neither man nor woman finds there is much point to sex, and this is often the focus of problems in relationships. Womb and ovaries govern female sexual desire. They define women as sexual beings and prescribe sex and sexual relations because it is the secretion of hormones which creates libido and sexual functioning. ...


Although this approach may accentuate the bio-chemical, it nevertheless demonstrates women’s resistances to the dominance of medical discourses. Women in this organization are active lobbyists intent on changing discourses around hysterectomy. Lauris, Robyn, Jenny, Angie and Jackie all belonged to this charity. Thus these women
were in the process of renegotiating medical discourses through the reconstructed dialogue of their own experiences of early menopause.

Nearly one third of the women I interviewed had had some kind of gynaecological surgery prior to having an early menopause. Most of these women volunteered that their enthusiasm for sexual activity had decreased after surgery, especially hysterectomy, and that the intensity and pleasure of intercourse were decreased as well. Researchers have noted that both a woman’s cervix and her uterus are sexual participators. During penetrative heterosexual activity a man’s penis pushes repeatedly on a woman’s cervix, rocking her uterus and the supporting broad ligaments and peritoneal membrane. Many women find this stimulating and can achieve an orgasm through this action. During orgasm a woman’s uterus and supporting muscles contract, as well as some of her vaginal muscles, heightening her pleasure (Zussman et al 1981: 725-727). This action aids conception as the cervix dips into the vagina at orgasm so assisting the transportation of sperm into a woman’s uterus. The removal of a woman’s uterus and cervix at hysterectomy can remove a source of orgasm as well. Even if a woman does have an orgasm through clitoral stimulation her broad ligaments which are detached, scarred over and which have lost elasticity may still contract. This may explain why Angie experienced pain at orgasm, not pleasure.

I became afraid of participating in sex. It took a long time for me to respond and when I did have an orgasm it was painful. I could still feel the pain the next day.

Angie.

Contributing to this potentially diminished sexual satisfaction is a decrease in the blood flow and elasticity of the cellular tissue of a woman’s clitoris, vaginal walls and breasts, which become thin and shrink. Sensitivity is reduced through lack of responsiveness of the nerves. This is due to the drop in the level of oestrogen that is directed specifically to a woman’s reproductive organs. Many of the women noticed a dry vagina, which is part of this process. Medical discourses consistently cite vaginal dryness as a primary aspect of oestrogen depletion (Stoppard 1994: 50, 90). This is an important contributor to decreased sexual comfort and enjoyment. It relates directly to male sexual enjoyment as well. This male connection may explain the prominence of attention given to vaginal dryness. Rarely mentioned is the, often dramatic, decrease in a woman’s sexual pleasure through the removal of her organs and the impact this has on her entire being.

I suppose it didn’t happen overnight but it was so dramatic it might as well have. Basically after the hysterectomy I completely lost interest in sex - in all ways. I stopped thinking of myself as sexual. You know I just didn’t feel interested in men anymore. Of course I still have sex with Ben but it is pretty routine. He noticed it too. But we sort of muddle along. What I mean is how I feel different about myself. You know if I meet an attractive man now there is no spark. I’ve always been a bit of a party animal and it was fun – you know to flirt and such. Of course my figure’s gone all dumpy too so I don’t feel good about my body. It’s like part of me has just disappeared. ...

You know I didn’t think about it until just then – when I said that. As if my uterus was my sexuality and they went in the bin together.
The stories of Robyn, Oona, Angie and Jackie indicate the complex interconnection between (hetero)sexuality and surgery. Their stories were not isolated. Nine of the women I interviewed who had had a hysterectomy and three women who had had a tubal sterilization prior to early menopause felt that their sexuality had been compromised by surgery.

Reinterpreting biology: changing sensitivities

Even women who had not had surgery or other incidents before having an early menopause found their sexuality changing. Women’s expressions of their sexuality incorporated their libido, relationships, attraction, activity and identity. The women interviewed commonly reported decreased or absent sexual desire that they related to their experience of early menopause. This appeared to be due to the complex interaction between decreased sex hormones, changes in self-identity, changes in relationships, decreased sexual sensitivity and the physical discomfort of penetrative sex.

In an effort to find a single quantifiable cause for decreased libido after menopause and gynaecological surgery medical science first isolated the hormone oestrogen. This hormone, it was claimed, was essential to female sexuality. Thus, the construction that a decrease or loss of oestrogen would negate a woman’s sexuality appeared. This sexuality was defined as the desire for heterosexual activity. Medical experiments giving selected women exogenous oestrogen, however, did little to improve the libido of these women. Focus turned to the so-called male sex hormone testosterone. The absence or decrease in this hormone currently is presented as the primary reason women’s sexual desire may diminish after menopause or surgery (Stoppard 1994: 182).

However, even testosterone supplements do not necessarily restore women’s libido in these circumstances as sexual desire is far more complex than just one hormone. For instance the hormone progesterone influences libido as well. When this is dominant it can cause both depression and decreased libido and, according to animal experiments, loss of interest by males (Grant 1995: 90-93). Some of the women’s stories reflected the possibility of this occurring. For instance Simone had been in a sexually-active and happy relationship for many years. After her early menopause she said that this changed.

The loss of femininity bothered me. I’ve got these lines on my face and some hair on my face. At the time it was a problem. I really don’t feel very female at the moment [my italics]. When I was going through the low point I really didn’t feel like a female at all. I just had no feelings. I was pretty devastated. It was the whole way I felt, not just libido [my italics]. I became very possessive of my husband. I lost my confidence and blamed him for that if he talked to someone else. I thought I wasn’t attractive to him anymore which caused an enormous emotional problem [my italics].

When I used to get depressed about things it was so out of character. I couldn’t cope. I begged my husband to try and understand the way I felt, but I couldn’t understand myself the way I felt. He was more demanding wanting to have sex and I was trying to explain that this is
not me. This is someone else, could you please help me get through this. I don’t understand it myself, try and help me get through it. It was very difficult for him to come to terms with that because here was this person who was very capable, now was this crying incapable person. I didn’t understand myself. I found it very, very frustrating. I couldn’t cope with the change with myself. Simone.

Simone’s story shows her sexuality as a complex, multidimensional and fluid interaction that included her sexual attractiveness. Moreover, Simone had constructed her sexuality and femininity around her bio-chemistry which she thought was indefatigable.

But I felt that I had this ovary that was going to keep me female. A portion of it was enough; it would go on forever. They said the little bit of ovary would be enough. But I was having problems with the way I felt. I didn’t really understand menopause. I understood that because I had lost most of my ovaries I was feeling like that. I went to see my G.P. [sic] and she ordered some blood tests. She told me that my husband had more female hormones than I did. That I was zero, zilch. I was minus something. Simone.

Like Simone a number of the other women were confused by the changes to their sexuality. Nearly all of the women commented that their feelings about their sexuality had changed. Younger women who had not been sexually active prior to having an early menopause felt excluded when their friends spoke about their sexual forays. Although most of the younger women eventually became sexually active and some found partners it appeared that this occurred a little more slowly than for their non-menopausal peers.

These responses appeared to be influenced by the perception each woman had of her own situation within age norms. For instance the knowledge that their peers were hetero-sexually active affected early-menopausal teenagers. None of the women who became menopausal as adolescents had been sexually active prior to having an early menopause. All had hetero-sexual relationships when they were older but described themselves as later than their friends. This finding is consistent with Neugarten’s (1996) suggestion that if a person is earlier than their peers to reach one age norm then they will be late for the next, and vice versa.

Older women spoke of loss of interest in sex, decreased intensity or absent orgasm, insecure feelings about their relationships and a difference in their sexual identity. When this array of circumstances was added to lowered self-esteem and poor body image this did little to increase women’s enjoyment of sexual activity. Most of the women related these changes in their sexuality to their early menopause.

The complex interaction of the different dimensions of sexuality and the impact on these by an early menopause could be quite dramatic. For instance Lisa’s E-mail response said:

It’s a long story but I ended up having a hysterectomy and one ovary removed at age twenty five. Two years later I had to have the other ovary removed and have been on H.R.T. ever since. I have had at least six doctors since trying to regulate my estrogen level (once they tried ‘Estratest’ – estrogen with testosterone – which gave me cystic acne). My doses have been raised and lowered, raised and lowered ...
I am now thirty and have been miserable for the past five years. I have developed hypothyroidism ... Anyhow – basically I’m told that I should be ‘just fine’ with the doses of estrogen I’m receiving (1.25mg) and I believe that due to my age, I should be receiving a higher dose. I know that they have guidelines for how much estrogen should be in your system while on H.R.T., but it is a proven fact that younger women have higher doses than this guideline ... doctors don’t seem to get that. My endocrinologist has just started to give me testosterone injections every two weeks. Hopefully it will help and not give me acne again.

Anyway – here’s what happened to me after the first operation (one ovary and uterus removed without knowing at the time that my remaining ovary was in severe distress from adhesions). I became totally manic. I did things like wash the car at three in the morning. I became extremely upset or angry over the smallest things. I couldn’t stand to be home or to sit still. I was obnoxious and insensitive. Sometimes I would be so depressed over nothing that I would not leave my room for days on end or cry in the middle of the grocery store.

*My sex drive was completely gone* [my italics]. I felt like a little kid on the subject. The thought never crossed my mind and whenever my husband ‘got the idea’ I either became angry or cried.

Then I had the other ovary removed. I weighed one hundred and five pounds when I had the surgery. Without changing my diet or lifestyle I gained forty pounds in six months. No joking. The doctors would not believe me that my diet and lifestyle hadn’t changed ... actually if anything I was more active because I wasn’t in pain anymore [from endometriosis].

*My sex drive still has not returned* [my italics]. In all honesty if I never were to have sex again I would never miss it. ... *I feel unsexual* [my italics]. My husband is extremely patient but I cannot expect him to go on without him feeling ‘desirable’ to me. In fact I do love him but sex just doesn’t cross my mind. The truth is I do love my husband and I don’t have sexual feelings or thoughts about ANYONE. I have been in a relationship before where I got ‘bored’ with the other person but I still had sexual thoughts about other people.

Also in respect of the my other problems (the cyctocele and all else) .. it has been so long [six years] that sex has not felt good, that I doubt that I will ever get a sex drive back. Despite being on testosterone, I have had no increase in sex drive at all. It feels extremely ‘imposing’ when I try to act like I want sex (for my husband’s sake) and it all seems like a whole lot of work for very little reward. It takes a very
long time to achieve an orgasm and then it is so miniscule that it’s a disappointment. I’d much rather have a back rub. Lisa.

Other women described how their relationships were important to sexual desire and enjoyment as well. Pam had early menopause when she was forty-one and had just been treated for breast cancer. Her story shows how she was able to resist and reinterpret negative discourses around her sexuality.

The fact of menopause itself then at that time was not such a big issue as there were other things emotionally important to me going on at the time.

However, there was a temporary sexual and unexpected set back. My partner (I was in such a destructive, interdependent relationship that the doctors and psychiatrists believed I was untreatable until we were apart) responded to the doctors request and lived separately from me but remained solidly supportive. He was the most gentle and supportive person while I was sick and dependent on him. He felt so tender towards me that our wonderfully energetic sex life (with volatile personal relationship) slowed down. He was affectionate, caring – we were not so volatile and he said sex was difficult between us as he didn’t want to hurt me. He saw me as fragile and breakable. I put it down to having gone menopausal and was beside myself until I caught him out for the first time with another woman.

THEN, I was in my mind a dried up, sexless menopausal woman. Yet this was wrong. I was never dry or uninterested in sex. Then I found a new lover ten years my junior. I realized my previous problem was in my ex-partner’s mind and not my own. My new lover didn’t believe my age, my cancer story and was not put off by the proof. So from then on my sexual adventures continued happily. Some years later a new man found me ‘dry’. I was. I was mortified and resorted to K.Y. I thought perhaps I survived those years because I was on the plump side and prone to producing enough oestrogen and moisture and now at forty-nine my ‘dry’ time had come. The problem was resolved, however, when we amicably parted and I found a caring man with the most loving and caring love-making techniques and I laugh now at thinking about using K.Y. Sexually I am competent, that despite myself, no matter how tired or stressed I am that body of mine wants to get its multiple or long-lasting orgasms, whether I want to go to sleep or not – and it occurs each and every time. I wouldn’t want to be twenty again, anxious that I won’t make it in time or have an orgasm at all. Pam.

Some of the women found their changing sexual identity was bound into other aspects of their lives. For instance Joanna went through a transition of welcoming an early menopause but found the side-effects worse than she expected and became almost indifferent to her sexuality.
I was glad when my periods stopped. I welcomed the menopause. I was sick of contraception. I was sick of periods. I was sick of always feeling ‘yuk’. I really welcomed it until my astonishment I felt worse and that was a big shock. I felt the most drained of energy that I’ve ever felt in my life. Getting up in the morning was such an effort. I had to drag myself out of bed. I wanted to get up. I can’t say I’ve ever been depressed because I haven’t. It was general lack of – well, nothing, no up and down. It’s that middle thing that I’m not happy with. The hot flushes were terrible. I hated those. I realized that I’ve not actually slept properly for a year. No wonder I’m tired. If I’ve not a whole had a whole night’s sleep for year no wonder I’m physically and emotionally exhausted.

So it’s been an odd thing with the menopause. On the one hand wanting it to happen and I think possibly even willing it to the reality of when you’re really in it thinking, ‘Oh, my God. This is horrible. This is not how I thought it would be’. I thought it would be a liberating experience, but actually it’s ghastly.

Femininity must be an issue for me as I feel totally unfeminine now. Another thing that is an issue for me is that I completely switched off sex. I am just not interested. I was very, very sexually orientated. Sex was a very important part of my life and now it’s completely gone which is odd. That’s liberating on one level. I was going out with someone. I stopped the relationship. There was no point. He needed it but I didn’t. I am very glad I’m not with somebody. Actually I couldn’t have coped.

I have been disappointed that the menopause is so bad. The aging doesn’t worry me. My skin’s been appalling. The worst it’s ever been. I didn’t get teenage spots. It’s a bit odd at this age. I don’t know what my skin’s doing from one day to the next. I’m assuming I’ll grow out of it.

I am totally emotionless. It’s weird. It’s not like me. I’m normally up and down. To have this kind of nothing is peculiar. It is quite monotonous to live with. I liked the way Germaine Greer wrote about how it’s a growing thing. I was traumatized about getting pregnant again. It’s just as well I’ve gone off sex. It’s very important for me to have my children but I don’t want any more.

When my doctor told me if I took H.R.T. I would look like Joan Collins I was horror struck. I don’t want to look like her; she’s a floosie. You grow out of all that. If I have to care about being that glamorous it would be awful. Not that I want to be in twin sets and pearls either.
I am not interested in sex at the moment. I would rather be with my friends. This isn’t madness it’s getting in touch with yourself. Some of the feedback I’ve been getting back from my friends is that I’m more direct. But I just don’t care. I feel more comfortable with myself. Joanna.

Simone, Lisa, Pam and Joanna, as well as many of the other women had different stories to tell of the changes within their sexuality. Desire, interest, enjoyment and identity were all bound together intrinsically with each effecting the other. Not only did most of the women suggest that their sexuality changed with early menopause but a number of the women expressed this as a continuing change. For some, like Pam, this movement culminated in sexual enjoyment; for other women their changing bodies led to a changing sexual identity.

**Sexual ambiguity and androgyny: the dilemma of dichotomous sexuality**

Even though the early-menopausal women I interviewed questioned their sexual identity many were able to reposition this identity through the concept of gender. They were aware that they were unable to reproduce but nevertheless identified themselves as heterosexual women. In other words they modified their sexual identity away from absolute sexual difference but still situated themselves within this difference. Although many of the women expressed the view that they felt that they were no longer ‘true’ women or identified a masculine element to their sexuality not one of the women thought of herself as male. Thus, these early-menopausal women identified their sexuality through the mobility of gender. Contemporary writings situate the menopausal woman within an expandable and fluctuating philosophy of sexual difference (Lupton 1994: 143-4). Fraser (1997: 180) articulates this within a feminist critique of “multiple intersecting differences”. Three of the women described their sexual ambiguity even before their early menopause.

I always thought I was meant to be a boy so the thought of losing my uterus didn’t matter. I had enjoyed giving birth and being a mother but I always felt that my uterus wasn’t meant to be there. Nicole.

It’s strange because I had always thought of myself as quite masculine sexually. I have always been the one who does the chasing, the one in control and I’ve had a great sexual appetite. I never wanted children. I could never visualize myself with a child. I’ve had two abortions so I know what it feels like to be pregnant. But funnily enough now that I can’t, with this menopause thing, I’ve even tried I.V.F. But it hasn’t worked and I’m not even going to even contemplate it anymore.

Sarah.

I have never felt really feminine. I’m not the tizzy type. I work in a girls’ school with nearly all female staff and I like women and get on with them. But as I said before I’m not a traditional woman. I have never thought of having children. It just doesn’t interest me. Marie.
These women suggested that their sexual identities were not bound to ritualized sexual difference. They articulated differences within this difference. This form of sexual identity could be aligned with a sexual continuum that places individuals along an uninterrupted gradation of multiple sexes. But early-menopausal women’s narratives constructed more than this; they constructed their sexuality through a state of constant flux. There is continuous debate within the realms of biology and the humanities on the structure of sexuality (Brown 1999: 15). For instance:

The principle of multivariate sequential determinism is the ultimate and absolutely imperative foundation of any trustworthy theory of the development of human sexuality. Among contemporary theorists, this principle is violated more often than it is obeyed. With ontological single-mindedness of purpose, people all too often follow a reductionist dogma. Theoretically they reduce the origins and development of human sexuality to a single and usually abstrusely defined determinant which typically belongs on one side or the other of the obsolete nature nurture fence. Foolishly, they juxtapose biology against the socioculturally acquired or learned, unmindful of the fact that there is a biology of learning and memory, mostly as yet undiscovered. Like the heredity environment protagonists, they wrongly equate the biological with the fixed and preordained, and the sociocultural with the unfixed and optional. Money in Greer 1999: 155-156.

The narratives of the women interviewed moved beyond the sequential interactive position between biology and culture suggested by Money (1988), Greer (1999) and Orbach (1997). They rejected any kind of progression in sexuality but rather displayed a highly variable sexual identity that defied the constraints of sexuality as a continuum. These early-menopausal women did not appear to have a distinct and quantifiable sexual dimension. Neither was their sexuality individually consistent but oscillated and changed within intangible dimensions of sexual ambiguity. Just as the sexual identity of many of the women I interviewed was modified by biology I have discussed already how sexual identity can affect biology. This was not linear or the result of a distinct two-way interaction. It was the discursive construction of changing and elastic bodies (Grosz 1994) constituted within the oscillating discourses of sexual identity.

For instance Lily described how she had expected to lose her sexuality at menopause. She found the reverse. She also found that her ability to earn more money than her partner led to their break up as “... it took away his manhood” (Lily).

It’s funny saying that because I feel more – well not actually sexy, but I can relate better now than I could then. Whether that’s because I wasn’t happy in my marriage and it was more an emotional thing I don’t know. Maybe I was rejecting him. But I’ve been on my own now for six years and had a couple of relationships. Sexual experiences grow with each one. My husband didn’t want to know me when I had a period so it’s good now I can rely on that not coming. Always from the very beginning I’ve suffered with heavy periods and
pains and since I’ve had the change the pains have stopped. And I can’t fall pregnant. I’m glad I don’t have to worry about that.

The first thing I thought when I got it [menopause] early was, ‘Thank Christ I had my kids early because I wouldn’t have stood a chance now’. Motherhood was everything to me. It was total – I breathed it, drank it – they always came first. Now I’m finding I’m getting my sexuality back. I know it sounds silly but I’m taking more pride when I go out. I know nobody sees it but if I’ve got nice lingerie on I feel nice. Before I always had grotty knickers. Now my periods have stopped it’s one less hassle I have to think about. I’m still the person I am regardless of whether I’m having periods or not. If you’ve got peace of mind over that, you’ve got peace of mind over other things. Because I always had heavy periods it was so messy. Now I get more aroused. Obviously everyone’s hormones are different. Nobody is the same so we shouldn’t be treated as a textbook. But for me – I feel sexually - the freedom’s there now. I thought I was going to have those blooming periods until I was fifty so I’ve turned it to my advantage. It’s lucky that I’ve been able to do that. Lily.

Robyn described an even more contrary sexuality.

I don’t really feel feminine but I don’t feel masculine either. It’s more like neutral – I don’t seem to have the energy at the moment – I mean to be really feminine. I just don’t feel sexual. But there are times when I do. Sometimes I feel quite energetic and go looking for it. I don’t feel it’s masculine but I feel strong then. Right now I couldn’t care less. I don’t want to be cute and weak either and have my partner smother me. I guess this [menopause] has made me more aware of who I am and not worrying so much about how other people feel. Especially in relation to sex. I think I grew up with some sort of expectation of sex as a fun thing to do – as if it was always like that – and that you had to do it. But quite honestly although it was a big part of my life it isn’t any more. I am more concerned with who I am in my own right not as attached to someone. Women’s sexuality is so often tied to who their partner is. I don’t feel like that anymore. I just want to be me.

Robyn.

Josie constructed her sexuality as fluctuating despite describing her preference for sameness.

It occurred to me that I was menopausal when I was twenty-five. It really didn’t bother me. It’s quite nice not having periods. I thought it was wonderful. No more worries. I had my first child when I was eighteen and the next twenty months later. Ever since I was a child I was only ever going to have two children, raise them and get rid of
them. I’m a very logical, methodical person so it didn’t bother me at all.

I’m on H.R.T. now. My G.P. said I’ll get osteoporosis if I don’t go on it. But I wouldn’t mind coming off it. I’d rather not be bleeding each month now and I don’t really know if I’m going to benefit from it. There must be other things that would help. I could go into a health food shop but I wouldn’t know what I was looking for. Considering breast cancer is a side-effect I’m surprised they don’t offer more screening – the N.H.S. [National Health Service] won’t give it to you under forty. But I insisted and now they won’t do it again for another five years.

A girl at work said it will help your sex life but it hasn’t made any difference. We had a good sex life. But Ed works all over the country so he’s quite often away. He works seven days a week. He works long hours so we might only pass each other in the bathroom at eleven o’clock at night. This last year has been very, very busy so we’ve actually seen very little of each other. Sometimes when I’m so busy I wish he’d go away but when he does I miss him. I do get jealous. For about six months I went through a stage of wearing skirts shorter than I’d normally wear and different make-up. But I got over that. If I wasn’t working I’d probably become obsessed.

I’ve got some very close friends at work. We see each other outside as well. It’s just lovely. I think the traditional role of the woman has changed. Neighbours were in and out of each other’s houses at all hours of the day and night and they had a support network. Your friends and family who lived close by. But now people’s doors are closed because of crime. Like the role of the woman has changed. Women have identified themselves and decided that they have the right to work and what you used to get from your friends and neighbours you actually get that at work now. I think family commitment has basically gone now.

I’ve never been out of work. I don’t see it as my husband’s role to provide for the family. I see it as my problem to at least assist in supporting the children and I don’t mean doing the washing and ironing. The same as I expect him to support me emotionally. Just because I’m their mother I can’t meet all their needs. I never define a role as being a woman’s or another as being a man’s. And my husband feels the same way.

Sexually I have been a bit up and down even though I like things to be the same. Right now I’m too tired to care but I like to feel sexual. I want it to be even between me and Ed. I want us both to be able to initiate it and enjoy it the same. But lately we haven’t had much to be honest. Maybe I’m a bit changeable. Not like me really. I’m so reliable usually.
Lately I’ve been wondering about where I’m at sexually. I used to be crazy about Ed but I’m all over the place now. I guess the menopause did make me feel different. In one way it was liberating but sex is different because I’m different. I wish I could put my finger on it because I like order. I don’t like all this changeable feeling. I don’t want to do the short-skirt thing anymore but I don’t really know what it is that I do want. Josie.

Ambiguity, androgyny and asexuality were recurring themes that arose during the interviews but these did not always trouble early-menopausal women. When it did this was due to the discord between a woman’s interpretations of her sexuality as indistinct and transitory and the pervasive construction of women as sexually specific. This sometimes resulted in anxiety about the perceptions of others and some of the women suggested that it emerged as a threat to relationships. For instance Shireen, who had her early menopause as a teenager, said that in her early twenties she found her partner’s expectations of her sexuality differed from her own. She said she didn’t feel like other girls and thought her partner tried to stereotype her into his expectations of a woman’s sexuality.

Other women found their experience of early menopause was incongruous with the construction of women as a reproductive body. For instance Fran’s reaction indicated that her sexual identity was aligned with menstruation and reproduction.

I want to know if I’m a woman or not. What am I now if I’m not a woman? A woman menstruates. She has a cycle. I have nothing. I can’t even have children. Fran.

Women who appeared to be least affected by the confusion early menopause places upon the dominant constructions of sexual duality were confident in their sexuality as part of a shifting spectrum. Their sexuality spanned their whole being and did not relate to the specifics of reproduction or to heterosexual intercourse.

Conclusion

Although the majority of the women I interviewed experienced changes in their sexuality this did not occur uniformly. Compromised sexuality differed between women. A number of the women found that their sexuality undulated and expanded through a mobile and multidimensional construction. Others found their sexuality problematic especially when this had been constructed through an inflexible sexual opposition. The spiritual, emotional, intellectual and physical shifts that often accompanied early menopause appeared to threaten this stereotypical sexuality.

The relationship between sexuality and risk was entwined with women’s narratives of their early menopause. Three of the women considered early menopause a punishment for previous abortions. In other words these women had constructed their sexuality as unsanctioned and therefore a health ‘risk’. Nearly half (twenty three) of the women I interviewed had had early menopause following gynaecological surgery. Many of these women had absorbed the medical construction of their sexual organs as diseased, unnecessary or placing their owners at ‘risk’. This ‘risk’ of women’s own sexuality not only changed women’s bodies through early menopause but also changed their sexuality.
Significantly, after their experiences of early menopause and changing sexuality, five of these women joined an organization aimed at reconstructing discourses of the so-called dangers of women’s sexuality.

Static constructions of sexuality were inconsistent with women’s varied experiences of early menopause. This was confusing for women who had internalized concepts of sexuality as being specifically ‘feminine’ or ‘masculine’. They found that their bodily experiences of having an early menopause compromised fixed ideas of sexuality and many of the women found their sexual identity continually shifting. Infertility, absence of menstruation, diminished libido and orgasm, pain at intercourse, weight gain associated with poor body image were all physical dimensions of sexuality associated with an early menopause. Thus the construction of early-menopausal women through absolute sexual opposition was enigmatic. It appeared that for many women the construction of sexuality as static, linear and predictable did not relate to their experiences of mobility within sexuality. These women reconstructed their sexuality as dynamic, context-related and ambiguous.

Chapter Seven

Fertility and Consumption

Both woman and femininity are cultural creations. The concept ‘woman’, like any other concept, does not correspond to something in the world. The word ‘woman’ does not have one referent; rather it is set up in a network of other concepts, for example, femininity and maternity. In Western culture woman has been identified with both femininity and maternity. Oliver 1995: 132.

Introduction

Woven through the fabric of history is the construction of women as inter-related with the concepts of fertility, femininity and motherhood. In this chapter I will use the narratives of early-menopausal women to express individual perspectives of these concepts. Although the meaning of having an early menopause differed for each of the women interviewed infertility seemed to prompt the most poignant response of all. Constructions of fertility, femininity and reproduction have differed throughout history appearing in the late twentieth century as a spectrum of varied and contradictory discourses. The dominance of medic-scientific constructions of women and their relationship with fertility and reproduction has been contested by other discourses such as sociology, feminism, philosophy and anthropology (Oakley 1984; McNay 1994; Grosz 1994; and Martin 1987). These discourses have deconstructed scientific discourses that reduce women to the biological pre-determinism of reproduction and reconstructive dialogues have altered the constitution of contemporary women. Neither these ontological nor the biological constructions of fertility and reproduction could be disengaged from the individual experiences of early-menopausal women.
I do not think any sexed identity escapes contamination by those dominant discourses which privilege heterosexuality and subsume women under a general category as man’s other and as potential, actual or failed mothers. Diprose 1994: xi.

The infertility of an early menopause did not concern all of the women interviewed. Some of the women had decided that they did not wish to have children; or were unable to become pregnant before they were aware that they were having an early menopause and had accepted their infertility with equanimity. Others already had a child or children and did not want further pregnancies. Several had confronted issues of infertility prior to having an early menopause and had chosen permanent contraception such as tubal sterilization. Many had faced the inevitable infertility of hysterectomy. However, the early-menopausal women who wished to have their own baby or more children found their infertility heart breaking.

When the blood test confirmed what I already suspected it was like a lump of ice going down inside me. It was a certificate that said it’s over really; that bit of paper.

A death certificate!

This is it – your dreams of having a baby are gone, signed and sealed.

I hadn’t emotionally accepted my childlessness. This terrific bereavement of not being able to have my own children had to be dealt with. What I still grieve about is that I was not able to go through the experience that I feel all women should be entitled to if they are women; the experience of being pregnant and giving birth.

I feel that it’s a role you’re reminded of by every blinking mum. I had the most excruciating periods through adolescence and was told, ‘Never mind it’s worth bearing because one day you’ll have a baby and it will get less. This is to do with your female function’. It seems so grossly unfair that I’d put up with all this agony for all these years because this great prize was going to be given to me at the end. I was going to have this baby to compensate. But of course it never materialized.

But you fantasize about the children that you might have had. Have you ever read Charles Lamb’s ‘Dream Children?’ He never had children and he was in love with somebody who married someone else. He dreams about the children that he might have had with this woman called Alice. I used to know the quotation by heart: we are not of thee, nor are we children at all, but dreams and must wait upon the tedious shores between millions of ages, before the existence of May. It’s that feeling of time. It’s gone. Beth.

The fertility fraud: deceiving women

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Early-menopausal women are unable to have a baby of their own. Some women have no eggs or follicles; others have no uterus. Sometimes women are born without a uterus and other women have their uterus removed at hysterectomy. Now and then women are born without ovaries, or they have nonfunctional ovarian vestiges. And occasionally women’s hormone production is so disrupted that women are permanently unable to ovulate. Whatever reason once a woman is completely menopausal she is unable to become pregnant using her own egg.

Twenty-eight of the women interviewed had children and twenty-two women had no children. By banding the women into cohorts through decades interesting patterns could be identified.

Seven of the eight women who had menopause as a teenager had no children. One woman had a child after menopause through I.V.F. treatment. Her later attempt at I.V.F. was unsuccessful, as were all three attempts by another woman. Three other women said they would like to try I.V.F. later and another said she was attracted to men who had children.

All of the five women who had menopause in their twenties had given birth to their own child or children prior to having an early menopause.

Twelve of the twenty-two women who had menopause in their thirties had children and ten were childless. Five of the latter group had delayed childbirth as they had assumed that childbirth would remain a viable option for them into their forties. Four women had had abortions and two of these women thought that having an abortion caused their early menopause. Two had had unsuccessful I.V.F. treatments. One woman who had children adopted another after she had menopause.

Eight of the fifteen women who were over forty at the time of their menopause had their own children. Two others had adopted children, one after unsuccessful I.V.F. treatments. Another had a partner with children and another had attempted to have a child using I.V.F. The remaining three women commented that they had never wanted to have children. One of these women had had an abortion and a tubal ligation.

A broad comment can be made about this group of women: those who had their menopause under the age of twenty were unlikely to have a child of their own; and the younger that women over the age of twenty years had an early menopause the more likely they were to have their own children. This latter finding was surprising as in contemporary Western societies it appears that more women are having their first child when they are in their thirties than in previous generations. Thus, as mothers this group of early-menopausal women sat outside the age norms of their peers.

<table>
<thead>
<tr>
<th>Age at menopause</th>
<th>Number of women</th>
<th>With children</th>
<th>Without children</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 – 19</td>
<td>8</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>20 – 29</td>
<td>5</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>30 – 39</td>
<td>22</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>40 – 48</td>
<td>15</td>
<td>8 + 2 adopted</td>
<td>5</td>
</tr>
</tbody>
</table>

The inability to have their own baby devastated a number of the women. Some of these women became involved in a merry-go-round of fertility treatments or assisted conception that succeeded only in stripping them of their self-esteem. The physiological capacity to become pregnant and have a baby distinguishes women from men and all of the women expected that this capability was their natural inheritance. Conception has been constructed as a choice and all of the women expected that at some stage through their life course they would have the opportunity to have a baby if they wished. None of
the women interviewed had considered that the choice to have a baby would not be a realistic option for them. Only one woman, Susan, was able to become pregnant using a donated egg and give birth to a baby boy. Although after the interview she became pregnant again through in-vitro fertilization (I.V.F.) this pregnancy miscarried.

The incapacity of medical technology to replicate the delicate process of viable conception was reported by five of the women. One of them was Stephanie. Stephanie was shattered by her infertility. During the period that I was interviewing the women Stephanie had three attempts at in-vitro fertilization and once had three embryos inserted for a period of nine days. Although we had only one ‘official’ interview we kept in touch by phone and would meet occasionally to talk. We continue to keep in touch through E-mail. Stephanie’s mixed feelings were bound into her complex life and overwhelming shock about her early menopause.

I feel emotionally removed from where I was then so it’s hard to put myself right back. When it comes back you remember but I don’t want to because I feel the pain again. It’s a delicate balance. To go back to the series of things would take forever. But our whole lives had been disrupted by a terrible family tragedy [a murder]. There was all that going on and then coming back and leaving life as we had known it. Becoming anonymous. I felt very much that everything had been taken away from me and that’s the negative way of looking at things instead of accepting the situation. Everything I’d known had just been removed. I just found I couldn’t cope with it.

That’s when I got this devastating news. On my thirty-ninth birthday I was told I had premature ovarian failure. And I lost it – absolutely! I couldn’t go home. I was in his [the specialist’s] bloody rooms and he told me this! He’d just taken the floor from under me and I was supposed to go down his staircase, go outside into Harley Street or wherever the hell it was and go back home. And we had workmen in the house. Where the hell do you go when someone’s just taken your life away from you? What do you do? I held on to the railings and got into a phone booth somewhere but I couldn’t say anything. And Chris was cross because he doesn’t understand. How can he understand? Oh God it was ghastly. Then I went to my mother’s the next day because I couldn’t stay with the workmen there.

I went down to my mother’s just to be quiet but that was a mistake. I should have just gone away by myself. I had all this stuff to deal with about my fertility. I just wanted a baby so badly. I had gone to the specialist because I wasn’t having any periods. He said, ‘Everything is fine. Maybe you’re pregnant. Come back for your results’. And I was happy to believe what I wanted to believe.

The whole thing I freaked out about was I was nearly forty and I was childless. That’s really what it was all about. The fact that I was nearly forty and childless meant that was it - I was washed up. That’s the end of my life. I could never imagine my life without being a mother [my italics].
I was outraged. Absolutely outraged. And there was nobody to blame. That’s the awful thing not being able to pin it on anybody or anything. There was nobody to focus it on. I was outraged. I just expected that I would get pregnant in my thirties. I genuinely did. I just thought it would happen. I certainly hadn’t bargained for my ovaries packing in.

So then it comes to H.R.T. I haven’t been able to do any research. I just have to trust what people tell me. My doctor was so pro and so adamant that I took it. He started me on some drugs that were supposed to kick-start me and they didn’t work. When I’m not on H.R.T. I’m so hysterical. I’m also taking antidepressants and seeing a psychiatrist. I just have to see who ever I can to help me. But you can’t get an appointment straight away which is a shame because I need to talk then. I got quite desperate because I couldn’t have an appointment. I should have insisted. But what do you say? ‘Hello. I’m off the wall. Please help me’. It was all so painful. I’m inclined to think the antidepressant is a placebo but I do feel much calmer. I started to reduce the dose but was worried I might revert to the harridan. I started the H.R.T. and then I went on to the fertility treatment.

But the thing is this news ABSOLUTELY DEVASTATED ME. I needed a year to absorb it. But a year down the line now I feel better able to contemplate it. I don’t know about this ovum donation. It’s probably my only chance of having my own baby. But it would be Chris’s child and somebody else’s and I would just be on the side lines of that. I wonder if I would think it would not really be my child. It wouldn’t look like your cousin or aunty or your mother. My friend said that when her baby was born they put her mother on her stomach. I haven’t discounted it. But the thing is how do you know you don’t get insanity or something in the genes. If only I’d known I could have harvested.

If only I’d known. This is such a myth that menopause happens to middle aged women. Or am I middle aged now? Is that it? Is that my number? It doesn’t matter what age you hit menopause then that’s your middle age of life. It’s perpetuated in all the bloody women’s magazines that menopause is this stage and it’s not. It needs to be broadcast that it’s not. If I’d read articles about this I’d have some information. But I knew nothing about it. I didn’t hear about it. But it’s a myth isn’t it that it’s only women over fifty. They make it sound like it’s such a rare exception when it’s not. I wonder if it’s happening more now with the pill generation. But if only I’d known I’d have done something. The thing is you can’t change it. And you hear about older women having babies.

I was so disturbed by everything. I had just had the worst news of my life. How could I expect to be anything other than screaming crazy?
My doctor said, ‘It’s your hormones’. I don’t think we are eligible to adopt and I don’t know if I am able to bring in one of those babies with special needs. I don’t think it’s quite right. There are things like if anything happened to Chris and I, I couldn’t expect anyone else to look after that baby. My mother is very against it. It’s just soul destroying. What’s the point of anything?

Stephanie.

The intensity of Stephanie’s story was heart wrenching. It was her story that first inspired me to find out what ‘premature ovarian failure’ meant to individual women. Lack of knowledge about the transience of women’s fertility seemed to influence women’s responses to early menopause. In the West women have achieved a degree of autonomy over conception. Throughout history women have spent a significant part of their lives trying to avoid pregnancy. There is argument to suggest that the encroachment of medical practice into the regulation of conception can be construed as a refinement of social control (Beames 1995). Control of conception has evolved as a site of political tension between the sexes. During the twentieth century reproductive knowledge and power transferred from ‘wise women’ into the hands of the male-dominated medical profession (Oakley 1984). The publication of knowledge that had previously lain quietly within the private domain of women was subordinated then assumed through medical authority (Willis 1989). In 1923 criticism of Marie Stopes’, then outrageous, book Married Love appeared in the medical magazine Practitioner noting that:

... popular handbooks written by women without medical qualification contained practical information of which medical men had been ignorant and ‘a great deal of which they might legitimately disapprove’. Rose 1992: 123.

Ignorance and disapproval of women’s private control of their own fertility remains evident within modern discourses of medicine that claim exclusivity over reproductive practices. Nevertheless, relatively reliable and safe methods of contraception have made it possible for Western middle-class women to delay having children until they have established a career, are financially secure, or until they feel confident in their choice of partner. These decisions are underpinned by the construction of woman’s fertility as a tangible asset that can be drawn upon at will. Having a baby is thought at least to be a possibility until middle age and often beyond. This perception of fertility as a constant and enduring aspect of adulthood influenced the women’s reactions to the infertility of an early menopause. I spoke to Dianne six months after she found out about her early menopause.

D: I went to see her [the doctor] because I was still feeling unwell. I had had some sort of virus over Christmas and had been told I had mumps although another doctor said it was glandular fever. She had taken some blood tests because I hadn’t had my period either. I was a mass of emotions and I knew I needed some sort of adjustment to the pill I was taking. I thought I had P.M.T. I just went for some help with my P.M.T. really. I’m a great believer in self-help groups and I really was hoping there was going to be a group or someone I could link in with. I wasn’t asking for a cure but someone who would
I understand. That was all I was hoping for. I was just gutted by the time I came out.

I’m thirty-four. O.K. I’m single but I always had hopes that I was going to have a family one-day. O.K. time’s going to run out eventually but I always thought that I would have some offspring. I thought I had another twenty years - at least – you know that feels like forever. But here was this woman sitting across the desk from me saying that this is the start of the menopause. She said, ‘You’re having early menopause’. I was gutted.

When I was first told I was partly numb and partly very, very emotional. I’m only just starting to get it in perspective. I just couldn’t believe it – my whole future just gone - no babies for me. I was absolutely shattered. It dragged up a lot of emotion. I decided the only way to move forward was one day at a time, or just part of the day at a time, or one hour at a time, or just one thing at a time. That’s how I’ve got through it. I think I have to be a level-headed sensible person but if it gets too much I’ve got a hot line to my friends. They were as devastated as I was really.

My doctor took me off everything – my vitamin pills as well as ‘the pill’ – I went cold turkey on all of these things. I was rather surprised she took me off everything, even multivitamins. G.Ps only know so much and I think her culture means she can’t get involved in women’s issues. It all sounds very good because it’s a Well Woman’s Clinic but she’s not that good really. I’d been on the pill a long, long time but she told me to stop it. I’m now wondering what’s going on. I’m confused. I want to supplement my diet. I need to be healthy. I’ve been very conscientious about my diet since I gave up smoking. I smoked from when I was sixteen until two years ago. I smoked about forty a day but I used nicorette patches to get off and it worked. I’m quite lucky like that. I haven’t had a drink in about six years. I don’t even drink socially. I decided what I want to put into my body and it wasn’t going to be alcohol. I have food allergies as well and so I control my diet. ...[General discussion on diet] ...

S: Dianne, can you tell what being menopausal means to you?

D: Well, once I started to get it into context it meant, ‘Well, was I a woman or not? What does this make me? Am I a freak?’ I was going around with this secret inside me which I didn’t share with anyone but I didn’t want to keep it all to myself.

There was something inside me that said, ‘Who are you?’ Because you grow up and you have your periods, they are the curse after all. I thought, ‘Hold on, who’s taking my curse away? The only time I want to lose it is when I’m pregnant. This means you won’t have children’. Dianne.
Some of the women felt that they had been betrayed by a socially-condoned decision to delay pregnancy and childbirth. None of the women had thought of their fertility as a finite or fragile resource. Nor had they thought that it could be eroded by external influences. Women found that their constructions of womanhood were so inextricably bound into concepts of fertility that it was impossible to remove themselves from this creation without fracture.

**The social value of motherhood: a baby of her own**

Throughout history the ability to reproduce has been revered and high social value has been placed upon the ideal of motherhood. This has led to various forms of social custom that continue to evolve around maternity. Although religious regulation of maternity through marriage and fidelity has declined, medical management has increased through the control of contraception, pregnancy, birth, abortion and more recently fertility treatments, various forms of assisted conception and surrogacy. Thus the construction of women through the primacy of reproduction has continued to be used as a political platform that claims the promotion of social stability. However, sustained exploitation of women’s reproductive capacity resulted in a backlash by women. Reproductive independence was challenged, contested and supposedly conceded within the political arena. The anticipated reproductive autonomy of women has been questioned (Martin 1993; Rowland 1992; Beames 1995) and remains a clouded issue.

Other social changes have threatened notions of the primacy of motherhood. The decrease in infant mortality, a rapidly increasing world population, unprecedented scientific advances and the economic profits of industrialization mean that Western societies no longer need limitless numbers of children to survive. The construction of motherhood is changing away from reproduction and reconstituting itself towards caring and servicing.

Despite these recent trends away from reproduction the role of women as mothers remains highly valued. Fran described how she tried to become pregnant when she was thirty-eight years old. Initially she did not relate her difficulty with becoming pregnant to an early menopause but when this was finally established she said:

> I remember trying to come to terms with the fact that I was never going to have children. I still get upset about it. I thought, ‘Now I’m menopausal Jeff will not want me. He can’t have children with me. I’m not going to meet someone who doesn’t want children. Most men want children.’

> But, I’m not a mother and I’m never going to be a mother. It has made me question my identity. If I’m never going to be a mother, what am I? I’ve always worked. That was my identity. But it’s not working for me anymore. It has ceased to have any importance for me at all.

> I have to come to terms with the fact that I am not going to have children. It isn’t going to happen. It is difficult for me to say it, although I know that that is denial. Fran.
Twenty-three, that is nearly half, of the women I interviewed had not given birth. Twelve of these women said that they desperately wished to have a baby of their own and five had attempted this through technically-assisted conception. Three others were adolescent or in their early twenties and considered that some form of assisted conception was a realistic option that would allow them to have a baby in the future. Another six had never had the desire to have a child. Nor had they considered any form of assisted conception or adoption. Three women had a hysterectomy before they had the opportunity to become pregnant. Caroline described her experience (also in Update 1997).

I was due to get married when it happened. I’d been bleeding mid-cycle so my G.P. sent me for a scan. Two ovarian cysts floated on the screen. When the radiographer pointed out the shape and darker lining of my womb, I thought how amazing it would be to see the outline of a baby. It never occurred to me that six weeks later I’d lose everything, plus that possibility.

Hysterectomy. I hadn’t given it a single thought. In fact, my fiancé and I told the consultant we wanted children. He listened intently, examined me and then sat us both down. I was so shocked, he suggested we both come back in a fortnight to discuss the options. But he said he couldn’t leave things too long in case the twelve centimetre cyst ruptured.

I woke up every morning realising I couldn’t go back in time. People tell me this is what happens with sudden loss. Your mind refuses to take it in. I’d had major surgery and lost my first ovary aged three. At twenty-two they found endometriosis. More surgery. Fifteen months of drugs. Then I’d been well for fourteen years.

I’d put it all behind me until I met Graham. I felt I had to tell him I might be infertile. But deep down I didn’t really believe it because, well you don’t, do you? Not until you have to. There was nothing to save; rampant endometriosis, ovary shattered by expanding cyst. I’d lost my fertility long ago.

I felt uncontrollably, ridiculously guilty. But no one else was worrying about unborn children, grand-children, nieces or nephews. They were desperate about me. Four days after the op. I got my first oestrogen patch. Without it, I’d have had bad hot flushes due to the dramatic loss of ovarian hormones – a SURGICAL menopause.

I was grateful, relieved. My feelings were somewhat punctured by my consultant’s advice ‘to stay on H.R.T. until you’re sixty – and by then we may be advising treatment ‘til you’re eighty’. I was thirty-six, with twenty odd years to go. Slowly my body began to heal but I felt a freak.
There were so many reminders; tampons left in drawers, kids in the street. A hairdresser’s innocent chat about her periods. Silly, little everyday things I couldn’t manage. Even the wedding magazine my finance brought me to cheer me up opened to a page on fertility symbols. How could I ever be a bride?

But we did get married – two years later than planned – and fortunately, I’ve found the right H.R.T. for newly-married life! But only after experimenting with patches, tablets, then extra patches. And doubling the original dose. ... Caroline.

The women’s responses to the inevitable infertility of early menopause differed. For instance, three of the women had adopted children. Beth adopted two children after she found that she had early menopause. Pam had adopted her children before she knew she had early menopause and Simone adopted a little boy after she had three of her own children and early menopause. Another two women had partners with children. One of these women, Anna, commented that she thought that fatherhood had influenced her choice of partner.

The chance of pregnancy varies with the different reasons for an early menopause and the probability of pregnancy following an early menopause for any reason is extremely low (Baber et al 1991). Anna found that the process of establishing the cause of early menopause took away her hope of having a baby of her own. She wrote by E-mail:

I started menstruating quite early, I think I was ten. Anyway, when I was about fifteen my periods became irregular. I went to the doctor’s and was tested for anaemia, diabetes and various other things. Each time I had a test a few months would pass before I returned. After all I was in no hurry to get this problem fixed. Having a period every six months was fine by me.

Eventually when I was seventeen the doctor was stumped and said he would test my hormone levels as a last resort. He said there was a slight possibility that he knew what it was (i.e. premature menopause, but he didn’t tell me this) but that it was extremely rare. Well I had a blood test a week for four weeks, then the usual wait for results. When they came through the receptionist called and asked my Mum to come with me to get the results. My Mum immediately thought it was cancer or something equally life threatening (not that she mentioned this to me), and I didn’t have a clue what it was.

The doctor explained that I was experiencing a premature menopause and that further tests needed to be done at a specialist women’s hospital. A couple of months later I visited there and they performed a minor operation which confirmed that my eggs had disintegrated and none could be removed and stored, which I had been hoping. Anna.
An early menopause can occur over a period of time and possibly one or two of the women might have been able to become pregnant before this process was completed. It has been reported that some early-menopausal women have become pregnant after hormone treatments and a few women with resistant ovary syndrome (probably a preliminary stage of early menopause) have become pregnant both with and without the use of hormones. Theoretically pregnancy is possible for women with follicular forms of an early menopause and for women whose early menopause is caused by auto-immune disorders (Baber et al 1991). But none of the women I interviewed connected these conditions with infertility prior to early menopause.

Most of the women valued their fertility highly as a choice whether they wanted children or not. When this was compromised by an early menopause six of the women turned to technology in their efforts to become mothers. Women who wanted their own baby pursued this goal through assisted conception in the form of in-vitro fertilization or related technologies.

These methods did make it possible for Susan to have a baby by using donated eggs from another woman.

My baby was born after a successful first treatment with donated eggs. The joy he has brought me is beyond words; there is also I have to say, still a sense of trauma, of having to adjust to an image of myself I never thought would become a reality, from a very early age.

I never experienced a deep and urgent sense of grief at my infertility, perhaps because it has been with me all my teenage and adult life. If the menopause had come a little later, say, in my twenties, things might have been different. I was happy to deal with the children of friends, and only became tearful about images of babies while I was pregnant! ‘While I was pregnant’. Even now I find it hard to imagine I was. Susan.

Assisted conception success rates are low and the women interviewed reflected the assertion that only a minority of women will give birth to a live baby following any form of I.V.F. (Rowland 1992). The emotional and financial costs are high as well and some of the women excluded themselves from I.V.F. programs after one or two unsuccessful attempts to conceive using technology. Others became caught in a web of seemingly uncontrolled medical experimentation in their attempts to become pregnant. For instance Beth described how she considered that her experiences with I.V.F. caused her early menopause. Despite her medical background in reproductive health she was unaware of the potentially detrimental effects of drugs used in I.V.F.

I desperately wanted someone to investigate me because I was starting to get a bit panicky about not getting pregnant. We had all the tests and I started on Clomid [an antioestrogen used in I.V.F.]. I was on that for a quite a while. I started to see a private consultant who put me on H.C.G. [human chorionic gonadotrophin – a hormone used to promote superovulation in I.V.F.] which I got from my G.P. and a locum refused to give it to me. He said it was too dangerous and not a lot was known about it.
Of course because I thought this was absolutely necessary as the next step I went and got the prescription from the consultant and got a friend to give me the injections. I only had them for three months because I had been made frightened by the locum’s reaction.

Nobody actually mentioned that there were any problems with taking the Clomid. It was just suggested that this would be to make ovulation more assured and might make conceiving happen more quickly. I hadn’t thought it through. I know it was that that caused my menopause but I didn’t want to consider anything other than just getting pregnant. I was getting this terrible fear that time was sliding away from me. Beth.

Grief and pain: fertility and failure

The infertility of early menopause was devastating for those women who wished to have their own baby. A number of women said they felt that they had been deprived of the intrinsic legacy of being a woman and for them their ‘failed’ ovaries have extended to ‘failed’ womanhood. This implied condemnation arose many times and negatively affected the self-identity of several women. Some regarded their entire life as a ‘failure’.

Suddenly I seemed to be mixing with women who had fantastic careers. What about my life? I had nothing to show for it. Well nothing you can explain to anyone. If you’re not in a career you play the role of the supporting wife and I had nothing to show for it. To make it worse when I initially started getting hot flushes we were staying with a friend for quite a long time because we were buying our house. I didn’t realise it was happening because the flushes were so small. I can’t remember if I was awake at night or not because to me the whole thing was traumatic. I can’t bear being dependent on anybody and I resented Chris for allowing it. I didn’t want to stay with anybody else. And she was one of those women who while reversing into a tight parking spot can conduct business on the phone at the same time. I started to feel less and less capable. It was all too much. And then when the menopause was diagnosed I just felt an absolute failure. I had no career and I was a failed wife and a failed mother.

Stephanie.

For some of the women like Stephanie the fight to have a baby of their own became an obsession. Five women faced ‘failure’, yet again, through technology. The technology was never blamed; only the women. Medical discourses construct women’s bodies as inadequate if a viable pregnancy does not result from I.V.F. ‘Success’ rates are based on implanted eggs, not live births (Rowland 1992). These discourses create the impression that technology has worked but women’s bodies have not; yet more ‘failure’.

You become so introverted when you’re doing this fertility stuff – you take your temperature every morning, you’re looking at your mucus, you’re looking at the way you are. You’re looking for signs of pregnancy. The cycle goes on and on.
There is a social pressure but it’s biological too because as you grow up you’re reminded that you’re potentially fertile by having periods each month. So much of your female psyche is built around our reproductive capacity.

When this fertility treatment didn’t work I had this terrific feeling of failure. I was mourning my own infertility; grieving for my unborn babies. I also wasn’t coping because I was having my menopause, which I didn’t realize at the time.

It was the last straw in a whole line of things I was failing at and I came very close to putting myself under a train. I had a feeling of lack of worth and failing and feeling that it was always my fault that things were wrong.  

Beth.

Many of the women who were interviewed endured this grief and pain alone. Most found it difficult to share. They felt that even their partner could not understand this assault on the core of their being. One early-menopausal woman wrote:

A bereavement can, however, be invisible to others. The loss of a cherished hope can often be as devastating as the loss of a person. There is no funeral, no formal goodbye, no obituary, nothing. Yet such a loss is no less significant for the lack of symbolic ritual.  


Faced with such overwhelming negativity it was no wonder that many early-menopausal women felt great sorrow. These women grieved for their lost ovaries, eggs, uterus, fertility, child or motherhood. And they grieved for the lost choices these might have provided. Grief could be healing; but it was rarely easy.

Although the grief of infertility in relation to I.V.F. technologies has become a public issue in places like Britain through the Human Fertilization and Embryology Act of 1990, grief largely remains private. In either case, grief is a process that does not always progress to the desired goals of acceptance and resolution. The processes of grief can be curtailed before these have been achieved. Generally it is accepted that grief includes the different and often consecutive or overlapping stages of shock, denial, anger, envy, resentment, and sometimes guilt (Bryan and Higgins 1995: 152). The stories from early-menopausal women reflected grief through a range of changeable discourses. For instance, one woman who went through menopause as a teenager and was finally referred to a medical specialist after years of consulting her general practitioner said:

… [the medical specialist] then told me I had a premature menopause and would not be able to have children. At the age of nineteen I started H.R.T. To say I was heartbroken was an understatement, I felt so ashamed and disgusted with myself I became really depressed. I started seeing a counsellor but to me that was a waste of time. All I wanted was someone to put me right which she obviously couldn’t do.  

...
My G.P. knew what was going on in my body and he could have arranged to have my eggs frozen when he realized. Now if I want children they won’t look like me. I always loved my long blonde curly hair when I was young and I have always dreamed of my child having the same. My boyfriend was very supportive, telling me he didn’t want children, only me. But it made me angry because I knew he did. Now the relationship has finished, nobody will want me. I’m not a real woman. I find myself thinking if this had never happened I would still be with him now.

Two months after I was diagnosed my best friend of eleven years announced she was pregnant; an accident. He [the baby] is now seven months and when I hold him I just feel like bursting into tears. I can see the love she has for him and I wonder if I’ll ever feel the same. Now my sister is pregnant, I don’t know how I’m going to cope but I’ll have to come to terms with it sooner or later.

On the positive side I feel a lot stronger and I cope with my problems more effectively. That is the only positive outcome. Tanya.

‘Real’ women: mothers and partners

It was apparent that the women interviewed were not an homogenous group bound together through inevitable biology. They were a diverse group of individuals constructed and constrained by different discourses. They were, however, classified at birth as belonging to a significant group, the female sex. As girls and women the attitudes of others (Mead 1934) and the cultural communities to which they belonged (Douglas 1989) influenced the self-identity of each individual. Self-identity is a process that adapts and changes to accommodate the values of various groups. These groups make up the social structure (Babbie 1994) and broadly within Western cultures the notions of fertility and femininity are revered and represented through constructions of motherhood.

In fact the concepts of motherhood and femininity are so intertwined that the discourses of psychology suggest that pregnancy and birth have been considered as “... overt proofs of femininity” (Fromm 1967 in Ussher 1995: 79). This construction is underpinned by religious ideologies that have glorified maternity while disregarding women as individuals. Since the post war period, with women increasingly involved within the public arena, motherhood still is deemed the ultimate goal of womanhood. Women are classified through their status as mothers or non-mothers even if they hold top public positions. By comparison prominent men rarely are defined through their fatherhood. The discourses of psychology even propose that women who are unwell or unhappy during pregnancy are rejecting their femininity suggesting that they are not ‘real’ women (Ussher 1995: 83).

Some of the women in the study embraced this psychological discourse and referred to themselves as not being ‘true’ women. Even early-menopausal women who did have children sometimes felt that their infertility negated their femininity. Thus, it was not only pregnancy and birth that women used to define their femininity; but it was also their potential.

I have never told anyone this – but after I lost my uterus I felt as if I had lost – well, my woman-ness. It sort of represented who I was as a
woman. You know I had that secret place where I could have a baby – if I wanted. I’ve got two children already. But I mean it was me. It was my centre and now I don’t feel like a ‘true’ woman anymore.

Anne.

Anne’s feeling about her infertility, tied inextricably to her feelings about her hysterectomy, probably would not create much interest medically as she already had children. But Anne’s feelings were strong and she related this aspect of her story in a whispered voice, leaning forward in confidence as if her story was so strange it could easily be disbelieved. In other words Anne felt that her dialogue was so marginalized that it would have no credibility within a more dominant discursive framework. Anne’s discourse indicated that while dominant discourses attract positive value to women’s potential fertility when they are childless these discourses disregard the potential fertility of women who have children already. Thus, it appears that dominant discourses of infertility relate to childless women.

This seems to be the case with negative medical discourses that describe women who are unable to have children. These discourses not only construct early-menopausal women through ‘failed’ ovaries, their fertility is said to be ‘lost’, or the women themselves are termed ‘barren’ (Bryan and Higgins 1995). Discourses that equate womanhood with motherhood reduce women’s complete identity to fertility. This becomes positive with increased status if a woman becomes pregnant and successfully gives birth and is negative if a woman who wants a child is unable to do so. These discourses have been critiqued by researchers of psychology and childlessness has been identified as ‘the curse of the barren womb’ (Ussher 1995: 99).

Childless women are a devalued group in society, seen as unnatural and unfulfilled: in failing to become mothers they fail to become women. ...

Society pities those women who are childless against their wishes and the pity reinforces their sense of worthlessness. The language which positions these women within the discourses of woman and mother is negative and degrading: barren, unfruitful, addle, arid – they all mean ‘of no effect’, or unproductive. If women are expected to receive their status and identity through childbearing, what is the fate of the childless woman? Ussher 1995: 100.

Some of the women internalized these discourses. Jenny commented that she found the prestige of motherhood was perpetuated through other women ostracizing infertile women.

I have often noticed that I am excluded from conversations – even pitied – because I don’t have my own child. Jenny.

Jenny said that she became (painfully) aware that birthing provided membership to an élite club. Men were excluded; and so were childless women. In this context women without children were constructed as ‘immature’ or as having omitted a rite of passage into adulthood. Little wonder at their despair.

The unhappiness of some of the women transferred to their relationships. A few of the women suggested that I talk to their partners. Husbands and partners sometimes
became caught in the sorrow of infertility and in the desperation of some women to become mothers. Young women especially were cautious about forming relationships and often avoided this altogether. Others did so tentatively finding it difficult to accept reassurances that they were loved for themselves and not for their reproductive capacity.

Others did not disclose the fact that they were early-menopausal until their relationship appeared to be consolidated although some found it easier to tell boyfriends or partners straight away. Anna perceptively noted how she was attracted to single men who already had a family. Her preference for a ready-made family provided an acceptable alternate type of motherhood for her.

Many of the women’s partners expressed great compassion for their wives or partners and some said that they shared the grief of infertility. One or two of the women’s partners offered to be interviewed describing feelings of concern and frustration as they tried to understand and ease their partner’s despair. Others supported their wives or partners through I.V.F. treatments in the best way they knew how; they contributed their sperm. One husband wrote his story for an early menopause support group.

It didn’t change the way I felt about [his wife] even though she found that very hard to understand. She thought I’d leave and never come back after she told me about her premature menopause. It was so hard watching her cry night after night – I felt so hopeless and helpless – there was nothing I could do. To me it was just one aspect of her that wasn’t really a problem. To her it was one huge part of her life that was a problem.

[After two and a half years waiting to get on an I.V.F. program] ... I just couldn’t take the pressure and I didn’t know the answers to her questions, like ‘why’ and ‘why me?’ I supported her as much as I could, though we very nearly split up over the stress we were under. It was a very hard time, but one thing that really helped was the decision to go public and tell friends and relatives; that took a huge amount of pressure off.

We finally got our first appointment at [the I.V.F. clinic] ... In two months they’d found an egg donor that matched.

Having to produce a sperm sample on the day was nerve wracking because so much depended on me. Three days later two embryos were implanted into [his wife]. I held her hand and prayed.

The next two weeks were the longest in my life. I went from feeling pessimistic to optimistic and back again. I felt [my wife] was far too hopeful and was worried about how to cope if the pregnancy test was negative.  


**Conception as technology: eggs as a commodity**

Provided a woman who has an early menopause has her uterus it is theoretically possible for her to sustain a pregnancy and give birth by using the egg/s of another woman and the sperm of her husband, partner or donor. This sounds simple but in reality it is complex. There are many subtleties of human life that cannot be replicated by science and
although assisted conception does work for some couples the majority do not take home a live baby (Rowland 1992).

All of the women in the study who wanted to have a baby relied on eggs donated by other women. If, during the process of an early menopause, it appears that a woman may have some eggs of her own left it is a theoretical possibility for these to be frozen and used later to attempt assisted conception. This theory did not relate well to practice as none of the women found that this was a realistic option. For instance, it was not always obvious when a young woman was going through an early menopause. In any case eggs by themselves do not freeze very well. If they are fused with sperm to become an embryo there is a greater chance of them being successfully frozen and thawed prior to implantation (Bryan and Higgins 1995: 98). A woman not in a permanent relationship would have to rely on donor insemination.

The women tried different methods of assisted conception. Usually donated eggs were fertilized using the sperm from each woman’s husband or partner. Although donor sperm also is available none of the women considered using this. Different techniques were used to insert embryos or eggs and sperm into the body of each recipient woman. The primary methods used were in-vitro fertilization (I.V.F.); I.V.F. and embryo transfer (I.V.F.-E.T.); and gamete intra-Fallopian transfer (G.I.F.T.) and their variations. Sarah explained her experience of I.V.F.-E.T.:

> It was very impersonal but I really wanted those babies – for Greg as much as me. On our second attempt I had three little embryos implanted. The doctor said the eggs were good. It had been such a hassle – waiting for the right donor – and trying to fit it in with work – early morning appointments for the injections - having to get Greg to come in and do his thing. But I felt pretty confident when they told me there was no reason for it not to work. But you know I never felt pregnant. I never felt connected to those babies. I stayed at home and was very quiet – but then I started bleeding – so I knew it wasn’t going to be. The doctor wants me to do it again but I just can’t. I tried to explain it to Greg – he thinks we should have another go. But what is it doing to me? Sarah.

Other women who had tried assisted conception expressed similar doubts to Sarah. But a few young women who had not attempted any form of assisted conception expected that having a baby this way was feasible. For instance Felicity had not really considered that her early menopause could preclude her from having a baby.

S: How do you feel about fertility?

F: Well, of course I’ve always wanted my own baby. When I’m ready I’ll go on the I.V.F. program. Not yet though. I could hardly bring it up with Rob. He doesn’t even know about my premature menopause. But it wouldn’t be a problem would it? When I’m ready. What do you think?

S: If that’s what you want to do. But you would need to be aware that it doesn’t always work – it isn’t necessarily straightforward.
F: I hadn’t really thought that it wouldn’t work. I just thought I could do it later. Of course that’s how they all met up at Daisy Chain isn’t it? They were at the fertility clinic at the same time. Felicity.

The Daisy Chain was the original name used by a group of women who decided to get together after they met through CHILD, the British National Infertility Support Network. At first known as the ‘early ovarian failure support group’ this group has now changed its name to the ‘premature menopause support group’ (Hawkridge 1999). Eight of the women I interviewed were members of this group. From a small group of women who met in each other’s homes this group has now escalated to an international information service with it’s own web site (http://www.daisychain.org). The Daisy Chain is a viable example of how women are able to resist dominant discourses and modify discourses around their own experiences.

To get a true understanding of I.V.F. and related techniques their results need to be evaluated; but results are not available in any comprehensive form. The public and private clinics that perform these procedures rarely publish their own data and the figures remain confidential. In any case much of the information about I.V.F. programs is ambiguous. For instance, it is claimed that some clinics are achieving pregnancy in up to forty percent of completed treatment cycles. This is optimistic news for would-be parents. However, a pregnancy does not equate with a take home baby. Only five percent to nearly thirteen percent of women who use I.V.F. and just over eleven percent who use G.I.F.T. will end up with a live baby (Bryan and Higgins 1995: 105-6). Critics of these procedures maintain that using these figures to describe success is inverted and that the failure rate of technology, which is up to ninety-five percent, should be used instead (Rowland 1992).

But the source of failure is passed onto women as explained in the words of one member of Daisy Chain:

I have just had my second negative egg donation result. My first attempt was Z.I.F.T. [zygote intra-Fallopian transfer] and my second I.V.F. with frozen embryos. Although I was warned I.V.F. had a lower success rate, you cannot prepare yourself for that horrible word ‘negative’. I don’t really think I can say how I feel because I am numb inside, the tears come out but it doesn’t seem to clear the hurt and anger I hold.

I feel more of a failure than ever before [my italics]. I haven’t got another donor so I feel the future is worthless. ... I wish I was happy and I try and try, but I feel so angry and empty – a bit of a freak as well. How far do you go? How much heartache do you put into this and how much money do you spend? Kim 1996: 3.

Reasons for the lack of success with I.V.F. and related technologies may be just that, that they are technologies or applied sciences. The human experience is more than a series of isolated bio-chemical events and other influences affect the delicate human equilibrium. In the case of I.V.F. it has been assessed that the difference between the pregnancy rate, quoted as the success rate, and the rate of live births is due largely to
miscarriage within the first three months of an I.V.F. pregnancy (Bryan and Higgins 1995: 110; Rowland 1992: 46).

It is reported that one of the reasons for lack of success with I.V.F. pregnancies is the age of eggs (Bryan and Higgins 1995: 110). For instance, the older a woman’s eggs are the less chance she will have of a viable pregnancy and live birth. As early-menopausal women in general use donor eggs, and the age of women donating eggs is controlled, these women should have a greater chance of success with I.V.F. than older women who use their own eggs. However, there are no data available to confirm if early-menopausal women have greater success with technological conception than other women. Certainly the women I interviewed seemed to reflect the less optimistic rates given by Rowland (1992) than the extraordinary rates claimed by some medical researchers (Bryan and Higgins 1995: 104).

Moreover, the women found that donated eggs were not readily available. The supply, even using different sources, has been unable to match demand. There is a chronic shortage of eggs and many of the women waited years before suitable eggs became available. This was not always easy as explained by Lara.

Stuart and I lived together for about two years before we got married. We turned up for our first attempt at I.V.F. using donor eggs and thought it would be a bit more proper if we were married before we really tried for a family. The first couple of attempts at I.V.F. failed. It’s a very upsetting time for us both and our families when we get bad news after all the build-up and waiting. Our third attempt was supposed to be about two months ago, I have to take pessaries three times a day and three pills every morning while going through this treatment and if a pregnancy comes out of it I have to continue this ritual for the first four months of the pregnancy. Anyway, the day before the embryo transfer the nurse at the I.V.F. unit phoned to say that all three of our frozen embryos had died and that there was nothing to transfer. Everything was off. This was even harder than going through the embryo transfer and being told it hadn’t worked, at least we would have had a chance.

We were told by the Unit that the next available egg donor might be about two years away as there are so few women volunteering for egg donation. I was frustrated, angry and thought that that was it, we’d had our chance and it hadn’t worked. I mean two years! That’s so far into the future I just can’t imagine what I’ll even be doing. The doctor said that a few women had come forward and donated eggs for their friends or sisters. I had been told way back when I first went through the menopause that it wasn’t permitted to use known donors in I.V.F., but this has changed now thank goodness. My sister who is eleven months older than me has two children aged three and ten months, she has always said that she would be willing to donate eggs for us if it were ever allowed.

My sister and I with both our husbands have all been to see a Social Worker about the forthcoming treatment. This is seemingly a requirement when known donors are being used. It should be early
next year when we go through this process again. The doctors are hopeful that this time it will work as Elaine is so young and we are from the same genes. This will be our only hope of ever having our own baby. It will be very upsetting and stressful for us all involved if it all fails but at least we’ll have had the chance.

Whether or not there’s someone in a similar predicament to me or not who knows....... Lara.

Women with specific requirements, such as those from an ethnic minority, may find it virtually impossible to get appropriate eggs. Shireen was concerned about this. She had written her story out for Daisy Chain and offered this as well as interviews and phone calls.

I came from a loving Asian family of six girls. All were well educated except me. As I grew up I always thought I would one day be married with children, but that notion was gradually shattered. Although we are a close-knit family ‘cultural pressures’ mean that issues such as infertility are seldom discussed or acknowledged. These ‘cultural pressures’ are reinforced by Islam which allows men to have up to four wives if any cannot conceive.

I started my periods at thirteen but they were never regular. By sixteen I began to worry as they became unpredictable with intervals of six or more months. Concerned about this I mentioned it to my mother who told me not to worry, that they would settle down by the time I was nineteen or twenty. This was confirmed by my G.P. My elder sister who is in the medical field finally told me to go to my G.P. for a simple blood test. A few days later there was an urgent phone call from my G.P. My father answered the phone and being a doctor recognised her voice. As she would not discuss anything with him my father assumed the worst – she must be pregnant. Mayhem broke then out at home. My mother became hysterical and my father tried to rationalise the situation.

Pregnant!!! I was only seventeen, this made me doubt myself. I tried in vain to explain to them that I had trouble with my periods and just wanted to be checked out. I was confused and worried as my G.P. said I must come back the next morning for more tests. My mother stopped talking to me and my father was convinced I had a urine test for pregnancy. After another confusing blood test I was sent to the hospital for an ultrasound scan. I remember walking into a room of pregnant women who stared me up and down. During the scan the nurse asked me how many weeks pregnant I was – I looked shocked, as tears built up in my eyes I replied, ‘I don’t know why I’m here, I’m not having my periods so I have to have a scan’. After meeting with my G.P., who was baffled, I was referred to a gynaecologist who told me I had symptoms of early menopause. I was immediately put on various H.R.T. which disagreed with me. They then tried various
brands of the pill which also had unusual side effects such as my eyebrows falling out. They eventually put me on a course of oestrogen which they said may trigger my body clock to start producing its own.

The turning point for my diagnosis came at age twenty-two when I attended a conference on infertility. After the speeches I spoke to a professor and told him my history. He instructed me to get an immediate referral to him and then carried out all the relevant tests including a bone density scan. He then, during a frank discussion, told me what I did and did not want to hear. I had primary ovarian failure. I had no eggs in my body. For once I was told the `score’ up front. I walked out of the hospital with the words ovarian failure raging through my head. I kept thinking, why me? They have it wrong, I’m still young. I tried to console myself by thinking I will become successful and don’t need to have children. On the other hand, other images and thoughts ran through my head; who will marry me now? what would people say if they knew? will I spend the rest of my life alone? Shireen.

The women found that there were few donor eggs available of any kind. Usually eggs were obtained from the surplus eggs of women on I.V.F. and G.I.F.T. programs, or women undergoing sterilization, or women donating for altruistic reasons. Despite the government regulation in some countries that state the only payment to women should be to cover incidental costs such as travel and child minding, this has been side-stepped by other arrangements. For instance some institutions have set up a bartering system whereby women can share eggs. Women undergoing some I.V.F. programs are offered free treatment if they are willing to donate some of their eggs to women without eggs of their own. This payment in kind is attractive when costs for I.V.F. can be several thousand dollars.

Private advertisements are starting to appear in local newspapers seeking egg donors (The Manly Daily 1999). The selling of human eggs potentially is big business. Independent transactions have been established whereby large payments are made to women willing to sell their eggs. Inspired by this cash incentive some women donate their eggs more than once. Ironically, some of the drugs used to super-ovulate women can induce an early menopause. This means that although there may be a financial profit for donor women, there may a biological loss of which they are unaware.

Thus the commercialization of life itself has become established. The selling of human eggs has even progressed to the institution of surrogacy. The Childlessness Overcome Through Surrogacy (C.O.T.S.) organisation that matches surrogates with commissioning couples advertises over the Internet (http://www.surrogacy.org.uk). The possibility of having a baby for early-menopausal women has become a commercial transaction; a stipulated financial sum can be exchanged for the opportunity to purchase human eggs prior to their expiry date.

I was told egg-donation was an option. Acronyms like I.V.F., G.I.F.T., Z.I.F.T. and H.R.T. were mentioned. ... Why can’t I do what a sixteen year-old schoolgirl can do without wanting to? Why can’t I have a child to love and cherish while others cruelly beat their children? Why is life so cruel?
But for now we’ll keep waiting and praying and saving. Melanie 1997.

**Conclusion**

Women’s responses to their early menopause were influenced by the dominant construction of women as innately fertile. All of the women expected that fertility was an asset given to them at birth; that the choice to have a baby would be theirs at least until middle-age. These discourses were not consistent with the women’s experiences and they were compelled to renegotiate their constructions of fertility. While many of the women identified with a negative construction of involuntary infertility others were able to resist these discourses and transit this morbidity through reconstructed dialogue.

Without doubt many of the women felt great sorrow at their individual infertility. Six of the women pursued technology in their efforts to become mothers. Only one of these women took home a baby through assisted conception. Other women explained how their attempts at I.V.F. came at great personal and financial cost. The negative discourses of ‘ovarian failure’ were transferred to ‘failed’ fertility, ‘failed’ femininity and ‘failed’ womanhood. In economic terminology their resources were consumed and they were bankrupt. This was problematic in a culture where the choices of consumption are seemingly unlimited. Women did not expect their fertility to be exhausted during their adolescence or young adulthood. Their experiences were incongruous with medical discourses that create women’s fertility as infinite and normalize motherhood for middle-aged women. By redefining the meaning of fertility, femininity and motherhood many of the women were able to recreate their identity. This shifting identity allowed many infertile women to see themselves as valuable in their own right and accept the spiraling parameters of their own reality.
Chapter Eight

Subjectivity and Uncertainty

If the social identity of the self cannot be distinguished from the lived body by which it is actualised and if one’s self-image cannot be distinguished from the living of this body as a whole, then it should not be surprising if changes in the body effect changes in the structure and fabric of the self. Diprose 1994: 117.

Introduction

An awareness of the self as an agent within the social structure is transacted through language and this discursive construction of subjectivity is always in a state of becoming. In this chapter the fluidity of subjectivity is articulated through the discourses of women who continuously reconstructed their self-identity in relation to their early menopause. This process was influenced particularly by the challenge the experience of an early menopause posed to the dominant constructions of women as united in a passive, heterosexual and unchanging reproductive body.

Early-menopausal women found that this interpretation was unrepresentative of their own experiences. They identified and articulated a range of experiences around their changing bodies and changing subjectivities. The inconsistencies between the dominant constructions of women and the individual experiences of early-menopausal women often intruded detrimentally into the self-identity of these women. This was particularly so for very young women and for those women whose identity was centred upon reproduction. These negative reactions appeared to be a reflection of the conflict between strict moral values that surround the medical constructions of women and the vacillation of individual experiences of early menopause.

Even though the lack of concurrence between discourses was problematic for many women most were able to question the static and universal construction of women and create and continually recreate their subjectivity through a mutable identity of the self. In other words despite discursive disparities many women were able to challenge stereotypical images of the identity of women and relocate themselves within a more expansive context that took them beyond the reproductive body.

Identity of the self: constantly becoming

Subjectivity and self-identity are connected in that they both relate to the self as in state of constant flux. The concept of self-identity relates to the ideology of the self. As a philosophy the identity of the self remains definitively unresolved within the various social disciplines. Nevertheless, the ideology of the self, as described by Mead in 1934 does provide a base for understanding the emergence of a sense of self as seen through the eyes of others. Ideological constructions of the self have no meaning without a cultural context. This makes an understanding of self-identity dependent upon situating the individual within their social structure (Douglas 1992: 232; Babbie 1994).

An awareness of the self as an independent agent is developed within this social structure and the individual is located within a culture of particular values and moral rules (Giddens 1993: 72). These are the underpinnings of moral communities that can be seen as constantly defining and redefining parameters of acceptable behaviour and have been
interpreted as supporting social stability. The identity of the self is inextricable from this cultural context and can be thought of as a process that is influenced continuously by the moral communities to which individuals belong (Douglas 1989: 39-55).

The public idea of the self evolves from the integrated reactions and thought patterns of the community and thus the moral values of communities construct the perception of the self in relation to others. The self-identity of individual women is the product of a broad philosophical representation of women in relation to the values of their cultural communities. These cultural contexts can modify dominant constructions of women.

For instance early-menopausal women whose self-identity was more inclined towards production than reproduction challenged and rejected the construction of women through the primacy of motherhood and monogamous hetero-sexuality. In other words some women created their self-identity away from reproduction. They did not feel that their intrinsic worth was related to their reproductivity; their self-identity was structured around their individuality and capacity for employment. For instance, Marie felt that her early menopause did not affect her self-identity negatively as she did not view herself as a ‘traditional’ woman.

The infertility of an early menopause didn’t bother me at all. I never intended having children. I’ve had boyfriends but I’ve never wanted to be married or have children. I’m a bit of a selfish person as I like my single state. I can please myself when I like. It’s good. I love it.

Sometimes I feel left out because most of my friends are couples and occasionally if I’m invited out I feel odd. But most of my friends are good and don’t make me feel awkward. I have a busy professional life and I’ve got a goddaughter. I have lots of friends and I’m very busy.

A lot of my friends used to ask me why I wasn’t married. There seemed no need. They don’t understand really. They said you’re a woman and you should be married and raise kids. It’s a stereotype and it never mattered to me. I just went my own way. I have always had my work and interests to occupy me and I’m never lonely. I think that’s why it doesn’t matter to me.

Marie.

Although Marie’s self-identity occurred within a cultural context which privileged women-as-mothers she was able to resist dominant discourses that constructed women through marriage and motherhood. Conversely, other women identified themselves almost entirely through their reproductive capacity and found that the infertility of an early menopause eroded their confidence in themselves as a woman. I take up Stephanie’s narrative again a few months after the first interview:

I was just devastated. My entire world, everything that has ever mattered to me dissolved when I realized that I could never have my own children. My whole life has fallen to pieces. I have been so depressed I’ve had to go on Prozac. I can’t imagine what that does to me but I feel better when I’m on it.
I’m in the middle of an I.V.F. treatment now. I’ve had two attempts already. Once I had three little embryos inserted. I was over the moon – and then nine days later I bled and - nothing. I can’t tell you how bad it made me feel. I just expected that I would be able to have a baby in my thirties – and then when I couldn’t do it on my own I just expected I.V.F. to work.

If I don’t have a baby from this treatment I don’t know what I will do. I feel so empty and useless, not a woman at all. Stephanie.

Stephanie’s self worth was tied intrinsically to her reproductive capacity which she identified as an essential component of herself as a woman. Despite her professional qualification she did not value her productivity as highly as she valued her expected potential for reproduction. To some extent, like Marie, she resisted discourses of her cultural context as previously she had noted her mother’s disapproval of ‘unnatural’ motherhood. Thus, Stephanie’s self-identity, which had been a product of the discourses that reduce women to a reproductive body, were de-constructed through the infertility of her early menopause and re-constructed as problematic through the disparity between her own experiences and discourses of a stable and predictable body.

**Subjectivity: a precarious process of change**

It is apparent that early menopause meant something to all of the women interviewed. These meanings not only differed between women but their volatility was a continual process of change within each individual’s construction of self. Subjectivity provides the means to understand this vacillation. For instance Sarah explained the movement within her construction of subjectivity.

I guess it’s changed me – I didn’t think of myself as a mother – when I was younger I mean. I could never imagine myself as a mother – maybe that’s why it [I.V.F.] didn’t work. But I didn’t want to be a mother – not until I met Greg. Then that was all I wanted – and to have this damn menopause thing. What a bummer! Or maybe it was all him – maybe I was doing it for him. He would love to have kids. And I wanted it too – for a while. But for sure I’m not giving it another go. He doesn’t understand and it is causing conflict within our relationship. He thinks that it is just a matter of keep trying until it works. But I’m not buying into that one. I feel that the drugs changed me. I was really depressed – more than I have ever been. I’ve wasted this past six months on trying – not to mention the money. I just want to go back to work now and re-establish myself there. Sarah.

Sarah’s subjectivity was a fluctuating process that was constituted within the discourses of her cultural context. Her subjectivity was not fixed but clearly was an undulating transaction of discourses. Sarah used these discourses to reconstruct her subjectivity. In other words Sarah was able to resist the compelling discourses that bound her to a reproductive body even before this choice was removed from her by early menopause. She did, however, reconstruct these discourses through reproduction for a
few months while she tried to have a baby through I.V.F. Sarah’s concept of self was volatile and contradictory changing within the constraints of innumerable discourses. Likewise Linda’s subjectivity was composed of a range of discourses.

When I first started noticing signs I was about thirty-eight but of course I didn’t know what they were signs of – that really was the problem. In a way the great unknown is the worst. I went to the doctor and asked could it be menopause and he said, ‘Oh, no. It couldn’t possibly be the menopause, it’s much too early’. That was the attitude. So you’re still left with this emotional turmoil and you don’t know why. You think, ‘Oh my god, I’m going totally bonkers’. People would say it’s too early and therefore you have no yardstick with which to measure it. ...

It was really the emotional turmoil. The best way I can describe it is feeling backed into a corner. Everything somehow seemed to conspire against me and I didn’t know how to cope. It just happened that unfortunately that was how my life was working out and I actually was backed into a corner. There wasn’t anything I could do. ...

So I dragged myself down to the Amarant Trust and they said, ‘Oh yes we think it’s menopause’, and they gave me H.R.T. Everyone says it’s good for the soul. In the end I chucked it away. I felt so bloody awful anyway - somehow it seemed to magnify it. It really was suicidal – it got so bad I thought, ‘It’s not worth it’. In the end I suppose my attitude was pessimistic and I thought I’ve got to get old sometime. What does it mean putting off getting old when I know I’m getting old because I’m taking those silly pills.

On the one hand I feel absolutely ancient and on the other hand I feel very young. I don’t suppose I feel very different from when I was fifteen or sixteen. I find it difficult to cope with. I feel I should behave in some old way and I can’t. All this oldness seemed magnified and concentrated on me. Life is organised in different stages. If you miss one, or feel you’ve missed one, you can’t say, ‘Oh, that bit’s done with, finished’. The hangover comes with you. I realised that I am forever the child. Because of this feeling of being backed into a corner I made decisions which seemed rational at the time but on reflection may not have been. As my mother says, ‘The good lord looks after idiots and children’ and classifies me in both categories.

Being menopausal comes to different women differently because of the people they are. I started off life wanting to have nothing but a family and a husband. I would have liked to have a child but it didn’t work out. I’ve had a peculiar life. I had a long-term affair with a married man so we couldn’t have a child. When menopause came I didn’t suddenly think, ‘Oh, my god I can’t have a child’ because I’d spent so much of my life trying to prevent it.
There was a feeling that now I am a confirmed lump of wood because when I was about twenty-five I was very desperate. I physically felt the need of a child but somehow the hump passed and I was alright. There was a feeling of loss that I have actually failed as a woman. I am not a modern person and so femininity is all femaleness. It’s defined in terms of bearing a child and, yes, it wasn’t there. So it was difficult to admit to oneself that one has failed. A woman has to make babies. Everything else comes into it but really that’s what she’s there for. If you don’t, in that sense as a female of the species, you have failed. That’s only part of me – an extra brick in the black wall of pessimism that surrounds my life. When people who have children complain I think, ‘Well, there is something of you that is going to be left. There’s nothing when I die. I may never have existed’. It’s basically the human race. It’s us reproducing ourselves. Something to look back on. This is a concrete achievement. This is something of me that stays here. I have contributed to the human race. Whereas if you don’t have children what have you contributed? Bugger all. Any old monkey can sit in an office and shuffle papers round you know. From that point of view I did feel very much a failure. But I think it was less painful because I’d got over the hump earlier and it was the prevention rather than the production that I was interested in for purely practical reasons. Yes there was an admission of failure but it was a passing thing.

I went off sex completely – totally uninterested. ... I had a wonderful dream. I dreamt I had an orgasm. I think I locked the orgasm up in my head and never allowed it to emerge – except on rare occasions. I think I was rather sex-obsessed in my youth – it would be nice if those days would come back but I doubt they will unless I meet ‘The Stud’.

I don’t think the H.R.T. was any good because to me it wasn’t just a bodily thing. The getting old bit, the absence of periods, the feeling that that part of your life is over and done with. Somehow the H.R.T seemed to concentrate the tension. You’ve got to get old sometime and why not now than in ten years time. If I’d wanted to have children it would have been different. And I’d hardly want periods. It was a blessed relief not to have to put up with it.

I feel like a sore thumb in today’s society. I allow people to do their own thing. I value my freedom too much. I try not to judge because my life has not been blameless. My enjoyment comes from work. I can balance myself reasonably neatly on the wall. I smoke myself silly at work all day. Work has always been home. Linda.

Linda’s dialogue included a variety of mercurial and contradictory discourses. She said she felt young but was prepared to be old. She said that she had wanted children and felt quite intensely that they were important but prior to early menopause had actively
prevented any pregnancies herself. She said she found her work menial yet her work also was her solace. In further conversation she spoke of the contradictory relationships she had with her partner, mother and father. Linda’s subjectivity was all of these things. She constituted her contrary subjectivity within a variety of changing discourses.

It was through this transience of subjectivity that early-menopausal women were able to bring meaning to their lives. Both Sarah and Linda negotiated institutionalized discourses and were able to resist these through the incompatibility with their constructions of self. For instance, Sarah had not considered having a child until her relationship changed. She had even had two abortions when she was younger. When she and her partner were unable to conceive she transacted medical discourses through agreeing to go on an I.V.F. program. But the failure of technology and the unwelcome changes Sarah felt prompted her to resist these discourses and reconstruct her subjectivity despite the compelling arguments of her partner and the recommendation of her doctor to continue with I.V.F. Linda also resisted medical discourses by ‘chucking away’ the H.R.T. prescribed for her. She did this as acceptance of the medical construction of early menopause as a deficiency disease changed her subjectivity. It constructed her as old whereas her construction of her subjectivity was youthful.

Too young for the menopause: disrupted social norms

Linda’s interpretation of her early menopause highlights the relationship between age norms and social norms. She viewed life as having ‘different stages’ and if one stage was omitted it was not left behind but was dragged along into the next stage. In this way early menopause re-emerged for some of the women well after it had occurred as an unresolved incompatibility between existing age and social norms. Thus early menopause blurs the boundaries between age and life stage norms.

Time and again women said that they were ‘too young for the menopause’. Sometimes their doctors, partners or family said the same thing. It is apparent that biologically this is not so. What is being expressed is the inconsistency of early menopause with existing age and social norms. Carly even described her menopause at the age of fourteen as “bizarre” and “... definitely not the norm”. Moreover, the negative weighting given to older women within Western cultures seemed to influence the reaction of some of the women to one of pessimism and shame.

Nevertheless, after they experienced an early menopause many of the women interviewed recreated their identity by shifting their understandings of menopause in relation to age and stage. Even though they might have considered that they were too young for the menopause these women were compelled to reassess the notion that menopause occurs only to older women.

In this way age and social norms are challenged and can change.

... our changing society has brought with it changes in the social meanings of age: blurred boundaries between the periods of life, new definitions of age groups, new patterns in the timing of major life events and new inconsistencies in what is considered age-appropriate behavior.


Women’s experiences of early menopause show that changes in norms are not just biologically or socially driven but that they are the result of a matrix of these interactions. Even though having an early menopause was not consistent with the age and social norms...
anticipated by any of the women interviewed their responses and changes in identity demonstrate the continuous transience of age and social norms.

**The body: when the physical is the moral**

Women described this mobility of the self through physical, intellectual, emotional and spiritual dimensions. Constructions of the body as an objective description and as a subjective experience represented the moral values and judgements of each woman’s cultural environment. Many of the women interviewed considered that an early menopause compromised concepts of their femininity. These assumptions were based upon anticipated or actual changes such as premature aging, weight gain, decreased libido, changing skin and hair quality. These physical elements influenced women’s body-image and to some extent determined how individuals identified themselves as women.

The moral values that construct women as a reproductive body represent inner fertility generically through a youthful and healthy body. This body is the external symbol of fertility and is the visual representation of femininity. These physical dimensions represent cultural concerns around reproduction (Shilling 1993). They are internalized as symbolizing the desired images of the female body and portray the ‘consummate woman’. Western cultures are obsessed by these images. Huge industries have been created around fashioning an illusion of the nubile body. This body represents the moral values of the community and women are judged through this visible depiction of cultural acceptance.

Early-menopausal women absorbed these moralistic meanings and identified them through their physical body. Some of the women were concerned about having an aging body. Although there is no literature to suggest that early-menopausal women age more quickly than other women this misgiving was a recurring theme. Frequently early-menopausal women told how they thought of themselves as having an old interior within a youthful exterior. Even as an adolescent Carly was told this by her doctor.

He told me that inside I had the body of an old women. I visualized myself as crumbling and decaying. It really freaked me out. I thought I would collapse and wither. It has given me no hope for the future and I feel even more alienated from my friends. How can I even talk to anyone about it? It’s too weird and definitely not the norm. I feel really strange and although I’m only twenty-two now I feel like I’m fifty.

Carly.

Nearly all of the women interviewed considered that they were too young for the menopause. Some of the women, like Pat, felt cheated of their youth.

We were living in Africa when I started to complete my periods – that’s a sign isn’t it? It was after my tubal ligation that I noticed suddenly I was menstruating every two weeks and I started putting on weight. I had been brought up in a medical household and I thought that periods were normal and I wasn’t bothered by them. So when this started happening I found it annoying. I didn’t go to a doctor in Africa. I waited until I came home. My first impression was that it was stress because we’ve lived such an extraordinary life living all over the world. I had always been very regular – I never had any troubles – easy pregnancies and births. Before we went to Saudi I had a tubal ligation.
I wondered whether that might have been connected. I was thirty-six and my periods stopped within four years of that.

In Rome I realised that I hadn’t menstruated for six months. They had become erratic and they stopped completely. I was more emotional and then the hot flushes started mainly at night. I didn’t think of menopause because I was so young. Then when I started having hot flushes I thought maybe this was menopause and I felt cheated, really cheated. I didn’t feel I should have to be worrying about this for another eight years at least. It’s another stage and I feel you should be older. My children were still young and I needed all that extra energy. I was cheated of my youth [my italics]. Pat.

Most of the women were unprepared to accept the role they thought of as belonging to menopausal women as this was thought to be synonymous with old age. Not only did many of the women feel that they had become old well before their time but they also viewed this negatively. They referred to themselves as ‘the harridan’, ‘not a true woman’ or ‘a confirmed lump of wood’. The appearance of being old appeared to haunt some of the women as they said that their skin had dried and that their hair had thinned. Felicity told how her hair had turned completely white after her teenage menopause. The extent of external changes in the main appeared to be subtle although sufficient to undermine the confidence of some of the women.

Jeannie, who went through menopause when she was seventeen, was concerned about her future.

What about when I’m older? I don’t know what’s going to actually happen to me. Am I going to age prematurely? When I get to sixty am I going to be like I’m eighty? You’d like somebody to be able to tell you. The lack of information is a real problem. I don’t know much about it. The doctors just use medical terms and I don’t really understand. My G.P. isn’t really involved. They just told me some people aren’t born with enough eggs and yours have run out. I said, ‘Can’t I make more?’ and they said, ‘No, it doesn’t work like that’. It’s just one of those things. But where do they go? Did I have as many eggs as everyone else and they’ve disappeared somewhere or did I never have them? Presumably I just didn’t make enough. Jeannie.

Moreover, early menopause made a number of the women feel old and this often was problematic. For instance, Verrian found her age completely incompatible with her concept of menopause. Even though she was not originally from a Western culture she identified more with this than the culture of her birth. When she went through menopause at the age of thirty-six she reconstructed her subjectivity as an older woman. Going through early menopause relieved her negative view of menstruation but the negative attitude of her partner in regard to lack of fertility led her to keep this secret. I interviewed Verrian eight years later in her working environment where she was a social worker. She was concerned about her retirement.
V: It made me feel old, I mean REALLY old. I thought this was the beginning of old age - and my mother said so too. She was late to have her menopause – she was fifty-nine. In fact I’m the earliest one in my family. I had a cousin who didn’t stop bleeding till she was sixty-four – she was so fed up by then. I remember my mother washing at the kitchen sink and bleeding from between her legs and rushing off to the bedroom to get pads. She had years of bleeding at any time. But you know my mother had a very natural lifestyle and so did my grandmother. We came from the Caribbean and they raised their own cows and my grandmother used a mortar and pestle to grind the flour. I think I had an early menopause because of the modern lifestyle - no one else in my family has had an early menopause. I have eight sisters and none have had an early menopause. I still don’t know why people should start early and why I should start early. I have my own theory that because I had such a bad time [heavy periods] that my system just gave up on me.

S: Has your perception of yourself changed since all this happened?

V: Every now and then I think to myself, ‘Oh, my god I’ll never be able to conceive again’. But only every now and again. And anyway I’ve never really wanted children if I’m honest. I didn’t enjoy motherhood. I wouldn’t enjoy motherhood at all now but I don’t have the choice. Whereas a man in his eighties does have a choice. I’m relieved that I can’t, but still the choice is gone.

S: How do you feel compared to other women your age?

V: I know I’m not fertile anymore and I know they are but it’s not a problem for me. It would be good to have the choice but it’s a choice I probably would not have exercised anyway because I know I’m not mother material. I just never wanted to be a mother – even though I’ve got a daughter. ...

S: Is your self-esteem related to your paid employment?

V: Yes. One of the things I’m dreading most is retirement. I cannot envisage it. I cannot imagine what I’ll be like. The thought of not having a job to go everyday is just - I don’t want to think about it. I don’t want to think that far ahead – I mean I don’t have that far to go – fifteen years. I’ll be forty-five next month – it’s not that long. I just can’t think ahead.

As a representational site of cultural values early-menopausal women found their bodies further modified their self-identity through their body shape. Some of the women gained weight, which to many was unacceptable, as slimness is regarded as a valued feminine characteristic. Often relationships with partners were affected by weight gain. Although none of the women felt that their relationships were threatened by weight gain.
alone, many partners expressed disapproval, which reinforced the negative self-identity of these women. I return to Verrian’s experience.

V: The other thing about this patch that’s worrying me is that once I started H.R.T. I put on a lot of weight. I’m a lot heavier than I look. I’m fourteen stone and I find that very difficult. I like my food just as anybody else but I try to eat healthily and the weight’s piling on.

S: How have you felt during the last few months without H.R.T?

V: My health has certainly improved. The headaches aren’t as frequent although I have one now. They can last a couple of days. The months leading up to when I came off it I just felt unwell – all the time mostly -nauseous and fat. All I know is that I’ve put on a lot of weight and I’m heavier than I actually look – I wear size eighteen clothes – I’m deceptive to look at. I’d give anything to loose weight. I’ve give anything to be ten stone or even twelve stone. Before I started on the H.R.T. I was a lot smaller. I put on weight when I went on the pill the first time and when I came off that one and went on to something else the weight just fell off. When I had my daughter I put on weight again over that period and I just lost it straight away. It seems that when I put on the weight and I stop what I’m doing it just comes off, but with this it’s not. In some ways it’s creeping up.

The weight gain is the biggest issue for me. I tried diets but they don’t work. I went to see my G.P. and she gave me appetite suppressants but I flushed them down the loo. It makes me feel awful. I don’t want to go out. I’m digging my heels in about buying new clothes because these are so tight and I don’t want to go into the twenties. I kept saying I’d never go to fourteen, never go to sixteen, never go to eighteen – well, I’m really digging my heels in now. I am really concerned about taking the patches and the tablets because I’m wondering what that is going to do for my weight. I sit a lot as well.

I find it stressful. My partner says things like, ‘You look alright – but – you could have a little bit off here and a little bit off there’ and things like that. And someone bumped into me and said she didn’t realise I was in the family way. I went home and emptied the fridge. I just couldn’t stop eating. The someone else said to me, ‘My god you’re fat’. But I just have to look in the mirror – but I don’t want people telling me I’m fat. Sometimes I wonder if I hadn’t taken the H.R.T. if I’d be any different. So it does impact on my self-esteem.

My partner could have been a little bit more supportive over it. ... While he doesn’t want me slim, he doesn’t want me fat. He’s always saying you could have a bit off here and a bit off there and yet when I say I’m going on a diet he goes berserk. His image of me is a negative one right now. It makes me feel pretty bad about myself. Sometimes I feel the relationship is threatened by it. If I’m honest and dig deep
enough I know it’s not – but sometimes you find yourself wondering. Verrian.

All of the women who found weight gain problematic were on hormone replacement therapy (H.R.T.). Ironically H.R.T. is promoted as a means of retaining the revered characteristics of ‘femininity’ (Klein and Dumble 1994: 334). Conflicting feelings created a dilemma for these women in regard to the continued use of H.R.T. Several of the women had taken themselves off H.R.T. in order to lose weight or in an attempt to reject the medicalization of their circumstance. Some women felt compelled to return to the use of H.R.T. Often the reason cited for this was an unwillingness to tolerate menopausal symptoms although some of the women admitted to having an ‘addiction’ to H.R.T. as described by Klein and Dumble (1994: 338). Other women said that they were frightened to stop taking H.R.T. This fear originated from the medical hype of future danger if early-menopausal women do not take H.R.T., at least until the ‘usual age’ of menopause (Baber et al 1991; Conway 1995). Thus, the self-identity of many early-menopausal women became committed to risk and so-called risk avoidance through taking exogenous hormones (Beck 1993).

The body was the site of further condemnation through the reported decreased libido of a significant number of early-menopausal women. The relationship between decreased libido, early menopause and self-identity has not been clarified in any study. However, concepts of femininity appear to be tethered to hetero-sexual activity and availability. Loss of libido was common amongst the women interviewed and disinterest in sexual activity negatively affected the self-identity of these women. Some of the women, like Simone, described a decreasing confidence in their ability to retain their partner’s fidelity generated from their own loss of libido. Broken relationships seemed an inevitable result for some women, and for others this had occurred already. Shireen tells of how she broke her relationship.

The whole thing was making me really angry – especially the infertility. One day I was so angry with my boyfriend I just shouted at him and told him to, ‘Go and find himself a woman’ – we split up after that.

Shireen.

**Embodied experience: reflection of social order**

The experience of early menopause transcended the biological. Women’s discourses rejected the Cartesian split between body and mind that has dominated Western discourses for three hundred years (Douglas 1992: 216-220). Early-menopausal women described more than the physical body of medical discourse or the moral body of cultural values; they described the lived body of the “embodied self” (Turner 1994: 7). Moreover, they described an assault to this embodiment through the uncertainty of a fluctuating subjectivity.

It has affected the way I am. My thyroid, my bad back, my weight – I feel so different – no energy. I have lost my joie de vivre. I suppose I’m still me but I’m not the me I know. All that stuff about fertility is gone – just sort of numbed out – I really am a different person to who I was before.

Robyn.
Early-menopausal women demonstrated not only a consciousness of embodiment; but also how the variations and undulations of embodiment shaped and reshaped their subjectivity. The relationship between the women’s construction of subjectivity, their body and their body as a lived experience was complex. It moved beyond the biological body and the ontological body and embraced the lived body as an intangible and volatile concept.

I felt as if I had another person living within me. I couldn’t understand this invasion and longed for the old me to return. Where I had felt in control this new person just ‘lost it’. It was really confusing.

I found it especially difficult at work because it’s an all male environment. Unless you have a cold there is no place for ‘illness’. Whenever I got hot flushes or felt that I was someone else I just wanted to return to the person I knew. Rebecca.

The high value placed upon women as a universal body of reproduction influenced early-menopausal women. This construction reduces women to a social role that values them for their sexual attractiveness, hetero-sexual availability, fecundity, motherhood and nurturing qualities. This construction of women through the primacy of reproduction is confronted directly by the infertility of early menopause and the demise of women’s ovaries as symbols of womanhood. Although the reduction of women to a reproductive body focused initially on a woman’s uterus, through a process of scientific evolution and classification her uterus lost primacy to her ovaries as the symbol of womanhood (Oudshoorn 1994: 8). The extension of interest from a woman’s uterus to her ovaries has been used by bio-medical discourses to condemn early-menopausal women to redundancy through the so-called premature failure of their ovaries.

I wasn’t really surprised to find that my ovaries weren’t working. I felt different to other women and I wasn’t having periods anymore. But I was knocked off my feet to find out that I didn’t even have any [ovaries]. There were just bits of them left. Streak ovaries he called them. I can’t tell you what it did to my self-esteem. Felicity.

The chaos and uncertainty surrounding the subjectivity of early-menopausal women represents the interaction among the body, culture and society. Women whose subjectivity was constructed through the definable, the known and the discourses of certainty were confronted by the changeability of embodiment. This anxiety reflected contemporary challenges to the philosophy of knowledge. As philosophical analyses reassess the idea of the lived body, philosophy itself develops (Turner 1994: 45). Thus, the changing subjectivity of early-menopausal women symbolizes the changing and uncertain world in post-modernity.

**Agency and change: recreating discourses**

Through a reflective process early-menopausal women who questioned the medical discourses that create women as a reproductive body and early-menopausal women as a failed reproductive body were able to recontextualise their corporeal body within broader dimensions. They did not see themselves as bound to a predictable or
unchanging sex; they viewed themselves as flexible individuals who were situated within a moveable and oscillating social structure.

I kept my early menopause to myself for a long time. Then one day at work people were discussing H.R.T. and I said that I was on it. My colleagues were stunned. They said that they thought H.R.T. was only related to menopause and older women. They couldn’t believe that someone young needed it.

I found it quite liberating to talk about it and it didn’t seem so negative any more. Now a lot of the younger people at work talk about early menopause; even the men. It has made me more tolerant and reflective and made my work colleagues more aware.

I found that the most difficult aspect of having an early menopause was the difference I felt being young and the idea that menopause was an awful thing that happened to you at middle age. It made me step into my next life-stage emotionally and psychologically even though I am young. ...

My relationship with my husband has not been affected. I am very independent and we don’t discuss it much. He didn’t ever want children anyway and I just accepted that as part of our relationship. So fertility is not an issue for me. I get a lot of satisfaction from work and my professional role.

Rebecca.

Rebecca was able to assimilate her early menopause within the context of her variable subjectivity. She described other changes, such as physical discomforts, and her initial confusion over these experiences. Being able to articulate her experiences as different from the discursive construction of menopause that she had anticipated allowed her to recreate her subjectivity. Without referring to any literature, academic study or other discourse on early menopause she rejected constructions of menopause as being negative and related only to midlife. Moreover, her subjectivity was modified away from the constructions of women as a reproductive body allowing her to transit through her early-menopausal experience positively.

Even women who were mothers and had viewed their reproductivity positively felt that this was only a part of who they were. Lily went through menopause when she was thirty-six years old and already had children. She welcomed her early menopause.

I thought it was heaven sent. I didn’t want to fall pregnant at that stage and I am glad that [fertility] has been taken away from me. I loved being a mother but now it’s time to move on.

It’s as though my life has done a complete somersault. I liked the way I was then but I like the way I am now. What I did then was right then and what I’m doing now is right now.

I don’t feel old. I’ve had a couple of relationships that have got sexual and I’ve thought, ‘At least I can’t fall pregnant’. I’ve turned it to my
advantage. It might be because my social life, like work, has helped me do it. Lily.

Lily interpreted her understanding of early menopause through the cultural definitions and values that were available to her (Turner 1991: 213). She rejected continuing menstruation and fertility as positive aspects of her life. Although she had enjoyed motherhood she said her menstruation was heavy and painful. She was concerned that her menopausal symptoms would be equally problematic. She ascribed this attitude to her mother’s experiences even though she was adopted.

I didn’t want to suffer like my mother did so I thought the H.R.T. was a good idea. My mother’s still having implants and she’s had a hysterectomy and everything. But you see she’s not my natural mother, so I can’t go by her history, she’s my adopted mother. Both my girls have inherited the bad periods the same as me. Lily.

Lily’s subjectivity was constituted through the cultural discourses available to her, in this case partly influenced by her mother’s experiences. She was able to incorporate early menopause into her life positively as she felt freed from the constraints of menstruation and contraception. In other words she constructed her identity as mobile and moving beyond reproductivity. There were other respondents as well who indicated that they were able to reject, at least partially, the medical interpretation of early menopause as a failure of the reproductive body. For instance Dana wrote from the U.S.A. by E-mail that she viewed her early menopause positively.

I was probably forty-two when I started skipping periods for four or five months or so. It was annoying because you can’t use any sort of rhythm method as birth control. Also, since you have no idea when it is coming it means that you have to use panty liners for work and sometimes it was just surprise, surprise!

I had three miscarriages before my first vaginal delivery of a live child (thank you god) – aged thirty-three. Then a C-section of next live child at age thirty-five (thank you again god) – no further pregnancies.

Having menopause meant to me - FINALLY, no more birth control!!! I would not consider taking hormones. I had no life changes except a few hot flashes once in a while. It is no big deal and I don’t need any help.

Now I plan to return to college for a Bachelor of Science and possibly a Master of Science with a career change involved! I don’t worry about losing my mind – it’s only loss of periods not Alzheimers! I just expect my life to continue on its path. I really seldom think about menopause. I certainly don’t expect to lose my mind – I really need it for the degrees I am planning to get!
Of course I think I am still a ‘real’ woman. I don’t buy into that crap that you have to ‘prove’ your womanhood by bearing babies and the loss of my childbearing abilities has nothing to do with who I think I am. I have been married for sixteen years and menopause has not affected our relationship. If my baby making abilities are gone now, HALELLUIAH! I sure don’t want to be forty-five and pregnant! And I don’t want to be fifty with a kindergartner – and I like my age – forty-five – old enough to have some life experience but young enough to enjoy a lot more of it!

Dana.

Conclusion

The women in this study articulated their subjectivity as a never-ending process of change. All of the women found that their subjectivity was affected to some degree by their experience of having an early menopause. For several women this was dependent upon external knowledge whereas others relied upon their own intuitive knowledge. Women who turned to their own discourses and understandings appeared to be better able to reconstruct their subjectivity positively in relation to their early menopause. Women whose self-identity was strongly committed to sexually-specific discourses of reproduction seemed more likely to reconstruct their subjectivity negatively.

These dichotomous interpretations of women’s responses to having an early menopause are representative of a broad spectrum of how women viewed themselves. The infertility of early menopause did not allow some of the women interviewed to identify themselves as ‘reproductive’ in opposition to men as ‘productive’. Nevertheless they still viewed themselves as women, albeit sometimes not as ‘true’ women. In this way their gendered-identity was altered by the experience of having an early menopause. Although they identified themselves as women this was not in sexual opposition to men. Their subjectivity was tethered to a transient representation of sexual mobility.

Women’s discourses constructed early menopause as lived experiences of ambivalent, changing bodies and fluctuating, fragmented and multiple subjectivities. Consistent with post-structuralist theories of the body, early menopause was a dynamic process of change. Women experienced early menopause differently and each woman articulated her experience through a wide-ranging and mobile construction of the self. Although the women negotiated dominant discourses of the body, construction of women and medical definitions of ‘premature ovarian failure’ they were able to resist these discourses variously through the changing discourses of their changing bodies. Women’s varied and fragmented accounts were reminiscent of the fracture and uncertainty of the contemporary Western world.
Chapter Nine

Conclusion

Her existence appears to fuzz the ‘natural’ boundaries between the sexes; neither maternal/virginal nor paternal/masculine, she is the supplement, the in-between. She begins culturally to enter a state of indefinable existence in terms of the dominant parameters of phallic sexuality and reproduction, which renders her redundant in a male-defined paradigm. This impossible condition operates culturally as a freak of nature, because her body/sex is no longer reducible to that of the ‘natural feminine’ state of representing the ageless (m)other, the forever silent centre of support for everyone’s fragile subjectivity.


Introduction

Early menopause is a changing concept that is constituted within a range of varied, volatile and, at times, competing discourses. In this thesis I have examined dominant constructions of early menopause; deconstructed these interpretations through a process of critical analysis and opened possibilities for a reconstructed dialogue of early menopause. In essence I have exposed the disparity between the reductionism of medical discourses that construct early menopause as a quantifiable bio-chemical fault and the discourses of early-menopausal women who constitute their experiences through mobile and fluctuating discourses. I do not suggest that these discourses are mutually exclusive but rather that they represent the fragmentation and diversity of discordant discourses of early menopause.

I have looked at early menopause through a poststructural and feminist analysis that allows for these multiple and mutable discourses. I examined medical discourses that have constructed early menopause as an anomaly of nature. A literature review showed that early menopause is not biologically determined but is simply a construction by dominant discourses. Moreover a feminist perspective revealed that the medical reduction of early menopause to a rare bio-chemical event has subordinated women who have an early menopause as ‘non-reproductive’. In this way women who have an early menopause have been marginalized as nonentities.

I used Fraser’s (1997) theory of cultural recognition and redistribution to underpin a critical inquiry of the invisibility and inequality of early menopause. Not only did this provide an understanding for the monopoly of medical discourses over constructions of early menopause it also allowed a critique of the construction of early-menopause through gender inequalities. According to Fraser (1997: 12) it is only through connecting these problematics that new ways of understanding can be accommodated. From this ontological location I sought an affirmative reconstruction of early menopause through an examination of women’s discourses of their embodied experiences.

Changing bodies: discourses of risk, naturalism and the self

I have not attempted to set one paradigm in opposition to another but have embraced discourse theory (Lupton 1995) that acknowledges the concurrence of different discourses and provides an explanation for discrepancies between knowledges. I have looked to theories of the body for an appreciation of this perspective as constructions of the body vacillate according to different interpretations. The emergence of the body
within sociological, philosophical and feminist theory has developed the interplay between the somatic and the symbolic body opening analysis of the body to multiple discourses. Medical discourses have been slow to absorb this fluidity of the body and continue to construct women generically through the biological determinism of sequential life-stages. Ontological debate has not critiqued this naturalistic construction of chronological life stages and menopausal women have been tethered to midlife.

Medical discourses have constituted early menopause through bio-chemical understandings as a natural female fault (Stoppard 1994: 7-13). Early-menopausal women are condemned through ‘premature ovarian failure’ as if women’s changing bodies originate from an innate malfunction of the natural body. This creation of early menopause through spontaneous pathology is singular, distorted and ignores women’s social context. Moreover, it ignores the contemporary pandemic of early menopause within the Western world.

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Discourses of risk, naturalism and the self are all bound into the construction of early menopause. For instance discourses that portray women’s bodies as troublesome and at risk of future danger are used to validate medical treatments that can cause early menopause. Historical anxiety over unconfined sexuality is transacted through the medical control of women’s bodies. Practices of risk avoidance, especially the removal of women’s reproductive organs at hysterectomy, are by far the greatest cause of early menopause. Yet the scale of this consequence of medical treatments is ignored by medical discourses.

Similarly naturalistic constructions of the body as immutable disregard the potential for bodies to be changed by their location in history. Contemporary Western environments can be detrimental to women’s bodies and cause an early menopause. Yet within a positivist paradigm changes that are insidious and vary according to individuals are interpreted as inconsequential. This further removes early-menopausal women from visibility. Intertwined with these perceptions is the concept of the body as a representational site of cultural values (Lupton 1995). Feminist, sociological and philosophical analysis have shown that bodies are modified by their cultural context and perceptions of the self influence the behaviour of individuals within their social structure (Grosz 1994; Shilling 1993; McNay 1994). In this way women’s bodies can be altered by social activities that unintentionally can cause an early menopause.

Although chronological age is recognised as a predictive marker of social behaviour the experiences of early menopausal women challenge the rigidity of the so-called ‘biological clock’. By ascribing a fixed timetable to physical changes, and concurrent social expectations, the subtlety of fluctuating expressions of the body is lost. Women’s experiences of early menopause show that the dynamics of social change are not only rooted in shifting discourse but also that the physical body is equally transitory. Bodies change due to their location in history. And biology is in such a constant state of flux that the fixing of social and physical norms to criteria such as sex or age is limiting. In this sense women’s experiences of early menopause articulate the melding of the chronological body with the social body through perpetual movement.

Thus social anxieties are expressed through corporeal bodies that are changing through the iatrogenic, environmental and cultural origins of early menopause. Medical discourses that embrace a positivist paradigm marginalize other discourses and in doing so disregard early menopause as an embodied experience. This cultural non-recognition has diminished women’s accounts of early menopause and failed to attribute these to early menopause as a contemporary occurrence.
Changing discourses: sexuality, fertility and subjectivity

The empirical data used in this thesis was obtained by listening to women’s narratives of their experiences of early menopause. Their stories opened up new discourses of early menopause. They embraced discourses of sexuality, fertility and subjectivity that can be interpreted as embodied dimensions of ontological discourses of risk, consumption and uncertainty. Thus early menopause can be reconstructed through an alliance between the ontological body, the physical body and the body as a lived experience. Women’s discourses that revealed this connection between these layers of the body also communicated the dynamism of the body, the self and the social structure. By merging these concepts it is possible to articulate a union between the cultural non-recognition and the social inequality of early menopause. The discourses of early-menopausal women were volatile and expressions of sexuality, fertility and subjectivity differed between women as well as being individually dynamic.

Early-menopausal women articulated a subtlety within their sexuality that was not constrained to a crude binary opposition between the sexes. Early-menopausal women described a sexuality that differed from dominant constructions of women as diametrically opposed to men. They did not see themselves as more man-like but as sexually-vibrant women. This sexual variation has been interpreted through a two-dimensional continuum (Grosz 1994: 19) or within a sexual difference of ‘multiple intersecting differences’ (Fraser 1997). Women’s discourses of early menopause expressed their sexuality as more than varied they expressed their sexuality through mobile and oscillating discourses of change.

In other words early-menopausal women constructed themselves as women whose sexuality was continuously diverse. Women’s discourses of early menopause rejected the absolute sexual difference that has been used to marginalize early-menopausal women. They expressed a gentle gradation of sexes that allowed individuals to slip in and out of gendered identities. Their discourses challenged the binary oppositions of modernism and the construction of bodies as passive and immutable. These women were not constrained by sex as biologically specific but they constructed their subjectivity within a mobility of gender. Their discourses of mobile ‘multiple intersecting differences’ called for a cultural recognition of multiple and mutable sexes within sexual difference. They also called for equality within discourses of gender that have devalued early-menopausal women as ‘non-reproductive’.

Underpinning constructions of bivalent sexual difference is the social value of fertility. Infertile women have been condemned throughout history and in the contemporary West burgeoning industries are structured around the control of the creation of life. The discourses that construct women through their roles in production or non-production, reproduction and non-reproduction are complex (Oakley 1993; Grosz 1994: 16) but have tended to neglect women’s discourses of infertility (Klein 1989). Women’s discourses of their experiences of early menopause confronted the dominant construction of women’s fertility as given, infinite and of inestimable value. Early menopause brought with it inevitable infertility and women articulated a spectrum of discourses around their own infertility and its relation to reproduction.

Some of these discourses reflected a dichotomous play-off between the values of production and non-production, reproduction and non-reproduction. Some women constructed their identity as productive through paid employment in the public sphere, others as non-productive within the private domain. Other women constructed their identity through the reproductivity of motherhood or conversely through the non-reproductivity of infertility. All of these concepts were transient and interlaced. Thus,
women’s changing bodies were constituted within changing discourses as each woman’s construction of production, non-production, reproduction and non-reproduction vacillated and occasionally overlapped.

Early-menopausal women, however, did not always construct their subjectivity through production or their fertility as out of control through non-reproduction. Reflecting the value of the body within contemporary consumer culture (Shilling 1993) some women constructed their fertility as a commodity that could be purchased. They expected fertility could be acquired artificially due to the dominance of discourses that normalize the role of technology in reproduction. A few women expected that they could pay for human eggs as any other commodity and that this automatically would allow them to be able to reproduce through in-vitro fertilization. For most the lack of success of this technology was unexpected and women were forced to renegotiate discourses around the ‘non-reproductivity’ of early menopause. This infertility became an intractable agony for some women. Other women were able to resist the disapproval of discourses that demeaned and commodified infertile women and reconstructed their identity through a fluctuating and felicitous subjectivity.

Each woman’s experience of having an early menopause was different and articulated through diverse and changing discourses. Just as the women’s bodies were in a constant state of becoming this continuous change was absorbed by, and incorporated into, each woman’s construction of her subjectivity. Thus discourses of changing bodies constructed new discourses of changing subjectivities. These constructions of the self were ongoing processes (Weedon 1998) that were inextricably bound to the bodily modification and transformation of early menopause. Yet the construction of the self as an autonomous agent within the social structure removed the possibility of uniting early-menopausal women as an homogenous group. Early menopause merely was one aspect of the multiple identities of each of these women (Denzin 1998). Their discourses were disunited through the wide variation in age at menopause, dissimilar bodily changes and disparate constructions of the self. Adolescents, young women and midlife women expressed their experiences of early menopause through individual meanings. Yet there was no lasting conjunction between these discourses as the meaning of each woman’s experience vacillated. Nevertheless these narratives could be layered, intertwined and joined with other narratives to open further discourses of early menopause as an embodied process.

Conclusion

In this thesis I have made the case that the dominant construction of early menopause as an innate failure of the female body subsumes the individual discourses of early menopause and subordinates early-menopausal women through gender injustice. I have suggested that early menopause is not a natural pathological event but that it is the contemporary result of historically-based practices of risk avoidance and social control. Moreover, I have proposed that the representation of early menopause as a malady, a female bodily failure, does not represent the reality of individual women but depicts a particular construction of menopause by dominant interest groups.

To view early menopause through women’s embodied experiences I turned to the discourses of early-menopausal women. These discourses challenged the medical reduction of women to a unified body of reproduction. They represented women through diverse subjectivities and perpetual fluidity that was shaped and reshaped by different discourses. Women’s discourses of early menopause disturbed the equation of menopause with midlife. They rejected the inflexibility of biological-determined chronological life-
stages and exposed the elasticity of bodies (Grosz 1994). For instance women’s age at menopause spanned over three decades. Adolescents, young adults and women at midlife all described their experiences of menopause as early based on their own cultural discourses. The markers of menopause differed as well and women had wide-ranging menstrual and other experiences. The most significant aspect of early menopause was the constantly changing meaning each woman constructed around her own experiences. These varied interpretations of women’s experiences have been subsumed by the discourses of positivism and finites and absolutes have been constructed where there is perpetual mobility. Even though to some extent the inflexible constructions of early menopause constrained women’s experiences of early menopause women also were able to resist these discourses. It is through this resistance that early menopause can be reconstructed. While no absolutes can emerge from a study of individual discourses interesting connections can be made.

This study would suggest that the construction of menopause as age-specific be re-examined. Menopause clearly can fall outside the current parameters of age norms. While some sort of allowance is made for women who have menopause before the age norm of menopause neither the incidence of early menopause nor its association with modern Western living have been addressed adequately. Moreover, women’s responses to having menopause that is ‘out of context’ with age and social norms indicate that ‘early’ menopause can be problematic for individuals. Women express physical, emotional and psychological difficulties when they do things that sit outside outside age and social norms.

Through merging poststructural and feminist critiques I was able to come to an understanding of early menopause through corporeal, ontological and embodied dimensions. The overlapping of these perspectives acknowledges individual differences between women and rather than unquestionably rejecting metanarratives embraces an overarching critique of gender inequalities. Through this perspective I was able to connect women’s discourses of sexuality, fertility and subjectivity with contemporary concerns of risk, consumerism and uncertainty. These themes reflect the moral values of modern Western cultures and expose early menopause as a metaphor of the fluctuating expressions of social anxieties. This complex relationship highlights the inextricable link between historical concern and contemporary anxiety over the human condition and weaves constructions of the corporeal body through concepts of the philosophical body. In particular early menopause exemplifies the changing bodies of modern women and the inconsistencies of the modern world. In this way a sociological analysis of women’s discourses of early menopause calls for a cultural recognition of women’s changing bodies and legitimates a gender rebalance through changing discourses.
I would like to interview women about their experiences of early menopause. Early menopause is defined as having your last period before the age of 45, or by self-definition if you think your menopause occurred early. The data collected from this interview will be used as part of my master of arts/doctor of philosophy degree in sociology. I have worked as a nurse practitioner in Family Planning for a number of years. I have extensive consulting experience and the competency to interview appropriately.

The aim of this research is to provide a social perspective of early menopause. I am interested in such aspects as:

- what early menopause means to individual women
- what life changes are experienced
- any differences within relationships
- the necessity or otherwise to seek outside help
- how early-menopausal women see their future.

This information will be sought through in-depth interviews where participants will be encouraged to express themselves in their own way. Each interview will be on a one to one basis and will take approximately one to one and one half-hours. The interviews will occur in a mutually agreed place where privacy can be assured. All information will remain confidential and no identifying details will be included in the study. Participants can withdraw information and the interview can be ceased at the request of either party.

With the consent of the participant, the interview will be taped and later transcribed by the researcher. Only the researcher will be aware of the identity of the participant. When all the interviews are complete the data will be collated. This collective data will be used to identify commonalities and themes of women’s experiences of early menopause. This qualitative information will then be contextualized and produced as part of my master of arts/doctor of philosophy thesis.

If participants feel the interview raises unresolved emotional issues, appropriate professional assistance can be organized. Please feel free to contact me at home on 0171 937 8395 or at work on 0171 388 0662.

Sheralyn McGuinness.

Supervisor: Dr. Karen Lane, School of Social Inquiry, Deakin University, Geelong, Victoria, Australia 3217. Phone: 010 61 52 271335.
Attachment 2.

HAVE YOU EXPERIENCED AN EARLY MENOPAUSE?

I would like to interview women who are experiencing, or have experienced, an early menopause. Early menopause can be defined as having your last period before the age of forty-five, or by changes attributed to the menopause if you no longer menstruate, or by self-definition if you think your menopause occurred early.

As part of my post graduate degree in sociology through Deakin University, Australia I would like to better understand women’s feelings about early menopause. I am interested in: what early menopause means to individual women; what changes are experienced; how women feel about any changes; if there are differences within relationships; the necessity or otherwise to seek outside help; and the view early-menopausal women have of their future.

THE INTERVIEW IS NOT A MEDICAL CONSULTATION

THE INTERVIEW IS CONFIDENTIAL

PARTICIPANTS MAY WITHDRAW AT ANY TIME

THE INTERVIEW WILL TAKE ABOUT 1.5 HOURS

PARTICIPANTS MAY CHOOSE THE VENUE

ANONYMITY IS ASSURED

THE INTERVIEW WILL BE TAPELED WITH THE CONSENT OF EACH PARTICIPANT

APPROPRIATE PROFESSIONAL ASSISTANCE IS ADVISED FOR ISSUES OF CONCERN

If you are willing to participate as an interviewee please fill in your name, address and telephone number at the bottom of this page and return it to the address below. I will then contact you to confirm your interest and arrange a mutually agreeable time and place to meet. No pressure will be placed on you to continue if you change your mind.

You may prefer to contact me by phone.
Sheralyn McGuinness (H) 0171 937 8395

Please tear off and return to Sheralyn McGuinness, 7 Argyll Road, Kensington, London W8 7DA.
THANK YOU.

NAME:
ADDRESS:
PHONE:
EARLY MENOPAUSE?
If you have experienced an early menopause can you spare one hour for an interview?
Non-identifying information used for sociological research.
For further information please ring SHERALYN McGUINNESS
0171 – 937 8395

What’s your story?
Can you spare one hour for an interview about your experiences of an early menopause?
If so, I would love to hear from you. I am researching early menopause for my doctoral thesis in medical sociology.
If you live or work in central London we could arrange a mutually suitable place and time to meet. If this is not convenient, are you able to write your story for me and send it by mail?
I would like to hear YOUR story. What your experiences have meant to you. How you found out you were experiencing an early menopause. How this did or didn’t affect you. How it affected any relationships. If it impacted on your self-identity. That sort of thing.
All information is confidential and no identifying material will be used. I will keep you informed personally, or through the Daisy Chain, about my findings.
With thanks,
Sheralyn McGuinness
7 Argyll Road
Kensington
London W8 7DA
Phone and fax: 1071 937 8395
E-mail: sherie@petermcg.demom.co.uk
EARLY MENOPAUSE
QUESTIONS AND TOPICS FOR DISCUSSION

1) MEDICAL HISTORY - family history, menstrual history, reproductive health, beliefs about menopause, menopausal symptoms (expected and experienced), sexuality and sexual experiences.

- How old were you when you first experienced menopause?
- What did you experience?
- How did you feel about this?
- What is your medical history?
- What does this mean to you?
- Do/did/will you take hormones (HRT)?
- If you have used HRT, what has been your experience?
- Have you had any pregnancies?
- What type of contraception have you used? For how long?
- Do you smoke? If so, how many per day and for how many years?
- What sort of diet do you have?
- Do you exercise?

2) LIFE STYLE AND LIFE COURSE – past and present.
- Did you experience any life changes?
- How do you feel about any changes?

3) BEING A WOMAN – role and image, support groups and networks, coping strategies, information flow.
- Did you seek outside help?
- How do you view your future?
- Do you worry about losing your mind?
- Do you think you are not a ‘real’ woman after early menopause?

4) PERSONAL BACKGROUND – friends, family and social life.
- Do you have a husband/partner?
- Have you experienced any changes within relationships?
- Has having an early menopause had an impact on your life?
Attachment 6. Contact after the interviews.

Letters:

Dear Sheralyn,

Thank you for your lovely card. It was nice to hear from you. I hope your work is coming together and I am glad if our conversations helped in any way.

At the moment I am busy with my exams. ....

After our conversations and my medical appointment I spoke to my parents about the whole situation. Surprisingly, they really understood and have been really supportive. I think it was the right time to finally have a serious talk about the situation.

This has made it a little easier for me, as now we can talk about it openly. It will be lovely to stay in touch. All the best with your work, I’m sure it will be a pleasure to read.

Hope to hear from you,

‘Shireen’.

Dear Sheralyn,

Thank you for your advice and suggestions to improve my health. It has been a great success. My general physical health has improved and I feel so much more settled in myself:

I wish you all the best with your endeavours and every happiness in your new life.

Thank you. Love, ‘Jenny’.

Phone conversations:

“It always helps me to talk about it. There aren’t many people you can say to – ‘Hey, I think I just ‘lost it’ because I’m in my menopause’. It all seems out of place when you’re mixing with young mums.

You know it is quite crazy when you think about it. I didn’t know what it was, but there seems to be a bit more information now. Did you see the article in last month’s ‘Women’s Health Magazine’ about a girl who had an early menopause?”
Anne.

“I really enjoyed the summary you sent. I was good to read about other women’s experiences. I hope I can read it all when you are finished. ... Talking about it has made me feel so much better about myself.”
Beth.

E-mail:

Dear Sherrie ...

I have been following a treatment with a Fertility Enhancement Therapy and I think it would be so interesting for you to talk to the doctor there and hear his views based on his research and practice. He maintains that there probably isn't such a thing as 'early menopause' but that its a convenient term used by the conventional medicine establishment to explain away something they dont have a better answer for. This makes him sound quite radical, but he's not, I find it very interesting as of course it is in my interest to believe what he says.....but its something along the lines of my reproductive system closing down as a result of 'stress' for want of a better word - not feeling 'safe' at a very primeval level....get the picture or am I explaining myself very very badly. ... [husband] is
very sceptical. I live in hope, but I hope not false hope. I've been seeing him for over a year, we'll see. Last year was rather a write off, it was a bad year. My mother died. ... I learnt some hard and bitter lessons, but the truth is always bearable, whatever it is, not easy necessarily, but bearable. I have never felt so totally alone before, physically, emotionally and mentally. Grief makes such fools of us, I don't EVER want to feel that raw again about anything, very frightening, but now its in the past and I look to the future. Of course to loose one generation and not to have a future one to pass things on to is very hard to endure, no sense of future, of permanence, of continuation, makes it all seem so pointless, so transitory, so temporary. Ah well, what the hell. ... Reality was a cold hard slap in the face and I am still trying to adjust, it is so much more possible now that ... is back, I suppose in some way its as if I need someone to love, or some outlet for the love I have to give (you must think I've gone completely round the bend Sherrie, all this bearing the soul bit - must be the Doris Wild Helmering and Caroline Myss I'm reading!!!!!) and suddenly at the time when I needed to do it most, there wasn't anyone. This must all happen for the same reason that its all or nothing, i.e. nothing much happening for several weeks and then three events all at the same time.....if you figure out the why of this, e mail me! Anyway enough gloom and doom from me.
I have been looking for our home since we left ..., that's six years now. I wonder if there isn't some subconscious current in me that doesn't want to live in England....some of the trouble is - all tied up with this infertility business - is I can't 'imagine' us, picture us, visualise us, living in a place with no family. But we will, things will work out, somehow, I'm sure. (I think). I will phone you. In the meantime, lots of love from England, 'Stephanie'.
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