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GENDER AND THE SOCIAL CONSTRUCTION OF ILLNESS

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CHAPTER 5

If a Situation Is Defined as Real: Premenstrual Syndrome and Menopause

> We should think about the consequences of defining a large proportion of otherwise well women as ill because of unpleasant feelings during part of their menstrual cycle. To assert the reality of their feelings—yes, this is essential—but to decide that they are abnormal and to be stamped out . . . that is another matter. (Laws et al. 1985, 36)

In the twentieth century, in Western culture, the menstrual cycle was transformed from a misunderstood and somewhat contaminating female phenomenon to a series of biomedical events—the hormonal inputs of puberty, preparation of the uterus for pregnancy, and cessation of reproductive function. From this biologically informed perspective, we learn that for most women, in the absence of conception, menstruation ensues; if a heterosexually active teenage to middle-aged woman doesn't get her monthly period, she suspects that she is pregnant. When a woman's ovaries stop their maturation of eggs, the cessation of ovulation sets off the process we call menopause. A woman's body no longer secretes pregnancy-preparing hormones that thicken the lining of her uterus; the lining no longer needs to be sloughed off in the absence of fertilization of the ovum, and gradually, the cessation of menstrual periods—menopause—occurs.[1] Any problems that accompany these cycles, such as pain, discomfort, or emotional reactions, have become medical. The solution is frequently a prescription for a hormone or other powerful medication, when stress management, nutritional supplements, and social supports might work better and have fewer long-term side effects.

Women's experiences of menarche, menstruation, and menopause are mediated by beliefs about femininity, desirability, and social worth. In Western culture, menarche is not a time of celebration, but the onset of the possible embarrassment of showing blood and the danger of getting pregnant. Menstruation is an occasion for put-downs about poor functioning "on the rag." Menopause has become a sign of aging and the end of procreative capabilities. Since a Western woman's social status is so intertwined with her body and reproductive biology, cultural values surrounding menstruation and menopause spill over into valuations of womanhood itself.

These negative feelings about oneself and one's body can intensify reactions to the cramps, bloating, and other physical reactions that often accompany hormonal fluctuations. Serious attention to these discomforts legitimizes a physical and social reality that historically was ignored, trivialized, or misunderstood. However, the medical and cultural interpretation of these reactions can also stigmatize women as mentally ill, unreliable, sick, incompetent, and weak. Although there certainly are women who do benefit from amelioration of disabling menstrual conditions, most women pursue their usual activities before and during menstruation and menopause (Yankauskas 1990). Nonetheless, there are multiple examples of how all women are said to suffer (and make others suffer in turn) from the "horrors" of "that time of month" or "that time of life." In our society, these syndromes denigrate women as a group and justify their subordinate social status (Laws 1983; Rittenhouse 1991; Zita 1988). Menstruation and menopause are real physiological and emotional events. A gendered analysis of sociocultural and biomedical interpretations of female procreative cycles as the sources of physiological and emotional disorders shows the power and legitimacy of Western medicine to shape these experiences. The onset and cessation of menstruation are now believed to be liminally dangerous times for all women, and this social reality affects women's everyday lives. To paraphrase a classic statement of sociology, "If a situation is defined as real, it is real in its consequences."[2]

Medicalized Menstruation

The events of the menstrual cycle vary in when they occur, how long they are experienced, and what physiological and psychological changes accompany them. In the course of biomedical research on the physiology of the female reproductive system, "normal" was defined and specified: time of first period (menarche), length of time between cycles, duration and amount

of flow, timing of cessation of cycles, and physiological and emotional accompaniments to all of these events.[3] The 28-day cycle, which Johanna Foster says is a widely accepted myth in Western culture, is based on an equally conventional month of four seven-day weeks, not on a lunar month, which takes 29.5 days (1996, 536–37). Even the dosage of the oral contraceptives that were so popular in the 1960s and 1970s was geared to a supposed "natural" menstrual cycle (Gladwell 2000). Yet, at present, in medical and popular publications, the divisions of the cycle differ in number, transition points, markers, and names:

> Not only are there discrepancies over how many phases constitute "the menstrual cycle" and what to call these supposedly distinct phases, but there is also contention in the literatures over how long some of these stages should last, particularly "ovulation," "postovulation," "premenstruation," "menstruation," and perhaps most importantly, the whole "menstrual cycle." (Foster 1996, 535)

The biomedical perspective on the physical, behavioral, and emotional effects of the menstrual cycle is thus a social construction, reflecting the high value Western science puts on regularity and control of bodily functions. As Joan Brumberg's (1997) social and cultural history of female bodies demonstrates, the biomedical perspective on menstruation colludes with corporate forces to create a commercial ritual for adolescent girls. Using girls' diaries and media advertisements to investigate the historically changing meaning of menstruation, Brumberg concludes:

> Unfortunately, many American girls grow up equating the experience of menarche and menstruation with a hygiene product. By creating a profit-making enterprise from adolescent self-consciousness, the postwar sanitary products industry paved the way for the commercialization of other areas of the body, such as skin, hair, breasts—all of great concern to developing girls. (p. 54)

Articles on menstrual problems in women's magazines are written by doctors or cite doctors, and the accounts of women's experiences in them reflect the biomedical view that these problems are individual abnormalities caused by imbalanced hormones (Chrisler and Levy 1990; Markens 1996). A medical consultation may or may not help an individual woman with her problem, but it is likely to result in a medical label for her symptoms. From a social perspective, the encouragement of girls and women to seek medical help for any and all menstrual problems contaminates the

status of womanhood with the expectation of regularly recurring illness (Riessman 1998). These "illnesses" are various: too frequent or infrequent menstrual periods, premenstrual physical and emotional reactions; difficulties during menstruation—in short, whatever does not meet the current medical measures for normal female functioning.

As a result, women's bodies are routinely made publicly visible, managed, and "protected" by a powerful institution of social control. One consequence is that despite the strong evidence of women's overall physical hardiness, *all* women are considered unfit for certain kinds of work and physical activity because of their procreative physiology. What supposedly makes females "real" women—their menstrual cycles—makes them unreliable workers, thinkers, and leaders.

Cultural Constructions of Menstruation

In many Western folklores, menstruating women are impure and contaminating. In the shift to a scientific view of menstruation in the late nineteenth century, notions of menstrual pollution were replaced by the idea that monthly periods were necessary to women's health (Bullough and Voght 1973). A twentieth-century version that challenges the cultural view that menstruating women are impure transfers the notion of impurity to men. In 1993, in a long article in *The Quarterly Review of Biology*, Margie Profet, a feminist biologist, presented an innovative biological theory of why women menstruate. Profet argued that "the function of menstruation is to defend against pathogens transported to the uterus by sperm" (p. 338). Using data from research on the menstrual cycles of primates and other animals where fertilization is internal, she claimed that the design of the uterus and the non-clotting quality of menstrual blood are evidence of menstruation's protective function in ridding the uterus of potentially harmful bacteria. Thus, in her interpretation, menstruation rids women of impurities instead of making them impure.

In actuality, menstruating is the mark of a woman's potential fertility, and it is her child-bearing capacity that was seen in need of protection, not her health. Thus, when more women began to attend college at the beginning of the twentieth century, scientific studies supposedly proved that if they used their heads too much, they would stop menstruating—they would no longer be fertile women. There were also dire warnings that too much exercise was bad for women's fertility (Vertinsky 1990).

In the late 1970s, as women increasingly entered athletic competitions, similar scientific studies showed that women who exercised intensely would cease menstruating because they would not have enough body fat to sustain ovulation (Brozan 1978). But when one set of researchers did a year-long study that compared 66 women—21 who were training for a marathon, 22 who ran more than an hour a week, and 23 who did less than an hour of aerobic exercise a week—they discovered that only 20 percent of the women in any of these groups had "normal" menstrual cycles every month (Prior et al. 1990). The dangers of intensive training for women's fertility were exaggerated as women began to compete in arenas formerly closed to them.

Emily Martin attributes the proliferation of research on the monthly inefficiency and unreliability of women workers to the goal of keeping them out of the work force during times of high unemployment, such as during the Depression (1992, 113–28). When women workers were necessary to arms production during World War II, other studies (sometimes by the same researchers) showed that menstruation was no hindrance to women doing any kind of work.

According to many feminists, the subordinate social status of women is the result of historic and economic processes; biology is used as a pervasive justification for their subordination but is not the cause of it (Koeske 1983; Lorber 1993b).[4] Gloria Steinem asked in 1978, "What would happen . . . if suddenly, magically, men could menstruate and women could not? . . . The answer is clear—menstruation would become an enviable, boast-worthy, masculine event" (p. 110).

Ritual Menstruation

Non-Western cultural models often present a more positive view of menstruation, construing its phases as positive life cycle events to be ritually celebrated (Buckley and Gottlieb 1988). Chris Knight (1991) has developed a theory that links menstruation and the origin of culture in prehistoric gathering and hunting societies. Using Martha McClintock's (1971) observations that women who live together often menstruate at the same time, Knight argues that since the women of a tribe worked together, they would ovulate and menstruate together.[5] They would then refuse to have sex with the men of the tribe and would encourage them to go away from the camp to hunt. They would induce the men to bring back the meat to be cooked with the promise of sexual relations during what would then be the

women's time of greatest fertility. The symbolic taboos on menstrual blood and on the blood of raw meat were, Knight argued, the origins of culture.

The more common conceptualization of menstrual taboos has been negative and oppressive of women: "Perhaps one reason the negative image of failed production is attached to menstruation is precisely that women are in some sinister sense out of control when they menstruate. They are not reproducing, not continuing the species, not preparing to stay at home with the baby, not providing a safe, warm womb to nurture a man's sperm" (Martin 1992, 47).

However, in nonindustrialized societies with high fertility rates, menstruation does not occur every month, since women are pregnant or breast-feeding during most of their child-bearing years. Menstruation is unusual, an anomaly, and it is sometimes seen as conferring magical powers; menstrual blood can be used for witchcraft—to harm or to heal (Buckley and Gottlieb 1988). Close readings of ethnographic accounts reveal that it is often unclear whether menstruating women have to be kept in seclusion because they are contaminating, or others have to be kept away from menstruating women because they are sacred and frightening:

> Many menstrual taboos, rather than protecting society from a universally ascribed feminine evil, explicitly protect the perceived creative spirituality of menstruous women from the influence of others in a more neutral state, as well as protecting the latter in turn from the potent, positive spiritual force ascribed to such women. In other cultures menstrual customs, rather than subordinating women to men fearful of them, provide women with means of ensuring their own autonomy, influence, and social control. (Buckley and Gottlieb 1988, 7)

Whether menstruation stigmatizes or endows women with charisma, it has been seen as something that disturbs the usual social order and must be contained (Martin 1992, 27–53).

Emotional Menstruation

The ideology that women are out of control around the time of menstruation has become attached to the premenstrual syndrome (PMS). Women who experience PMS are said to be particularly excitable during the week or so before they menstruate—exhibiting mood swings, aggressiveness, anger, and even violence. The same notion of uncontrollability colors menopause, the time of cessation of regular menstrual cycles. Here, however,

the woman is said to suffer more than those around her—from the embarrassment of hot flashes, insomnia from night sweats, and general emotionality. The onset, occurrence, and cessation of menstruation are caused by hormonal shifts that are, in themselves, normal physiological events that can have diverse bodily and behavioral effects (Lennane and Lennane 1973). The question is, why are these accompanying effects considered "symptoms"? And is the translation of diffuse "feelings" into a clear "diagnosis" benign or detrimental? The answer to the first question depends on a woman's culture and the extent to which the menstrual cycle is medicalized in her social world. The answer to the second question depends on how diagnoses of PMS and menopause are viewed, in medical as well as lay discourse.

The current view of PMS and menopause as producing uncontrollable emotions and behavior is reminiscent of the view of pollution as that which disturbs the social order (Douglas 1966). As Sophie Laws says,

> The "symptoms" of [PMS] which the doctors show most concern over—depression, anxiety, and so on—are mental states which do not "fit" with women's culturally created notions of ourselves as nice, kind, gentle, etc. "Mood change," as such, is often listed as a symptom—demonstrating that change *as such* is not culturally acceptable. . . . There's just no room for women to have strong feelings of their own, disrupting this comfortable flow of emotional services. (Laws et al. 1985, 35)

In this sense, PMS and menopause have replaced menstruation itself as antisocial forces that need to be subdued. To counter this view, some feminists have reinterpreted menstrual mood swings as having positive rather than negative effects, describing, for example, premenstrual tension as a heightened energy state (Guinan 1988).

PMS: Hormonal Hurricane or High Energy State?[6]

Premenstrual tension was described and attributed to hormonal causes sixty-five years ago (Frank 1931); since then, most research has followed the biomedical model—defining it as *a* syndrome, with *a* hormonal cause, *a* pathology located in the *individual*. Much of the medical and lay focus has been on the psychological aspects of what was called Late Luteal Phase Dysphoric Disorder and Premenstrual Dysphoric Disorder in the American Psychiatric Association's official diagnostic manuals (Figert 1995; Gitlin and Pasnau 1989). More recently, the pharmaceutical industry, through a

multimedia advertising campaign, has claimed that Premenstrual Dysphoric Disorder (PMDD) is a more severe but widely experienced form of PMS. It is cited as an official psychiatric diagnosis with accompanying pharmaceutical treatments. According to one study done under pharmaceutical auspices, PMDD affects approximately 5 percent of menstruating women in the United States (Frackiewicz and Shiovitz 2001).

Premenstrual psychological effects are genuine problems when they interfere with a woman's capacity to carry on her normal social functions, when they disturb her social relationships, and most notoriously, when they cause violent acting out (Rittenhouse 1991). However, critics have noted that there is considerable confusion about PMS—whether it is a single syndrome, when it occurs, whether the psychological effects are hormonal, how many women have debilitating effects, and whether the effects are necessarily negative.

The diffuseness and multiplicity of symptoms are indications of diagnostic slipperiness—close to one hundred different symptoms of PMS have been listed (Laws et al. 1985, 37–38). Some women experience premenstrual bodily changes, others emotional ups and downs, and still others a combination of both, in mild, moderate, and severe forms:

> The emotional states most commonly reported in studies of PMS are tension, anxiety, depression, irritability, and hostility. Somatic complaints include abdominal bloating, swelling, breast tenderness, headache, and backache. Behavioral changes frequently reported are an avoidance of social contact, a change in work habits, increased tendency to pick fights (especially with a spouse/partner or children), and crying spells. (Abplanalp 1983, 109)

There is some question about the cyclicity of PMS. Many women and men experience mood swings by the day of the week; for women, these may modify or intensify menstrual-cycle mood swings (Hoffmann 1982; Rossi and Rossi 1977). Mary Brown Parlee (1982b) found that individual women were less likely to attribute psychological mood swings to menstrual cycles than to other causes, such as reactions to difficulties at work or at home; when the data were grouped, however, the presence of menstrual mood cycles was magnified because the other patterns were idiosyncratic. Daily self-reports gave "a picture of what might be called a 'premenstrual elation syndrome' that is the opposite of the negative one embodied in the stereotype of premenstrual tension" (Parlee 1982b, 130). Retrospective reports from these same women described their feelings in

stereotypically gendered terms. They interpreted PMS as a medically permissible aberration from otherwise socially expected performances of femininity.

Stereotypically, women suffering from PMS are said to be cranky, irritable, angry, violent, out of control. These characteristics assume some kind of comparison—with the same woman at other times of the month or with an idealized notion of the behavior of a "normal" feminine, heterosexual woman of reproductive age. One woman physician sardonically commented that perhaps the effects of what is defined as premenstrual syndrome—anger and irritability—stand out because this behavior is in contrast to three weeks of pleasant sociability (Guinan 1988). Sharon Golub suggests that comparisons with men would be useful: "While women's moods may vary cyclically, there is no evidence that women are more prone to anger than men. In fact, the opposite is probably true. Witness the far higher rates of crime and accidents among men. Some have suggested that the worst part of being premenstrual is that that is when women are most like men" (Golub 1992, 204).

Control groups, however, are rarely used in research on PMS (Fausto-Sterling 1985, 106–7). Samples are usually not diversified by racial or ethnic group, religion, social class, age, or sexual orientation, nor are cycles followed for a long period of time. Subjective feelings of tension, agitation, depression, and anger are loosely defined and poorly measured. The menstrual cycle is assumed to be the cause of mood changes, never the other way around, even though research has shown that hormones are as affected by behavior as behavior is by hormones (Kemper 1990; Koeske 1983). The notorious connection between premenstrual tension and crimes, suicides, and other destructive actions may be due to emotional stress that causes both changes in the menstrual cycle and pathological behavior. Brown Parlee (1982a) found that women taking important examinations are as likely to be premenstrual or menstruating as women committing crimes are.

The controversy over whether PMS could be used as a defense in murder trials made the syndrome a household word in 1981 (Laws 1983). An equally contentious battle went on during the late 1980s over whether to make PMS an official diagnosis in the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R), which delayed its publication by two years (Figert 1995). In this battle, the feminist Committee on Women of the American Psychiatric Association (APA) enlisted professional and lay women's groups to prevent the legitimation of a

diagnosis that they felt had the potential of stigmatizing all menstruating women as potentially "crazy." They argued that even a careful definition that emphasized severity and intractability of psychological reactions to a primarily physiological phenomenon was likely to be misconstrued as constantly recurring instability and irrationality. However, without an official diagnosis, third-party insurers would not pay for treatment of PMS as a primary psychiatric disorder.

The issue of who was to treat was interwoven with the question of the definition of the disorder (Figert 1995). If the problem is due to hormonal imbalance, then it is the province of gynecologists; if the problem is primarily emotional, then it should be treated by M.D. psychiatrists. Psychologists, social workers, and other mental health workers who did not have M.D. degrees claimed the right to treat what they defined as a social situational problem. Feminist women's groups pushed for self-treatment and alternative health care remedies for the discomforts of a normal physiological process. The Institute for Research on Women's Health in Washington, D.C., using feminist networks and the mailing list of the National Coalition for Women's Mental Health, focused media and the public's attention on the issue, and encouraged a letter-writing campaign to the APA.

The outcome was a compromise—listing in the Appendix of the DSM-III-R and also in the DSM-IV. Such placement indicates that the syndrome needs additional research for verification and use as an insurable diagnosis. It was a defeat for the professional and laywomen who wanted to keep PMS out of the manual entirely, Figert argues, and a victory for the PMS researchers who wanted criteria to make their research "more definable, specific, and fundable" (1995, 68). But the criteria (physical and psychological, not social situational) then shape the way the research is designed and predicts the ultimate outcome (medical or psychological treatment, not changes in relationships or lifestyle). As Brown Parlee points out, the call for more rigorous criteria of menstrual cycles frequently means that even in social scientists' research, physiological measurements of hormonal levels are built into the research design, necessitating collaboration with biomedically trained researchers (1994, 98).

Although positive mood changes have been reported for over a decade, they are almost never looked for in most PMS research (Martin 1992, 128–29; Parlee 1982b). Martin suggests that from a feminist perspective, premenstrual tension can be positive—not only a release of ordinarily suppressed anger at the everyday put-downs women are subject to, but a different kind of consciousness, concentration, and creativity: "Does the loss of ability to concentrate mean a greater ability to free-associate? Loss of muscle control, a gain in ability to relax? Decreased efficiency, increased attention to a smaller number of tasks?" (1992, 128). Women who have autonomy in their work could find these times productive, but factory workers, data processors, nurses, mothers of small children—the majority of women—cannot afford the loss of self-discipline. Given the way work and time are organized in industrialized societies, "women are perceived as malfunctioning and their hormones out of balance rather than the organization of society and work perceived as in need of a transformation to demand less constant discipline and productivity" (Martin 1992, 123). Since work and family life are not likely to be reorganized, women who are overwhelmed by the pressures of their daily lives may find it necessary to claim illness periodically, as a means of getting relief without blame (Parlee 1994, 104–5).

Menopause: The End of Womanhood or the Beginning of a Valued Status?

As with PMS, the biomedical accounts of menopause have outweighed social analysis and commentary in professional and lay discourse (Bell 1990). Western culture imposes a negative connotation on women's experiences of their bodies and emphasizes a separation of body and mind. Western women are given no chance to contemplate their bodies as located in time and place and as *theirs* to control (Levesque-Lopman 1988). Women experience menopause as a culturally constructed process mediated by beliefs about femininity, desirability, and productivity. It has become a sign of aging and the end of procreative capabilities. Since Western women's social status is so intertwined with their body and biology, menopause has been seen as virtually the end of womanhood (Zita 1993). In contrast, Peruvian women gain full adulthood around the time of menopause, reaping social and financial benefits and freedom from daily chores for large extended families (Barnett 1988).

Affluent men or those who have attained secure positions in academe or other professions had, in the past, not worried as much about aging as middle-class women had, but their cultural protections may be disappearing. The highly fluctuating economy and women's growing financial and psychological independence make men vulnerable to the marketing of facelifts and other cosmetic surgery, hair transplants and dyes, exercise and

sports regimens (Gullette 1993). Despite talk of a male climacteric, the markers of aging in men are not yet as medicalized as menopause is. So the pressures on men to "do something about aging" are less likely to be backed by a powerful medical ideology that translates natural processes into illness and routinizes hormonal replacement therapy in the name of "feminine forever."[7] No one seems to be arguing that men over fifty are not masculine.

What makes menopause different from PMS is that the condition itself, not just its effects, is seen as a medical problem. Cessation of menstruation, the result of no longer ovulating, has become a "deficiency disease" to be cured by permanent hormone replacement therapy (McCrea 1986). Despite the evidence of lay knowledge about menopause and treatment of its accompanying effects by herbal medicines and high-soy and other diets, biomedical treatments are assumed to be the only legitimate resource (Agee 2000; Goldstein 2000). The use of estrogen, popularized in the 1960s, was supposed to cure psychological as well as physiological effects of menopause—to energize, tranquilize, counteract depression, increase libido, alleviate hot flashes, minimize night sweating, and reverse vaginal dryness. By the mid-1970s, the danger of endometrial cancer led to medical recommendations that estrogen, also known as hormone replacement therapy (HRT), be used only for symptoms directly related to lower hormone levels (body temperature fluctuations and vaginal changes), at low doses, and for a short period of time. Instead, drug companies came up with an estrogen-progesterone combination that they claimed was safer, although there were reports of possible increases the incidence of breast cancer with its long-term use (Lewis 1993).

Around the same time, a new reason for extended use of HRT emerged—preventing the loss of bone mass and forestalling the possible development of osteoporosis. A recent clinical conference on osteoporosis recommended a combination of prevention tactics in addition to HRT—calcium in diet and supplements, exercise to increase bone mass and strengthen muscles, balance training, stopping smoking (Anonymous 2001; see also Cauley et al. 2001). An additional indication for long-term hormone replacement is prevention of heart disease, but HRT use is not unequivocally beneficial (Grodstein et al. 2001; Mosca et al. 2001). Perhaps because of the complexity of treatment outcomes and side effects, many women find it difficult to decide whether to go on or continue long-term hormone use, even though it is heavily promoted by physicians and by the pharmaceutical industry (Griffiths 1999).

Early studies of symptoms of menopause were done on women who had sought medical help or who had had hysterectomies. In order to track the occurrence of perimenopausal, menopausal, and postmenopausal symptoms in a more general population, a cohort of 2,572 women aged forty-five to fifty-five years in 1981 were selected from census lists in thirty-eight Massachusetts cities and towns (Avis and McKinlay 1995).[8] The sample was diversified by size of city or town, per capita income, and racial identification. The women were interviewed for thirty minutes by telephone every nine months over five years. At each interview, they were asked questions about their menstrual status, physical health, utilization of health care, and sociodemographic status. On a rotating basis, they were asked about their social support networks, their lifestyle (including depression), and their help-seeking behavior. This carefully constructed survey found that "natural menopause seems to have no major impact on health or health behavior. The majority of women do not seek additional help concerning menopause, and their attitudes toward it are, overwhelmingly, positive or neutral" (Avis and McKinlay 1995, 45). Almost 69 percent of the women did not report being bothered by hot flashes or night sweats, and 23 percent did not report having had them at all. Only 32 percent said they had consulted a doctor for menopausal-related symptoms, and these women were likely to have been depressed before menopause. The authors conclude that the stressful impact of other life events far outweighs the stress of menopause.

Other studies have also shown that the incidence of supposedly universal symptoms of menopause are not experienced by every woman. Japanese women are much less likely to report experiencing hot flashes or night sweats during the year after their menses had ceased than women in Manitoba, Canada, and Massachusetts in the United States (Lock 1993, 36).[9] Interviews with 603 postmenopausal Indonesian women found that less than a third reported having had hot flashes; they used an herbal drink and daily servings of papaya (which is estrogenic) as a remedy for hot flashes and for vaginal dryness (Flint and Samil 1990). A Netherlands study of 4,426 women and 4,253 men between the ages of twenty-five and seventy-five used data from a general health questionnaire administered to a sample of general practitioners' patients (Van Hall et al. 1994). The researchers found that the only symptom directly related to menopause was excessive perspiration. Diffuse complaints, such as dizziness, headache, tiredness, nervousness, sleeplessness, listlessness, palpitations, aggressivity, irritability, and depression were neither gender-specific nor

age-specific. These authors concluded that "there is no rationale in prescribing estrogens for psychological problems or mood disorders occurring during the climacteric or the postmenopausal period" (p. 47).

Margaret Lock's study of menopause in Japan found that it was not medicalized: "The dominant physicians' discourse, which they share with nearly all their patients, remains one in which *konenki* figures as a natural transition, one through which both men and women must pass, but during which, because of their biological makeup, women are thought to be more vulnerable than men to physical and emotional difficulties" (1993, 293). A visit to a physician is encouraged for women only to check that there are no other health problems, and hormonal replacement therapy is used very conservatively; herbal medicine is preferred. Without widespread use of hormonal replacement, Japanese women have one-quarter the mortality rate from heart disease and half the incidence of osteoporosis of North American Caucasian women, despite a less dense bone mass; their life expectancy is the longest in the world (pp. 295–96).

Menopausal symptoms are not even universal among inhabitants of the same country. As part of the Study of Women's Health Across the Nation (SWAN), researchers interviewed 14,906 multiethnic, multiracial, middle-aged women. Based on self-reported medical histories from women of Caucasian, African-American, Chinese, Japanese, and Hispanic groups, the consistently statistically significant factors that were identified as experienced during menopause were hot flashes and night sweats (vasomotor symptoms) and psychological and psychosomatic symptoms, such as depression and headaches (Avis et al. 2001). Controlling for age, education, health, and economic status, Caucasian women reported significantly more psychological symptoms and African-American women reported significantly more vasomotor symptoms. The variety of ways menopause is experienced by different women has been termed "local biologies," suggesting that there is no universal menopausal "syndrome" (Lock and Kaufert 2001).

If menstruating is so problematic, why is the cessation of menstruation construed as such a problem, asks Sharon Golub, and gives as the answer, "fear: fear of aging, fear of loss of sexuality, fear of getting depressed, fear of loss of health" (1992, 236). Yet when these connotations of menopause are teased apart, the health aspect elicits more negative attitudes than when menopause is construed as a sign of aging, like gray hair and retirement, or when it is seen as a life transition, like puberty and leaving home (Gannon and Ekstrom 1993). Furthermore, women on the other

side of the menstrual divide, those who are a year past their last period, have expressed very positive feelings—"of beginning a new life, of feeling great, of being wonderful, and of enjoying their lives" (Dickson 1990). The study of postmenopausal Indonesian women also found a high incidence of reports of positive feelings—affection, excitement, well-being, energy, and orderliness (Flint and Samil 1990).

Feminist analyses look beyond the individual to sociocultural phenomena—the social status of older women, differing images of sexuality for women and men, and place in a constellation of family and friends.[10] These phenomena, which vary from culture to culture and by social class, structure the experience of menopause. Thus, aging women in the United States are supposed to turn to their doctors for help; in Japan, they expect to be looked after by their daughters-in-law (Lock 1993, 386). Among upper-caste women in India who are segregated from men, menopause lifts their restrictions and gives them the freedom to socialize outside the home and to travel (Flint 1982, 367–69). For American women, "it meant pleasure at avoiding whatever discomfort they felt during periods and relief from the nuisance of dealing with bleeding, pads, or tampons. . . . For those women sexually active with men, it meant delight to not suffer the fear of pregnancy" (Martin 1982, 175). But not an elevation to a more valued status.

Marcha Flint's suggestion for Western women is to "bring all aged crones into view, not as spectral shadows, but as women in our full presence, substance, and power" (1993, 75). Germaine Greer's manifesto is even more confrontational: "Though the old woman is both feared and reviled, she need not take the intolerance of others to heart, for women over fifty already form one of the largest groups in the population structure of the Western world" (1991, 4).

Politics of PMS and Menopause

Reviewing her own twenty years of work on menstruation, the conferences she has attended, and the proliferating literature on PMS, Mary Brown Parlee concludes that "biomedical researchers' knowledge claims . . . have come to prevail over those of social scientists. . . . As in the popular culture, biomedical literature now routinely and unproblematically (incontestably) refers to PMS as some*thing* some women 'have.' Permitted scientific disputes now concern what causes 'it' and how 'it' can be treated" (1994, 103). The same thing, she suggests, has happened to menopause. In

both instances, drug companies profit from enormous markets for their products; gynecologists profit from expansion of their practices in a time of declining births; psychiatrists (especially those in managed care) also benefit from a larger pool of patients; physician-researchers' quantifiable projects get funds from government agencies, medical centers, and drug companies. A longitudinal study found an overall trend of increases in estrogen prescriptions from 1980 to 1995, indicating the predominance of the medical system in defining and treating menopause (Bartman and Moy 1998).

However, it is not simply entrepreneurial interests that drive the trend of medicalizing women's bodies and procreative experiences. In the medicalization of PMS and menopause, one of the main interest groups has been women themselves. The biomedical model of PMS and menopause has advantages for women. Just as in the late nineteenth century, when middle- and upper-class women used the sick role as a way of opting out of the obligation to bear numerous children and run households to suit their husband's wishes, women today may get temporary relief from multitasking and a partner's attention to their needs with a diagnosis of menstrual complications legitimated by the ultimate authority, the physician (Ehrenreich and English 1973; Parlee 1994). For working-class women with access to medical care, who had no such recourse in the nineteenth century, medical attention may be better than no attention.

When PMS and menopause produce debilitating physical and psychological symptoms for certain women, prescriptions for tranquilizers, mood enhancers, and hormone replacement have certainly been helpful. But so have herbal remedies, dietary supplements, exercise, and yoga. So, what are the dangers of the medical diagnosis of PMS and menopause? First, it frequently results in treatments that have bad side effects. Second, it objectifies and pathologizes women's bodies and procreative cycles. Third, it focuses attention only on the negative aspects, the concomitant discomforts and emotional upsets that bring a woman to the doctor, and ignores the positive aspects frequently reported in field surveys. Fourth, it makes women periodically "sick," and their reputations as reliable workers, and especially their potential for positions of authority, are seriously damaged. And finally, women's anger and protest over the conditions of their lives are safely defused by a diagnosis that can be contained within the medical system.

Transforming Diagnoses Back into Women's Troubles

Since so much of the current perspective on PMS and menopause is biomedical, it is important to look at what goes on in the doctor's office that turns presenting symptoms into medical diagnoses. In her analysis of medical encounters between women patients and men doctors, Kathy Davis describes how patients' emotionally loaded reports of diffuse complaints are shaped and focused into treatable medical syndromes by doctors who are genuinely trying to ameliorate the patients' distress (1988, 330–46). Her accounts suggest the process by which women's search for help for disturbances of the body and emotions around the times of menstruation and its cessation get turned into medical diagnoses.

In presenting their reasons for coming to the doctor, Davis notes, patients not only describe their symptoms or the progress of an ongoing illness, they also complain about their social troubles, their suffering, their distress: "Patients defined their problems as part of the activity of complaining rather than as a complaint, as an experience rather than a diagnostic category, as something serious enough to feel bad about, and themselves as persons deserving both sympathy and respect" (p. 333). The physicians' task is to use medical expertise to sort out what is significant in the patient's "story about trouble." The physician could tell the patient that she had no treatable medical condition and just listen for the time allotted for the visit. But physicians are trained to "do something," and so they adapt the patient's presenting complaints to fit the most likely medical diagnosis and urge the patient to accept it and the treatment that goes with it.

The encounter, Davis notes, is not one of overt power and coercion. The patient comes to the doctor as an expert for help with something she feels she cannot handle on her own. The doctor, in turn, feels obligated to offer practical help. Since the physician's perspective and knowledge are biomedical, the patient's troubles are transformed into a medical diagnosis. What is medically significant is the patient's physiological or psychosomatic reactions, and not the patient's social situation or social status. The remedy is a prescription for medication, not help in understanding what is wrong in the patient's life or support for doing something about her troubles herself. "Not only were the women's problems shorn of their contextuality and forced into professional schemes of relevance, but the GP seemed unable, in many cases, to understand what made the problems problematic in the first place" (p. 345).

Although Davis did not have a comparison group of women physicians, Sue Fisher's (1995) work on the similarities and differences of women patients' medical encounters with men physicians and women nurse-practitioners suggests that even health care workers committed to a caring style maintain asymmetrical power, set the limits of appropriate topics for discussion, and pressure for compliance with what they think is the best treatment. The nurse-practitioners do, however, pay much more attention to the patient's accounts of their lifestyles and current social situations, grant more competence and knowledge to their patients as women, and are less likely to reproduce conventional ideas about appropriate feminine roles and behavior. They also tend to suggest treatments tailored to a patient's specific needs.

Women physicians are located between men physicians and women nurse-practitioners in the medical hierarchy. Unless they have set up a consciously feminist and patient-oriented practice, they may not act differently than men toward women patients (Lorber 1985). However, as we saw from the research on the medical encounter, women physicians do listen and talk more. They are as likely as men physicians, though, to use medical diagnoses of menopausal problems and suggest treatment by drugs or hormones (Bush 1992).

It is probable that only by going outside of the conventional medical system can menstrual and menopausal discomforts be demedicalized. Alternative healing practices, such as diet, massage, exercise, and nutritional and herbal remedies, may be more appropriate to the diffuse and periodic symptoms so embedded in a woman's daily life than the hormones and tranquilizers doctors are likely to prescribe (Harrison 1985).[11] But the search for treatment does not resolve the larger question of why the subtle or marked physical and emotional changes that accompany menstrual cycles are considered abnormal and social problems and not part of normal variations in the rhythm of days, weeks, months, and years. For that, a different perspective is needed, one that is fully aware of gender issues, as well as the accompanying effects of racial ethnic discrimination, social class inequities, relationship status, parental responsibilities, work pressures, and all the other situational aspects of women's whole lives:

> If we are to respect ourselves as women we have to own all our states of being as parts of ourselves, even, and perhaps especially, the painful ones. If we are angry or sad before our periods, there is anger or sadness in us, and there are reasons for it. The menstrual cycle does not impose extraneous problems on a woman—it is part of her. (Laws et al. 1985, 57–58)

Summary

In this chapter we have argued that a biomedical focus on menstruation and the menopause, currently the perspective legitimated by medicine and scientific research, can have dangerous consequences for individual women and for the status of women in Western society. Medical attention turns diffuse physiological and psychological symptoms into diagnoses of illness. Reports in the scientific and lay media ignore positive feelings frequently reported in surveys and interviews of women who do not consult doctors—feelings of elation, energy, and well-being.

While the treatment of premenstrual, menstrual, and menopausal physiological and psychological effects do bring relief to women who suffer from them, the syndromes have been stretched into expectable stages of every woman's life. These syndromes then contaminate the social status of women in general because they are cited as validations of women's unreliability as skilled workers and, especially, their inability to hold positions of authority.

Construing menopause as a deficiency disease has led, in the United States, to widespread prescriptions of long-term hormonal replacement therapy for specific symptoms, such as hot flashes, night sweats, and vaginal dryness; for diffuse symptoms, such as depression, sleeplessness, fatigue, and sexual disinterest; and for prevention of heart disease and osteoporosis. For an individual woman, short-term hormonal use might be a useful remedy for extremely discomforting symptoms, but long-term use carries the risk of breast and uterine cancer. For women in general, the connotation of menopause as a lack of the crucial mark of womanhood (potential for procreation) undercuts the status of older women as full human beings.

Cross-cultural and cross-national studies give evidence of contrasting views of menstruating women and women who have completed their childbearing. In some cultures, menstruating women have an aura of spiritual and creative power. Similarly, in countries that mark the passage of life transitions ritually and socially, the onset and cessation of menstruation are important events in that they change a woman's status—from child to marriageable woman, from mother to respected elder.

Feminist critiques of the biomedical model of menstruation and menopause have focused on its negative use in rationalizing the subordinate status of women in Western society. They have also publicized the potential risks and side effects of long-term therapy with antidepressants, tranquilizers, and hormones, as well as the stigmatizing consequences of

labeling all women as potentially periodically incapacitated or emotionally out of control. Without denigrating the discomforts and debilities some women experience, they have recommended short-term specific use of medical remedies and the effectiveness of alternative medicine. They have also argued that research on the social psychological and situational aspects of menstruation and menopause would produce fuller knowledge of women's feelings and behavior at "that time of month" and "that time of life."

Notes

1. Not all cycles are ovulatory; anovulatory cycles are common when menses first start and as they are stopping (Foster 1996: 537–40).

2. The exact phrasing of the sociological theorem, from a book by Dorothy Swaine Thomas and W. I. Thomas, is: "If men define situations as real, they are real in their consequences" (1927: 47).

3. Katz Rothman points out that the same adherence to supposedly normal timing of physiological events governs medicalized childbirths (1982: 257–74).

4. Brown Parlee feels that it is not a coincidence that widespread attention began to be paid to PMS as a prevalent woman's illness at the same time that feminism became a significant social movement (1994: 101).

5. For other studies on menstrual synchrony, see Golub (1992: 69–70).

6. Fausto-Sterling used the phrase "hormonal hurricanes" in her chapter on menstruation, the menopause, and female behavior (1985: 90–121).

7. *Feminine Forever* was the name of the book popularizing estrogen use written by Robert Wilson (1966), a gynecologist from New York City who had set up a foundation to promote estrogens that was supported by over a million dollars in grants from the pharmaceutical industry (McCrea 1986: 297). The popular literature at the time estrogen was first widely used in menopause was blunt in its description of the postmenopausal woman. The author of *Everything You Wanted to Know about Sex but Were Afraid to Ask* said in the 1969 edition, "Not really a man but no longer a functional woman, these individuals live in the world of intersex" (quoted in Fausto-Sterling 1985: 111).

8. The standard epidemiological definition of natural menopause is twelve consecutive months of amenorrhea with no other cause; perimenopause was defined as a change in cycle regularity or periods of amenorrhea of eleven months or less (Avis and McKinlay 1995: 46).

9. The comparative statistics on rates of hot flashes and night sweats are:

Japan—15.2%, 3% of 1,104

Manitoba—41.5%, 22.2% of 1,039

Massachusetts—43.9%, 11.3% of 5,505

10. Callahan 1993; Greer 1991; Lock 1993; Martin 1992; Voda et al. 1982.

11. One of the most famous remedies for "female complaints" was Lydia E. Pinkham's Vegetable Compound. First marketed in 1875 out of Mrs. Pinkham's home in Massachusetts, it was manufactured for a hundred years (Stage 1979). Its ingredients were "Unicorn root, Life root, Black cohosh, Pleurisy root, and Fenugreek seed macerated and suspended in approximately 19 percent alcohol" (p. 32). The recommended dosage was three spoonfuls a day.