A discourse analysis of the construction of menopause in South African newspapers

By

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Abstract

The researcher aimed to explore the construction of menopause through and by available discourses within South Africa. A postmodern paradigm and social constructionist framework informed the choice of discourse analysis as methodology. South African newspapers containing texts related to menopause were utilised. English articles that are available on a publically accessible library database were selected. The basic guideline for selection of 37 texts was the keyword menopause. The researcher identified and explored eight dominant discourses and two supplementary discourses. The researcher concluded that discourses are interconnected and that each discourse is strengthened or resisted by multiple complementary and conflicting discourses forming a network through which society understands and experiences their reality.

Key terms: menopause, midlife, women, discourse, reflexivity, postmodern, constructionism, Parker, gender, qualitative.

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Chapter One: Introduction

According to Bilić and Georgaca (2007) social constructionism views reality as constructed through and by language and perpetuated through daily social interactions and institutional practices. People come to experience and understand their world as a result of these social processes. According to social constructionism phenomena such as mental illness are not located within individuals and do not represent a defect in a specific individual's mind or body, instead these phenomena are located within the social and cultural context (Bilić & Georgaca, 2007). Meaning and perspectives are constructed by and within discourses operating within a given cultural context and thus 'mental illness' is a social construction perpetuated and confined by the discourses surrounding what is considered healthy or unhealthy and what is considered normal or abnormal (Lantz & Booth, 1998). Medical discourse constructs and maintains 'mental illness', it defines the reality according to which people are diagnosed and treated within medical institutions (Parker, Georgaca, Harper, Mchaughlin, and Stowell-Smith, 1995). Thus, discourse operates to create subject positions of power through which certain members of society are empowered or subjugated.

Although researchers are reminded that they should not disregard the possibility of an organic basis for distress or dismiss the influence biology can have in affecting an individual's experience and understanding of his or her world, they should also remember that the meanings attributed to these biological processes are socially constructed (Parker et al., 1995). These meanings are influenced by knowledge/power offered by institutions and ideology and may differ according to the discourses available across different cultural and historical contexts (Parker et al., 1995).

This understanding of knowledge/power in relation to institutions was important to the current researcher as through this research she acted on part of the institution of psychology, which operates to diagnose and treat mental illness. An individual can only access reality through the discourses that are available to them (Mills, 1997). Thus, an exploration of discourse can allow for an understanding of the reality experienced by individuals who are described as mentally ill, or who are the subject of the medical profession's interest for varied reasons (Mills, 1997). Discourses simultaneously

construct and perpetuate the objects about which they speak and are inseparable from their given cultural and historical context (Wodak & Meyer, 2001). Thus, discourse constructs phenomena into being. The circulating discourses within a given context impact on an individual's experience of different phenomena. Menopause, a biological state during which a woman's fertility capacity ceases and her hormones become erratic, is one such phenomenon. Although menopause has been discussed extensively from a medical perspective, the psychological effect of menopause on women's experience of midlife is a concern for all mental health professionals, including psychologists. The language used to construct menopause as a phenomenon within a given cultural context shapes the experience of menopause.

The study focused on menopause (which is discussed in detail in chapter two) and looked particularly at the ways in which menopause is constructed differently across various contexts and creates different subject positions for women experiencing midlife. In some cultural contexts menopause does not even appear in the given culture's language, while in other contexts it is a well-known diagnosable disease that is treated with high risk medication (Storck, 2009; Zeserson, 2001). Thus, the phenomenon of menopause differs markedly according to the discourses available across different contexts. Discourse analysis allows researchers to explore how language operates to construct phenomena into reality. Discourse analysis researchers also explore the different experiences of such phenomena across different cultural contexts. The different constructions of 'menopause' across different cultural contexts specifically India, Japan and America, are discussed in chapter two. However the researcher also focused particularly on the uncertainty of available menopause discourses within the South African context.

The research aimed to explore the menopause discourses available to women going through midlife within the South African context. In order to accomplish this goal she explored a segment of media data and conducted a discourse analysis of the texts that were selected. Through this research process the researcher hoped to reveal the various constructions of menopause operating through and by social discourse in South Africa.

The rest of this dissertation contains a detailed explanation of the research focus, process and results. Chapter two contains an extensive review of current literature and

research. Chapter three contains a discussion of the theoretical perspective that guided the research process. The methodology is discussed in chapter four. The chapter contains an overview of the researcher's adapted path for the analysis, which was formulated from Ian Parker's (1999) various guidelines. Chapter five contains the analysis. In this chapter menopause discourses within South African texts are identified and their implications for women's experience of midlife explored. The discourses identified are discussed further in chapter six. Lastly, chapter seven contains the conclusion and recommendations for future research.

Chapter Two: Research Review

This chapter discusses some of the current research on menopause as a biological phenomenon that is defined within and by medical terminology. In addition the various, conflicting experiences of women from different cultural contexts in relation to menopause are discussed. Menopause is first discussed as a biological phenomenon whereby menstruation ceases during the midlife stage for all women. Thereafter different experiences of women from cultural contexts including North America, India and Japan are discussed. The different understandings and meaning systems surrounding menopause are considered in relation to the different cultural contexts in which they are shaped. The media, as an important vehicle for the perpetuation and circulation of menopause discourses, is discussed. The chapter ends by questioning how menopause, a biological phenomenon, may be constructed differently within the South African context. The importance of exploring this question through investigating the menopause discourses available to South African women is highlighted.

Menopause

Menopause is a phase in every woman's life that marks the end of fertility (Lyons & Griffin, 2003). From a biological perspective it is defined as the cessation of menses due to a depletion of oocytes (Scott Peccei, 2001). It marks the permanent end of the cyclic functioning of the ovaries and thus of menstrual periods (Beers, Fletcher, Jones, Porter, Berswits, & Kaplan, 2003). Menopause can be confirmed after 12 consecutive months without a menstrual period (North American Menopause Society, 2010). All women go through menopause, which occurs roughly between ages 45-55 years and forms one of five life stages in women. Theses stages are pre-puberty, puberty, peri-menopause, menopause and post-menopause (Storck, 2009). During puberty, which occurs at roughly 12-13 years of age, menstruation begins and the increase in the levels of the hormone oestrogen results in the development of secondary sex characteristics such as breasts, rounded hips and thighs. At the start of puberty the ovaries contain roughly 500 000 eggs, while at the stage of menopause there may be roughly 3000 eggs remaining (Jaff, 2008). Medical doctors describe the ideal menstrual cycle as a 28 day

hormonal pattern, however a minimal 12% of women follow this ideal pattern (Jaff, 2008).

Menarche, the first menstrual period, marks the capacity of a young girl to conceive and fall pregnant. It therefore marks the physical transition of a young girl into a woman. Menarche also further establishes gender identity due to the new role the girl can now play in reproduction (Schlebusch, 1990). According to Gergen (1990) nature has designed woman to be destined to fulfil a maternal role. Without this special role being fulfilled the human species would become extinct. In this way, a woman's reproductive role gives life meaning as she also physically produces life (Gergen, 1990).

Peri-menopause usually lasts 3-5 years prior to the last and final menstrual period and many of the symptoms of menopause, such as those described by western medical models, manifest during this phase. A symptom is defined as "physical or mental sign of disease" (Thompson, 1996, p. 924). According to Jaff (2008) it is important to remember that peri-menopause, like puberty, is a normal process and that it is not, as some medical media assume, a disease to be treated. Menopause marks the final menstrual period, evident by there being no menstruation for the next 12 consecutive months. Post-menopause is the last stage during which symptoms dissipate and eventually diminish altogether.

There are three different paths to menopause. Natural menopause is the type commonly described in the media and is experienced by women aged between 45-55 (Northrup, 2001). It is a gradual, natural and biological process. This is the type of menopause discussed in the remainder of this research study. The second type of menopause is known as premature menopause and usually occurs in younger women due to disease or chronic stress (Northrup, 2001). The third type is artificial menopause, which Northrup (2001) describes as an abrupt incidence of menopause that is induced by disturbances in the functioning of the reproductive organs that may necessitate administration of drugs or surgical removal of reproductive organs.

Menopause is not a new phenomenon and has been mentioned by many ancient civilizations. Biblical transcripts suggest that menopause has been a phenomenon for at least the past 3000 years. Greek and Roman records also allow researchers to infer there has been no change in the manifestation of menopause and that menopause has developed

in women around the age of 50 for the past 2,500 years (Scott Peccei, 2001). Some evolutionary biologists view menopause as a hominine adaptation in that it allows women of post reproduction age to invest increased maternal care into already existing offspring (Scott Peccei, 2001). These biologists consider menopause to be a positive adaptation and evolutionary selection for the termination of reproductive capacity at midlife, during the evolution of the human species (Scott Peccei, 2001). As a result of their infertility menopausal women invest more time in rearing their already present children. According to Scott-Peccei (2001) menopause can also be viewed as adaptive because older mothers are more at risk for dying during childbirth and for foetal defects. Women over the age of 40 have a 10% risk of having a baby with Down syndrome and they also have an increased risk for stillbirths (Scott Peccei, 2001). Menopause is assumed to be a biological adjustment to aid the survival of the human species (Lyons & Griffin, 2003). These theories are all centered on the belief that women are destined to be mothering agents (Gergen, 1990).

The term climacteric refers to the pre-menopausal, menopausal and post-menopausal stages. The word has Greek origins and means 'ladder', referring to the hormonal and physiological end stages that a woman passes through leading up to the cessation of menstruation (Du Toit, 1990). According to medical disciplines during peri-menopause hormones, such as oestrogen and progesterone, gradually decline and menstrual periods become irregular. Medical experts attribute the various physiological and psychological changes women experience at midlife to these hormonal changes (Jarvis, 2009). Western medical models typically describe menopause, a natural life stage, as a diagnosable disease that can be treated. The physiological and psychological symptoms described by the medical model are discussed below.

Physiological symptoms. The medical model explains menopause as a universal experience during which, due to the erratic changes in hormone levels, women experience various physiological symptoms (North American Menopause Society, 2010). The changes during peri-menopause may begin gradually and last between two to fourteen years or they may appear suddenly and last only a few years. According to medical experts the onset and duration of peri-menopause is dependent on an individual's

body chemistry and whether or not she has had surgery or medical treatment (Jaff, 2008). Jaff (2008) further explained this variation through reference to a woman's biological clock. During middle age each woman's clock ticks away towards declining ovary functioning and the end of her reproductive capacity. Jaff (2008) also described the body as a machine that functions well in youth, regulating hormones, body temperature and reproductive capacity very efficiently however, at menopause this machine begins to malfunction and women begin to suffer various symptoms as their bodies go into disarray. These symptoms may be experienced as mild, moderate or severe (Beers et al., 2003). Symptoms of menopause include irregular menstrual periods, hot flashes, sleep alterations, night sweats, weight gain, headaches, urinary problems, vaginal dryness and various other body changes (Storck, 2009; Jaff, 2008). Irregular menstrual periods are usually the first salient sign of menopause. Menstrual periods may become shorter, longer, heavier or lighter (Beers et al., 2003). Hot flashes are one of the most commonly experienced menopausal symptoms in western societies. This symptom usually involves excessive dilation of the blood vessels, such that the face and neck appear red and get warm (Beers et al., 2003). Hot flashes can occur at any moment and often cause embarrassment. The terms 'hot flash' and 'hot flush' are used interchangeably in western literature (Zeserson, 2001). However, the term 'hot flash' refers to a sudden increase in heart rate, increase in blood pressure and rise in body temperature. As a result of the increased blood flow to peripheral areas such as the skin, some women may begin to sweat, and this is referred to as a 'hot flush' (Zeserson, 2001). When they occur at night hot flashes are known as night sweats and can disrupt sleep. A hot flash can last from 30 seconds to 30 minutes (MayoClinic, 2009). According to medical models sleep patterns are disrupted during menopause and many women experience fatigue.

Medical models in western societies describe various changes to the menopausal woman's body. Vaginal tissue becomes thinner and lubricating secretions become watery, which often results in decreased interest in sexual intimacy (Storck, 2009). Breast tissue atrophies. Menopausal women's skin is expected to become drier, more wrinkled, sag and lose flexibility. In societies where ageing is viewed negatively these changes may cause women emotional distress and anxiety (Northrup, 2001). Hair may thin and start to grow on the facial area. Northrup (2001) explains that some women experience dark hair

starting to grow on their chins and upper lips, and this can be distressing for some women. These body changes may be viewed as a loss of feminine characteristics (Greenglass, 1982). In addition to changes in a woman's physical appearance and characteristics, medical models warn that menopause is a stage of increased risk for serious diseases that require professional medical attention.

Medical experts describe menopause as a stage of increased risk for many serious diseases. Menopause is seen as a risk factor for developing osteoporosis (Shoebridge & Steed, 1999). Cholesterol levels may increase and women may become more susceptible to heart disease, stroke and other cardiovascular diseases (Storck, 2009). Since cardiovascular disease is currently a leading cause of death in women, menopause is an important risk factor that needs to be managed in health departments in order to minimise costs to the economy (Northrup, 2001). Lastly, urinary tract problems may occur during peri-menopause resulting in urine leakage. The experience of menopause may precipitate psychological distress.

Psychological Symptoms. Western medical models describe psychological symptoms such as depression, anxiety, confusion, forgetfulness, fatigue, low self-esteem, tearfulness, difficulty concentrating and irritability as common during peri-menopause (Jaff, 2008; Jarvis, 2009). These symptoms fit many of the prescribed diagnostic criteria for anxiety and depression (Sadock & Sadock, 2007). Thus, women undergoing menopause may be diagnosed with anxiety or depressive disorders. Mood swings are commonly expected from menopausal women. Menopausal women are characterised as experiencing alternating swings of aggression, irrationality and tearfulness. A linear relationship is drawn between hormonal changes and psychological symptoms such that these symptoms are anticipated and regarded as normal regardless of social and cultural contexts (Powers, 2001). Western medical models normalise these physiological and psychological symptoms during menopause and explain them as a universal experience. However, research indicates that not all women share the same experience of midlife.

Western Women's Experiences

Women's experiences during menopause do vary according to their cultural and social contexts. However, medical science attempts to diagnose individuals according to certain assumptions. These assumptions include reductionism, which is the assumption that individuals can be understood according to sets of objective, universal criteria that are independent of social contexts (Powers, 2001). The assumption of determinism offers linear views of aetiology in attempts to predict and control disease (Powers, 2001). These assumptions are applicable to the western construction of menopause. Within western society, medical experts view menopause as a diagnosable condition that is applicable to all women regardless of their social context. It offers a set of criteria that may be expected during menopause and holds the linear view that erratic hormones are solely to blame for symptoms experienced during menopause. Women living within these social contexts are expected to experience menopause in accordance with the definition provided by the dominant bio-medical discourses. Within the medical field research has been conducted to attempt to understand the way in which women function. For example, this research makes use of the assumption that women pass through predetermined life stages in chronological order in a universal manner. As a consequence of this endeavour, normal processes of menstruation and menopause have been defined within and according to medical terminology (Powers, 2001). According to Powers (2001), menstruation is medically described as the failure of a woman's capacity to have a baby, while menopause may be considered the failure of a woman's femininity. Diagnosis reviews a woman's history as well as present signs or symptoms (North American Menopause Society, 2010). Western medical models suggest that menopause is a condition that may be treated with hormone therapy. The predominant treatment, known as Hormone Replacement Therapy (HRT), is aimed at reducing menopausal symptoms and bone loss. HRT may be administered in pill, patch, injection or cream form (Storck, 2009). Although HRT does improve most symptoms it also increases a woman's risk of heart disease, breast cancer blood clots, gallbladder disease and side effects such as headaches (Storck, 2009). It is therefore unsurprising that menopause is anticipated with anxiety and associated with negative expectations and a loss in self-esteem in women within these cultural contexts (Weber, 1997).

Western cultures such as those in North America are aesthetically driven and are obsessed with youthfulness, vitality and beauty (Winterich & Umberson, 1999). Women's perceptions of menopause are therefore likely to be affected by various gender and menopausal stereotypes circulating in the media, which construct menopause as a sign of aging and ill health (North American Menopause Society, 2010). Western ideals of beauty are associated with a youthful female body and menopause is constructed as a period of 'loss' because, as Winterich and Umberson (1999) explain, the menopausal body symbolises aging and the expiration of a woman's beauty and reproductive capacity. Thus, within western society menopause is understood as the loss of youth and womanhood. Menopause stands in contrast to the western ideals and standards that women are confined to uphold as a result of the gender discourse.

Mary Gergen (1990) stated that growing older may be particularly distressing for women because they are defined more narrowly than men. She critiqued Erik Erikson's life span developmental theory, a well-established developmental theory (Gergen, 1990). In Erikson's theory women are described as vulnerable to distress if they do not bear children, as their bodies are designed to produce children (the womb is seen as a cavity needing to be filled) and thus childbearing gives meaning to a woman's life (Gergen, 1990). According to this theory, women's reproductive capacity defines their purpose in life. It can therefore be assumed that with the onset of menopause this sense of identity and purpose is lost. Jaff (2008) stated that many women experience a feeling of loss as a result of their psychological attachment to their wombs. This loss naturally can result in grief and depressive symptoms (Jaff, 2008). However, when these symptoms are described as depressive or anxious and are addressed in the therapeutic context they may diminish.

Although studies have found that some western women view menopause as a natural life change and not a condition necessitating treatment, research has shown that some women are still uncertain about menopause and acquire most of their information from the media, such as newspapers. This leads to many misconceptions (North American Menopause Society, 2010). Bilić and Georgaca (2007) conducted a study focusing on representations of mental illness in the media and found that society develops an understanding of mental health problems from media representations and therefore

develop expectations regarding their experiences. Thus, women may rely on available media representations of menopause to construct a frame for understanding menopause. Many women in western cultures perceive menopause as marking the aging process. In western society, which is aesthetically driven, menopause is associated with a loss of social status, fertility and femininity. Northrup (2001) explained that within an aesthetically driven society women, who are accustomed to gaining attention and power due to their feminine beauty, find the gradual loss of feminine characteristics and beauty during menopause and natural aging difficult. It is therefore understandable that many western women are susceptible to psychological distress, such as depression or anxiety, during menopause (Jarvis, 2009).

As previously mentioned, the gradual changes experienced during menopause mark the loss of the reproductive role for western women. Menopause is also associated with aging in western culture, a society in which older people are devalued. Women may therefore experience a subjective loss of prestige and social status (Arber & Gin, 1991). Several studies have investigated the effect of menopause on western women. A study by Morris and Symonds (2004) found that the appearance of biological symptoms of menopause negatively impacted the women living in Wales's public role within their work environment. This resulted in the manifestation of psychological symptoms such as anxiety. Welsh women commonly experience physiological symptoms of menopause, including hot flushes. In Morris and Symonds's (2004) study, women felt pressure from their work colleagues to conceal symptoms. As a result anticipated symptoms, such as hot flushes that are perceived to be uncontrollable, led to immense embarrassment and exacerbated anxiety. Although many of the women interviewed by Morris and Symonds (2004) viewed menopause as a natural process in life, the influence of their social context created anxiety and distress related to the physical signs of menopause. A similar study by Skultans (cited in Du Toit, 1990) focusing on women from the South of Wales, concluded that menopause was a cultural rather than a biological concept, and that the concept itself was operating to convey a cultural rather than a biological truth. The study emphasised that there are other alternative 'truths' available to shape the phenomenon of menopause. Women's associations with and perceptions of menopause seem to depend on the manner in which their cultural contexts understand aging, fertility and aesthetic

appeal. Although the cultural connotations regarding menopause can impact negatively on an individual's experience of a natural life process, some cultural contexts allow the process to be experienced neutrally or even positively.

Non-western Women's Experiences

In some non-westernised countries and cultures older women are valued more and offered more freedom than young women, who are more restricted. In these cultures menstruation is often viewed as a social taboo (Weber, 1997). Young women are sometimes actively secluded during their menstruation. Menopause is therefore connoted positively as it marks the end of menstruation and thus the removal of certain restrictions. As a result of menopause women are gradually permitted to become part of a respected senior generation and hold a more privileged position within the social hierarchy (Weber, 1997). Although within these cultures menopause still signifies aging, much like in western societies, in this context aging is associated with freedom from the fears and restraints of child-bearing and entry into a new life stage (Greenglass, 1982). Research suggests that the division of labour is influenced by gender roles within society, and thus by a women's reproductive status (Wright, 1996). Women of child bearing age are denied participation in social activities and are not allowed to engage with specific social groups (Wright, 1996). Menopause thus liberates these women from their reproductive role and makes them eligible (by virtue of age) for a more dominant position in society (Arber & Gin, 1991). Thus in some non-westernised societies aging is associated with prestige and not with stigma. Menopause, as a sign of aging, may mark a gain in social status.

There are several examples of cultural groups in which the prescribed western medical model of menopause does not fit with individuals' experiences. For example, Rahjput women in India and Arabic women in Israel have been found to manifest no physiological or psychological symptoms during menopause except for the cessation of menstrual periods (Flint, as cited in Weber, 1997). Flint (cited in Weber, 1997) reported the absence of notable symptoms such as hot flushes, night sweats, anxiety or depression usually reported in medical models. Flint's (cited in Weber, 1997) study found that the cessation of menstruation allowed these women to end their veiled seclusion and engage more freely in the larger society. In these cultural groups menopause thus allows an increase in community status. Following menopause women are permitted to engage in

greater social participation and menopause thus marks a sign of increased prestige (Schlebusch, 1990). Menopause is also associated with a positive shift in these women's role in the community. According to Du Toit (1990) non-westernised women's lack of negative psychological symptoms during menopause is linked to the welcome new roles and increased status that they experience. Following menopause these women are able to be more equal to men within these male dominated societies. Thus, the absence of psychological menopausal symptoms may be a result of the positive connotations associated with menopause within that cultural context (Weber, 1997).

A study by Lock (cited in Weber, 1997) explored the social construction of menopause by Japanese women. Although Japanese society is highly traditional, Japan is also a modern, highly industrialised country and is in some respects much like western societies. However, menopause is experienced differently within Japanese culture. Japanese women rarely report either physiological or psychological symptoms of menopause. Although the Japanese language recognises several different experiences of being 'flushed' with heat, such as feeling flushed after a hot bath or after eating spicy foods, there is no precise word in Japanese for the menopausal hot flush (Zeserson, 2001). Society uses language to construct reality and thus the absence of the term 'menopausal hot flush' implies that this experience does not form part of the Japanese culture's discourse. Lock (cited in Weber, 1997), suggested that the low frequency of reports may be a result of Japanese women viewing menopause as a natural life change. In addition, it may be due to cultural expectations imposed on these women to put their family's needs ahead of their own and to progress through menopause silently and without complaint (Weber, 1997).

According to Zeserson (2001) the term 'hot flush' is beginning to appear in Japanese media and this appears to serve other people's interests rather than the interests of menopausal women. According to Foucault, knowledge is power and thus medical discourses serve political agendas (Hook, 2004). Medical experts and pharmaceutical companies are in a position of power relative to consumers (Hook, 2004). The availability of certain discourses within society provides an indication of the value certain issues or problems hold within that society. Society's knowledge/power relations are embedded in the construction and operation of such discourses (Zeserson, 2001).

Although dominant medical discourses construct menopause as a hormonal condition and disease marked by oestrogen deficiency, menopause is also constructed by other discourses (Lyons & Griffin, 2003). Women within different cultural contexts, where different discourses are available, may experience menopause with a sense of liberation and view it as freeing them from the demands of the mothering role and from pregnancy (Lyons & Griffin, 2003).

The experience of menopause thus differs markedly depending on a woman's cultural context. Western medical models' assumption that all manifest physiological and psychological symptoms during menopause is thus controversial (Greenglass, 1982). In western cultures menopause is strongly associated with depression (Peters, 2008). However, studies have shown that depression as a diagnostic category suffers from issues of cultural validity and the western assumption that depression can be diagnosed as a universally valid disorder has been questioned (Jadhav, 2000). The medical model presents depression as a universal phenomenon and cultural differences are set aside as simply artifacts. Western psychiatry appears to have naturalised its cultural distinctions and presents empirical data as if it is scientifically objective and universally applicable (Jadhav, 2000). Brown (1978) described depression as a socially constructed phenomenon. Brown (1978) believed that certain scientific studies exploring changes in bioamines during depressive states simply reflected the effect of social and psychological factors. Although Brown (1978) does not reject biochemical factors he maintains that a multi-factorial approach should be used and that social factors are more influential than biological variables in the development of depression.

According to Northrup (2001) modern terminology implies that a woman's hormones exist as a separate entity to the rest of her life. Western medical terminology suggests that mood swings, anxiety and depression are solely caused by erratic hormones, and that no other concerns and life events have an effect on menopausal women. There are many possible reasons why women may be increasingly anxious and depressive at the stage of mid-life. For example, well documented findings concerning the empty nest syndrome describe how some women experience feelings of grief when their children leave home and they lose their role as care takers (Northrup, 2001). However, within a

dominant bio-medical discourse where hormones and biological agents are viewed as the single reason for mood changes, alternative views are silenced.

Understanding the dominance of the medical discourse is important when attempting to understand the experience and portrayal of menopause within the western context. Although some women do experience psychological symptoms such as depression during menopause, other women do not experience any psychological symptoms. According to Jaff (2008) some women experience obvious signs of their transition while others are not even aware that they are going through menopause. Jaff (2008) then asserts that experiencing a few, some or all of the symptoms she lists in her book is normal and she assures her readers that millions of women are having a similar experience. She thus normalises and objectifies the very process that she is attempting to position as unique to each individual.

Although studies such as the one by Brown (1978) provide support for a multicultural exploration of menopause, the pressure of western medical models often results in contradictory experiences of menopause being overlooked (Jadhav, 2000). Women rely on medical experts to guide them through their confusion. A study by Winterich and Umberson (1999) found that many women were convinced by their doctors to start taking HRT medication to prevent symptoms, although at the time of the consultation they were not experiencing any symptoms or distress. This clearly reflects the power of bio-medical models of menopause. Although some women may experience psychological and physiological symptoms during menopause, this is definitely not a universal experience. Instead, experiences of menopause appear to be rooted within cultural contexts and vary depending on the various discourses surrounding menopause and the role of women within that particular society.

Gender

Women's varying experiences of menopause may be linked to circulating gender discourses within different cultural contexts. Although biological sex is categorised in society according to innate anatomical characteristics, gender is socially constructed (Kendall, 2004). Gender is constructed through learnt behaviours and the acquisition of culturally communicated roles, which reflect specific implicit beliefs concerning

masculinity and femininity. These roles govern men and women's responsibilities in their social context and include a set of beliefs as well as rules for appropriate appearance and behavioural patterns (Wright, 1996). Gender discourses create assumptions about women and men that are repetitively constructed and perpetuated through language. These assumptions result in the construction of gender stereotypes (Friedman & Schustack, 2006). Gender stereotypes are generalised beliefs regarding a certain group or category of individuals (Passer & Smith, 2004). Stereotypes form schemas (mental representations) which individuals use to organise and understand their world. In this way, stereotypes operate as scripts through which individuals learn to socialise themselves into gender appropriate roles (Shaffer, 2002). Every cultural group has norms regarding expected gender behaviours. Gender identity is constructed socially and thus children internalise sex-role stereotypes and wide-spread beliefs concerning women (Friedman & Schustack, 2006).

Culture shapes traditional gender roles and individuals' experiences of the prescribed expectations that govern those roles (Gatz, Pearson & Fuentes, 1981). Gender roles and stereotypes can thus change over time and across different cultural contexts. For example, what is currently accepted as appropriate feminine behaviour may be markedly different from what was accepted in the past and what may be acceptable in the future. Discourses are not static. Gender roles are taught and perpetuated as part of an acculturation process.

People become socialised into gender roles through acculturation, a child's gender-appropriate behaviour is reinforced and rewarded, while inappropriate acts are met with disapproval (Du Toit, 1990). Gender forms a pivotal part of an individual's identity. Feminine discourses dictate that certain ways of being are appropriate for women, for example being emotional, passive, nurturing and gregarious (Friedman & Schustack, 2006). According to Mills (1997) the discourse of femininity actively positions women within discursive constraints related to the constructed subject position. Femininity is a rigid discourse that places limitations on women and offers them an oppressed position (Mills, 1997). Women are thus forced to either act within these constraints and be oppressed by the dominant masculine discourse or identify themselves

with a masculine or a marginal discourse, which makes them vulnerable to alienation, social pressure and ostracism (Gergen, 1990).

Discourse serves to normalise gender roles within a specific cultural context, thus within a certain context women may feel pressure from society to fulfil the reproductive role and bear children (Friedman & Schustack, 2006). Literature suggests that women are often defined by their biology, and experience pressure to align with culturally accepted ideals of the feminine body in their youth. This results in feelings of anxiety when their physical bodies start to deteriorate (Parker et al., 1995). According to Gergen (1990), Freud, the father of psychology, believed that a woman's identity is derived from her role within the family, both as a man's sexual partner and as a mother to her children. This way of thinking has become common in current psychological thinking and the study of mental health.

Theories on hysteria are often gender biased towards the female population. The word hysteria is of Greek origin, '*hysteron*' which means womb. The ancient Greeks believed that the womb was a type of animal that longed to produce children and if it remained empty it caused distress and affected the carrier (Parker et al., 1995). Thus, women brought for medical attention were believed to be influenced by their wombs (Parker et al., 1995). The recommended cure for this disorder was placing a woman with a man and encouraging her to produce children. Although times have dramatically changed and medical science has developed new insights, women still appear to be defined as simply reproductive and hormonal beings. In this way a woman's physical being is seen as separate from the rest of her life.

Thus, a woman's reproductive role forms an intricate part of her gender identity, and the loss of this role during menopause has specific connotations given the socially constructed discourses surrounding menopause within various cultural contexts (Wright, 1996). Kaufert (cited in Du Toit, 1990) states that menopause is either seen as stereotypically positive or stereotypically negative, depending on the specific cultural context. In western society menopause is seen as signifying aging and the loss of the reproductive role. Western society places a high value on women's reproductive role, youthful beauty and feminine characteristics and therefore the loss of these attributes during menopause can impact negatively on women's sense of self and psychological

functioning (Greenglass, 1982). Women within western cultures may see menopause as marking the loss of all features that construct them as women. According to Shoebridge and Steed (1999) menopause exposes and jeopardises the attribution of roles within society as it is an end-of-gender marker.

According to Gergen (1990) when a woman whose identity is defined by youthful beauty and the reproductive role realises that she is experiencing menopause she may feel that she no longer functions as a complete human being. Thus, women may become depressed during menopause for multiple, interacting reasons and not only due to the influence of fluctuating hormones and biology (Jaff, 2008). For example, women who have chosen to focus on their families and household may become aware of lost opportunities in their youth. During this time women may also experience their children leaving home, retirement, and a redefining of a relationship with their spouse. They may grieve a loss of value, purpose and meaning within their lives. Many of these women may experience difficulties with their self-esteem as they realise that they no longer meet the standards of beauty and youth required by western society (Gergen, 1990). Many western women attempt to hide wrinkles, age spots, varicose veins and hot flushes and thus participate in the current feminine discourse.

Gender discourses are constructed within cultural contexts and operate within the mental health field. Various authors including Brown (1978) have questioned the assumption that depression is a universal, objective and reliable diagnosis. In addition, other authors have suggested that the diagnosis of depression is gender biased (Johansson, Bengs, Danielsson, Lethi, & Hammarstrom, 2009). Men and women manifest symptoms of depression, and other mental illnesses, differently. The current dominant discourse within the mental health field constructs women as more likely than men to be depressive due to their internalisation of emotions and stereotypical passivity. Thus, the simple fact of being female is seen as a risk factor for depression (Powers, 2001). Men are more likely to be diagnosed with depressive symptoms related to their external environmental stressors, while women are more likely to be diagnosed due to their internal physiology, such as hormones (Johansson et al., 2009). Thus, women's external stressors, which include the multiple roles of mothering, marriage and occupational stress, are given less attention in scientific research and media portrayals

than their physiological characteristics. Mills (1997) suggests that it is the social discourses operating on women's bodies, not isolated bioamines in their physiology, that stimulate mental health disorders such as anorexia, bulimia, neurotic disorders and depression.

The literature reviewed in the section above shows that menopause has been extensively researched and linked to a variety of diagnosed diseases. Menopause is therefore a well-established phenomenon in the health domain. However, the literature also highlights the interplay between gender discourse and menopause discourse. Menopausal women may be more vulnerable to being diagnosed with depressive and anxious symptoms, not only because they are going through menopause but because they are female. Gender discourses powerfully construct and prescribe gender roles. Women may be in positions of power or be oppressed as active agents of gender discourses within their cultural contexts (Johansson et al., 2009). The media plays a powerful perpetuating role in normalising these discourses.

The Experience of Menopause: A Phenomenon of Socially Constructed Discourse

The experience of menopause is not universal, despite the assertions by western medical models. Menopause discourses vary across cultural contexts and are linked to various other discourses, such as discourse surrounding gender and science. These discourses also change over time as they reflect the political and cultural interests during that time and within that context. According to a study by Morris and Symonds (2004) women born into one generation were taught by their mothers that menopause was a natural life phase. However, at mid-life these same women find themselves living within a different construction and understanding of menopause, one in which menopause is explained by medical experts as a pathological condition. Diagnosis and categorisation of mental illness are loaded with assumptions that infiltrate medical terminology and that are eventually accepted as objective truths (Parker et al., 1995).

Diagnoses are not permanent entities reflecting an objective reality; rather they are dynamic descriptions of behaviour that act to construct a representation of disease or mental illness. These constructions may vary across cultural and historical contexts (Powers, 2001). However, they often operate within medical domains as objective truths.

Once a phenomenon is presented as an objective truth it becomes unthinkable for individuals to go against the advancement of science and to refuse to accept the given truth as a way of understanding the world (Powers, 2001). When individuals enter the mental health system the symptoms they present are compared to diagnostic criteria, regardless of the various precipitating psychosocial stressors involved. Thus, the disorder is located within the individual and not within their social context (Parker et al., 1995). Medical science serves to individualise distress and simultaneously set it apart from its social context (Parker at al., 1995).

During menopause women continue to experience other stressors, including things such as health problems, martial conflict and family issues, which may be more important to them than menopause (Winterich & Umberson, 1999). However, biomedical models marginalise psychosocial stressors and focus on biological reasons for symptoms (Johansson et al., 2009). Discourses that construct menopause as negative and symptomatic provide the expectation that all women will experience menopause as problematic (Shoebridge & Steed, 1999). A study of post-menopausal women found that women who did not experience any symptoms during menopause except for the cessation of menstruation reported continuously anticipating the emergence of symptoms. They believed that these symptoms were unavoidable and an inevitable part of the menopausal process (Shoebridge & Steed, 1999). This was particularly evident in women who made use of the popular media to gather information.

The media provides a representation of what menopausal women should expect during the peri-menopausal stage. These expectations are likely to influence women's experience of menopause within a particular cultural context.

Media

In this research project the researcher explored the various discourses concerning menopause within South African media. Menopause is not a universal experience but is culturally determined. Given the culturally diverse nature of South Africa it is likely that South African society makes use of discourses of menopause that are specific to the South African context. It is important that these discourses are recognised within clinical

practice. In addition, the study aimed to highlight the power of the media in relation to the creation and perpetuation of discourses surrounding menopause.

Images of mental illness are evident in cinema, news and entertainment sections of the media and have a powerful impact on society's beliefs about mental illness (Parker et al., 1995). These societal beliefs are often considered more accurate than an individual's own experience. The media's representations of mental illness are predominantly negative. Lyons & Griffin (2003) reviewed the discourses concerning menopause presented in newspapers and magazines in Britain. The study found that dominant discourses construct menopause, a risk factor for diagnosable physical and psychological diseases, as a negative life event and requiring medically recommended treatment. Journalists often quote medical experts, such as psychiatrists, to justify and validate their descriptions of mental illness (Bilić & Georgaca, 2007). Medical experts make use of scientific jargon and terminology that reinforces their powerful position as experts. Repeated coverage of these discourses can result in an internalised representation of mental illness, just as gender stereotypes are internalised as part of the individual's identity. In this way, people with mental illness come to define themselves in accordance with existing discourses (Bilić & Georgaca, 2007).

In a study of women undergoing menopause, the participants explained that their families, friends and doctors all had ideas concerning menopause that were based on negative discourses of menopause. These negative discourses had an impact on the menopausal women's experiences (Winterich & Umberson, 1999). According to Lyons and Griffin (2003) many women gain an understanding and expectation of menopause through the discourses contained in the media. It is possible that the expectation of menopause within society actually may shape a woman's experience of menopause (Northrup, 2001). Dominant medical discourses offering knowledge about menopause hold power in society. Discourse is never simply conversation, repeated exposure to a discourse leads to people feeling forced to attend (and even conform) to the descriptions provided by the discourse (Shoebridge & Steed, 1999). Discourses thus influence people's identity and understanding of the world. Women at midlife may feel anxious and self-conscious as they become aware of the objectifying scrutiny of society and realise

that they are defined by medical experts as manifesting symptoms of abnormality (Parker et al., 1995).

Medical discourses are active within popular media and influence individual's experience of phenomena (Lyons & Griffin, 2003). South Africa is a culturally diverse society and as such many of the cultural beliefs do not fit western models. It is therefore important, especially within therapeutic practice, to explore the various menopause discourses circulating within South African media. From a postmodern paradigm and social constructionism framework this study undertook a discourse analysis of newspaper articles. It was hoped that this exploration would add to an understanding of how menopause is constructed for South African women (Lyons & Griffin, 2003).

In conclusion this chapter discussed some of the current research concerning menopause as a biological phenomenon. In addition, the chapter highlighted the existence of other discourses concerning menopause. Although menopause is often presented as a universal phenomenon, research on the different experiences of women from cultural contexts such as North America, India and Japan suggest that this assumption of universality is misguided. The different understandings and meaning systems surrounding menopause are shaped by and within the available menopause discourses. The media was discussed as a means through which menopause discourses are perpetuated and circulated within a society. The chapter concluded by highlighting the motivation for this study's exploration of the menopause discourses currently available within the South African media.

Chapter Three: Theoretical Framework

In this chapter the social constructionist theoretical perspective and the postmodern paradigm, which formed the theoretical framework for this study, are discussed. The epistemology and ontology of the postmodern paradigm and social constructionism framework are discussed in an integrated manner. In relation to a postmodern stance, Scheurich (1997, p: 50) argues that "separation of epistemology and ontology is artificial" and that reality and knowledge are intrinsically linked. Thus although the two concepts are discussed under their own headings, it is acknowledged that neatly separating these concepts is not possible.

Modernism

The modernist paradigm holds various assumptions about the world. In particular, it assumes that researchers can determine universal truths by means of objective methods of inquiry (Gergen, 1992). In addition it assumes that certain absolute truths exist and prevail throughout different cultural and historical contexts. Western medical models predominantly follow modernist paradigms and assume that truths can be objectively studied and that human conditions can be reduced to linear explanations. The western medical model provides objective diagnoses, symptoms and treatment of medical conditions. The modernist medical model thus provides a universal description of menopause. However, modernist models have been critiqued based on the fact that the experience of most phenomena differs markedly between cultures. There is an increasing awareness that the experience of certain phenomena, for example menopause, is relative to the way in which that phenomenon is constructed within a specific cultural context. Theorists such as Kuhn questioned modernist beliefs and initiated the shift towards postmodernism (Hergenhahn, 2005).

Postmodernism

Postmodernism is a time of uncertainty and fragmented beliefs that makes assuming absolute truths impossible (Parker, 1992). According to Kuhn and Feyerabend what is considered as truth is a matter of perspective, and perspectives are produced in

communication during social interchanges (Gergen, 1992). Thus, the seemingly objective truths contained within medical models and scientific disciplines are actually produced by social processes (Gergen, 1992). Discourse forms and maintains what becomes accepted as truth within a specific cultural context (Freedman & Combs, 1996). In this way, current knowledge does not reflect absolute truths, but instead offers multiple perspectives that are dependent on a given cultural and historical context. Reality is created through the process of social interaction (Hergenhahn, 2005).

Social Constructionism: Theoretical perspective

Social constructionism explores the ways in which meaning and interpersonal understandings are formed through social interactions (Lock & Strong, 2010). It maintains that social reality is constructed, collaborated between people and propagated daily through interactions and institutional practices (Bilić & Georgaca, 2007). Within psychology, social constructionist theory aids the exploration of the social construction of the psychological processes of individuals (Bilić & Georgaca, 2007). People come to experience and understand their world through social processes. Meaning is constructed through discourses operating within a given cultural context.

Identity is a theoretical construct that is constructed by the surrounding family and cultural context (Parker et al., 1995). Thus, identity is not a permanent stable phenomenon but rather a continually dynamic, interpersonal construction that is produced and negotiated though social processes (Bilić & Georgaca, 2007). Thus, menopause may result in a shift in a woman's identity. Recognition from other people and feeling supported play a vital role in an individual's sense of security (Parker et al., 1995). When an individual's sense of self and their identity is threatened they may suffer social pressure and anxiety.

Social constructionism considers discourses about the world to be artifacts of communal interchange (Gergen, 1985). Social constructionist theory allows researchers to place knowledge and psychological constructs, such as menopause, within cultural and historical contexts. Researchers are encouraged to challenge taken-for-granted beliefs and the commonly accepted understandings that have been constructed through social interaction and that are accepted as truth (Gergen, 1985). Traditional, western

conceptions of objective and apparently culturally unbiased knowledge are also questioned. Through understanding the ways in which illness is constructed through social interactions, the social forces that form and affect society's perceptions and understanding of health and illness within that specific context can be understood (Brown, cited in Lantz & Booth, 1998). According to social constructionist theory physical and mental illnesses are not individualised and described as defects in the person's body or mind, but rather are located within a social and cultural context (Bilić & Georgaca, 2007). These contextual factors serve to construct mental illness.

The social construction of illness is perpetuated through discourses concerning health and illness (Lantz & Booth, 1998). Recognising that social factors such as language are critical to understanding the construction of 'illness' requires looking beyond the knowledge/power assumptions provided by scientific discourses, and attempting to reveal the ways in which discourse operates to constitute reality. The focus thus turns from 'the mad' towards the individual's social and historical context (Parker et al., 1995). Medical discourses serve to construct and maintain mental and physical illness and in this way create realities in which people are described as abnormal and are subjugated (Parker et al., 1995).

All knowledge, including knowledge supported by medical experts within scientific fields, is socially constructed and thus there are no objective truths regarding physical and mental disease (Johansson et al., 2009). Parker (2008) explains that medical experts do not passively describe behaviour as pathological, but instead are active agents of medical discourses. Through their descriptions of behaviour these medical experts actively construct the very differentiations of normal and abnormal they use to diagnose individuals. Medical professionals operate to produce what they set out to find (Parker, 2008). Medical discourse is assumed to represent objective truths, and individuals are therefore expected to accept diagnoses and take responsibility for their illness (Parker et al., 1995).

However, within social constructionism it is important to avoid disregarding an organic basis for distress and minimising the influence of biology by deconstructing language (Parker et al., 1995). Biological processes do influence people's experiences and understandings of the world although the meanings attributed to these biological

processes are socially constructed (Parker et al., 1995). These meanings are often influenced by the knowledge offered by medical institutions and thus may differ depending on the specific historical and cultural context.

Thus, the discourses around menopause in a particular society will influence the way in which women in that society experience menopause. Through the exploration of these discourses it becomes possible to call them into question and reveal the power operations that sustain them. Shoebridge and Steed (1999) highlight the hidden political agendas that may lie behind the construction of menopause as a medical illness. According to these authors in societies where medical discourses dominate describing menopause as a medical illness is economically beneficial to individuals working within the medical health domain, such as doctors, psychologists and psychiatrists. Zeserson (2001) explained that words related to menopause in the western cultures are beginning to appear in Japan through the media. Thus the construction of medical discourses surrounding menopause led Zeserson (2001) to suggest it served other people's interests rather than those of menopausal women. Through studying discourse it becomes possible to reveal the political agendas that sustain the discourses.

Ontology. The use of a postmodern paradigm for research has ontological implications. Postmodernism rejects the idea of a single unitary reality, and thus adopts a relativist perspective (Gergen, 2001). All objects are described though the conscious-being experiencing them and are constructed by interpretive strategies that are socially set in motion (Crotty, 1998). However, stating that reality is constructed through social interaction does not imply that the world and its objects are not real. The external world is perpetually already present, but is meaningless in isolation, thus necessitating the use of a realist position (Crotty, 1998). Thus, objects are constructed though the sense that society makes of them and need to be interpreted within their historical and cultural contexts (Crotty, 1998). The ontological perspective of postmodernism is therefore both realist and relativist. In relation to menopause, the biological changes in hormone levels and the other physical changes associated with the aging process are an objective reality. However, the connotations these changes hold for women are socially constructed.

An individual's accessible reality is dependent on available discourses (Mills, 1997). Thus, the way in which events and experiences are understood is dependent on discursive structures. In this way, the meaning attributed to an experience by a particular society is assumed to be the only true representation of those events or experiences. Individuals' perceptions are limited to the parameters offered by dominant discourses and are thus only able to understand reality through discourse (Mills, 1997). In relation to menopause this means that women's experiences of menopause are shaped by the menopause discourses available in their particular society and historical period.

Epistemology. The postmodern paradigm is informed by a constructionist epistemology. According to this epistemology knowledge, and thereby meaningful reality, is constructed through social interaction and an individual's experience of the world. Epistemology provides a manner of understanding and describing how people come to know what they know. Constructionist epistemology maintains that there are no objective universal truths (Crotty, 1998). Instead, meaning is constructed through the circulation and repetition of discourse within a given cultural and historical context.

Knowledge. According to Mills (1997) knowledge is all matter encompassing consciousness and all variations of meaning constructed in history by society to interpret and form reality. Alternative knowledge is not offered the same importance as dominant knowledge. For example, medical science holds authority as representative of objective truth about health, while alternative medicine is oppressed as an inferior knowledge relative to science (Mills, 1997). Although qualitative studies have consistently found that menopausal women attribute many of their depressive and anxious symptoms to the impact of social factors, such as work and family stress, medical articles adamantly state that the predominant reason for these same symptoms is erratic hormones, a biological truth independent of a cultural and historical context (Johansson et al., 2009). A further example of how the medical model operates may be seen in media representations and medical knowledge concerning schizophrenia. According to the medical model schizophrenia is a predominately biological disease and the model negates the array of complicated context related factors precipitating mental illness. Individuals may attribute

more credibility to the medical model's version of 'truth' than to their own experiences. This occurs as a result of the powerful position that medicine holds in western society, where medicine is seen as representing absolute truth (Parker et al., 1995). This discourse thus actively perpetuates the medical subjugation of individuals described as mentally ill.

Knowledge is often produced through the oppression of certain people, such as those seen as mentally ill, and the simultaneous production of other individuals as superior, such as those outside diagnostic categories. Knowledge is interconnected and inseparable from power (Mills, 1997).

Power/Knowledge. Power operates through practices, institutions and ideology without a conscious intention. It creates tension and forms a network of interacting forces between groups (Powers, 2001). Thus, whenever there is power there will also always be a form of resistance. Power creates different positions of power, such as domination or oppression. In addition, power creates different subject positions and what may be accepted as truth by society. Discourse can function ideologically by presenting an oppressive view of the world that limits certain individuals and empowers others confined to its reality (Parker, 2005). Discourse can operate to define what is abnormal versus what is accepted as normal within a given cultural and historical context. In this way it can operate to construct certain power relations. Language functions to organise social bonds through which some people are included and others are excluded (Parker, 2005).

Power operates through discursive practices and individuals thus become agents of discourse and act within the parameters of that discourse (Powers, 2001). For example, Powers (2001) explains that psychiatry and medical knowledge do not construct power but are instead an effect of power regimes that are constructed within cultural and historical contexts. Medical experts (such as clinical psychologists) within these regimes of power act as agents of medical discourse and are in a position of power relative to consumers of medical services. This knowledge/power position offers medical experts the right to speak while simultaneously silencing other voices, such as those of menopausal women.

Powers (2001) views medicine as a form of dominant patriarchal discourse within which the female body becomes a target of power. The body thus becomes the site of

power and of resistance. This is reflected in the dominant gender discourses surrounding the female body that were discussed in the previous chapter. In addition, diagnosis of menopause according to certain symptoms allows medical experts to generalise the experience as universal regardless of a woman's social context.

In western society women who experience certain symptoms of illness during menopause are seen by medical experts as being normal, while women who remain symptom free during menopause are considered abnormal. However, the experience of menopausal symptoms may lead to further oppression based on the prevailing gender discourses. The situation is further complicated by gender discourses operating within organisations. A study of Welsh women conducted by Morris and Symonds (2004) found that women felt they had to manage their bodies to fit within their occupational environments which were assumed to be non-gendered. However, the norm against which the women were compared was constructed based on the non-symptomatic male body. The women in the study reported feeling as if they were a nuisance during times of pregnancy, menstruation and menopause as these times were felt to be disruptive to their work. The women felt they had to control their bodies to fit within the organisational framework.

Various systems of meaning place specific categories of people in positions of power, while simultaneously oppressing other people outside of these constructed categories (Parker et al., 1995). The subject is a product of power and acts as an agent of discourse (Mills, 1997). Through analysing discourse a researcher can explore these systems of meaning that operate to construct reality (Mills, 1997).

Discourses.

From a social constructionist perspective, society not only utilises language but is also recursive (Hare-Mustin, 1997). Language forms society and organises the ways in which society constructs reality (Hare-Mustin, 1997). Language assists in creating and maintaining specific forms of cultural behaviour and beliefs systems. In addition, language is a product of culture and thus members within the same cultural context will speak the same language and share the same perspective of reality. Local truths communicated by language construct and sustain a given understanding of phenomena,

such as menopause. Thus, the experience of a particular phenomenon varies across different cultural contexts (Gergen, 2001). Discourse is formed as a result of language and contextual communication about the world (Mills, 2004).

According to discourse theory meaning is formed from a pre-existing, culturally-shared language (Hare-Mustin, 1997). Discourses simultaneously form and perpetuate the objects about which they speak and are inseparable from their cultural and historical context (Wodak & Meyer, 2001). According to Bilić and Georgaca (2007) discourses structure how people think and provide an understanding of the world. Discourse operates to construct people within specific categories as subjects and objects of discourse (Powers, 2001). Discourse constructs ways of being and behaving. A discourse enforces power/knowledge effects within society and constructs reality. Medical experts act as agents of medical discourses and form the subjects upon which they construct diagnoses (Parker et al., 1995).

Medical Discourses Related to Menopause As A Disease. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is one of many diagnostic frameworks upon that medical experts use as a basis for their diagnoses. However, the DSM has been critiqued for reflecting economic interests and western constructions of the self (Parker et al., 1995). The DSM is thus empirically invalid as it reflects social constructions that change across cultural and historical contexts rather than absolute truths. Diagnostic categories construct the very problems they wish to describe (Parker et al., 1995). These diagnostic categories are actually discursive structures that offer certain positions of power to constructed subjects relative to medical experts. Discourse thus offers constraints to subjects falling within constructed categories and simultaneously constructs a subject position for individuals who fall outside these categories (Mills, 1997).

Gender discourses operate to generalise specific ways of being male or female. Discourses surrounding gender, youth, health and aging affect the way in which menopause is constructed and experienced within a given cultural context. These discourses offer specific positions for individuals to assume and enact (Parker et al., 1995). Powers (2001) sees scientific knowledge as masculine and thus in societies where medical discourse is dominant individuals in masculine subject positions will be in

positions of power relative to individuals' holding feminine positions. Discourses of femininity and medical discourses are thus interrelated and offer different positions of power to women depending on their cultural and historical contexts (Parker et al., 1995). Through reviewing the social context as a text, a discourse analysis allows for exploring the way in which discourse constructs reality and produces readily available systems of meaning within society (Bilić & Georgaca, 2007). Discourse analysis explores how certain perceptions have become accepted as 'truths' (Bilić & Georgaca, 2007).

An analysis of discourse allows researchers to question taken-for-granted assumptions and the power they have in relation to people's experience of the world (Wodak & Meyer, 2001). The current dominant biomedical discourses construct menopause as an illness. These medical discourses are active within popular media and clinical domains (Lyons & Griffin, 2003). However, within the culturally diverse South African context many people hold cultural beliefs that do not fit western medical models. It is therefore important, especially within therapeutic practice, to reveal and explore the various dominant discourses that are currently circulating and perpetuating the menopause discourses within South African media. This study undertook a discourse analysis of newspaper articles in order to explore some of the discourses available to South African women and attempt to understand how menopause is constructed in the South African media (Lyons & Griffin, 2003).

In the following chapter Ian Parker's approach to the analysis of discourses is discussed. The chapter also outlines the adapted discourse analysis process that was followed in this study and discusses the steps involved in the discourse analysis.

Chapter Four: Methodology

In this chapter rationale for the use of a discourse analysis methodology is discussed. Parker's approach to the analysis of discourse is discussed as a backdrop to a detailed description of the adapted method of discourse analysis used in this study. The steps used in the analysis of the selected texts are discussed. The manner in which texts were selected is clearly explained and the ethical implications of the research are discussed.

Discourse Analysis

This study was conducted from a social constructionist perspective, and therefore within the study reality is viewed as constructed through the use of a shared language within a given cultural context. Discourse holds power, it governs social practices and influences the manner in which people experience their world (Hare-Mustin, 1997). Dominant discourses operate and are perpetuated though the media. Media texts, such as newspaper articles, can be analysed using various methods including narrative analysis, thematic analysis and content analysis. However, the social constructionist perspective used in this research informed the choice of discourse analysis as methodology. In this research study an exploration of menopause discourses operating within South African newspaper articles was undertaken.

Although the epistemological foundations remain the same there are various approaches to conducting a discourse analysis. In this research Ian Parker's approach to discourse analysis was used. This specific method of discourse analysis was selected due to the researcher's familiarity with Parker as well as the complementary match between his approach and the research aims. The researcher aimed to explore the various menopausal discourses circulating in the South African media. Parker's method of discourse analysis is useful in understanding how discourse constructs reality (Mills, 1997). However, his work on knowledge/power was particularly valuable in relation to this research topic. Discourse serves to construct what is perceived as 'truth' and thus knowledge operates to construct positions of power within society. Parker's work allows for an exploration of discourse. In this study Parker's guidelines were used to explore

how the psychological construct of menopause is constructed within the reality defined by menopausal discourse within the South African context.

Society uses and is used by language (Parker et al., 1995). Parker's method of analysis offers ways of revealing how language offers different positions of power to people in their given cultural contexts. This is important when exploring the ways in which menopause discourses construct different subjects and the different positions of power these subjects occupy in relation to various readers of the texts.

Discourse analysis is an established qualitative method that allows researchers to systematically interpret the social world as a system of texts (Van Dijk, 1997). The media influences and shapes societies' opinions; it impacts the ways in which problems are conceptualised and constructs certain problems as more important than others (Gollust & Lantz, 2009). Discourses construct knowledge and cultural 'truths' and are circulated in society through and by language in texts such as newspapers, magazines and advertisements (Parker, 2005).

Parker's twelve standard, systematic steps of discourse analysis were considered too ambitious for a mini-dissertation that included 37 newspaper articles. Time constraints and the length of the newspaper articles made the use of the twelve step approach impractical. Thus, alternative methods of discourse analysis, suitable for broad selections of texts, were explored during the research review. The section below summarises Parker's criteria for identifying discourses and his guidelines for reading texts. In addition, the section describes how these guidelines were adapted to meet the requirements of this particular study. The section also includes a summary of a study by Lyons and Griffin (2003). The researcher adapted some of their guidelines in her analysis to meet the requirements of the text and aims of this research. Lyons and Griffin (2003) adapted Parker's approach in their discourse analysis study. Parker's guidelines and studies influenced by his ideas were also used to assist the researcher in formulating a specific path for her analysis.

Ian Parker's Criteria for Identifying Discourses in Texts

The discourse analysis method used in this research was based on the guidelines provided by Parker. Parker (2002) states that discourse categorises the social world and

includes systems of statements that actively construct objects. Parker (2002) also explains that an analysis of discourse requires the researcher to take a critical stance towards language, he then provides seven criteria that can be used to identify discourses in texts and explore the contradictions between the identified discourses. According to Parker's (2002) method of discourse analysis an analysis should also include relations of power and ideology within and between discourses. The seven steps summarised below are a summary of Parker's seven criteria, which he carefully describes and explains in chapter six of his book called Critical Discursive Psychology (Parker, 2002).

Criterion one states "a discourse is a coherent system of meanings" (Parker, 2002, p. 145). According to this criterion the different uses of language, pictures and speech all construct a version of reality about a specific phenomenon. Statements in discourse can be grouped to form a coherent construction, for example certain words and terms may be used repetitively and thus limited terms become available to describe an object. A fragment of discourse may be spoken of in the text that links to knowledge of the wider discourse.

Criterion two explains: "a discourse is realised in texts" (Parker, 2002, p. 147). According to Parker (2002) discourse can be at work in a text and the text may be located in discourse. Texts are given meaning through interpretation by the reader, when the text is translated into words the discourses may become more salient. Researchers should ask themselves which discourses inhabit the text. In this criterion various connotations, suggestions and consequences of the text are explored. Different discourses may evoke different meanings and speak to different audiences. For example, a menopausal woman, a non-menopausal woman and a man would all be likely to read text differently.

Criterion three states: "a discourse reflects on its own way of speaking" (Parker, 2002, p. 148). Although some texts may not include some of the frequently repeated terms and words that form part of the discourse's coherent system of meaning, when the discourse is reviewed as a whole there are always cases where the terms are used. In this way the discourse takes itself to be an object. It is important for a researcher to explore the contradictions in the discourse and the way in which these contradictions are handled. Discourse usually has both explicit and implicit meanings and researchers should be aware of the possible hidden meanings of the discourse. Reflexivity focuses on the

analysis of the researcher's role in the research process, as during the process of discourse analysis the texts inherently speak to the reader. Discourse analysts must therefore reflect on the language they use to describe the discourse by treating the discourse as an object. Researchers should also reflect on the possible moral and political influences in the choice of the discourse described.

Criterion four states: "a discourse refers to other discourses" (Parker, 2002, p. 149). An analysis of text to explore discourse can only occur through the use of different discourses. The analysis of a single discourse can open up for an awareness of a wider network of multiple inter-related discourses. Discourse surrounds and takes for granted the availability of other discourses. Possible contradictions in one discourse allow for explorations of other discourses operating within the text. There is thus an inter-relationship between discourses.

Criterion five states: "a discourse is about objects" (Parker, 2002, p. 151). Through the process of analysis the researcher must objectify discourse as the object of inquiry. According to Parker (2002) there are two layers of objectification. The first layer involves the 'reality' that the discourse attempts to describe. For example, the word 'menopause' describes the physiological reality of the cessation of a woman's menstrual periods. The second layer of objectification reflects the connection between the object described in the text and a social discourse outside the text. The object thus gains meaning through its relationship with systems of statements related to discourses operating within the text. Thus, while discourse constructs an object, discourse analysis explores discourse as an object (Parker, 2002).

The sixth criterion states: "a discourse contains subjects" (Parker, 2002, p. 152). In addition to constructing objects discourse also constructs subject positions for readers of the text. Although objects within the first layer of objectification may have an independent meaning outside the discourse, the same objects are offered a different meaning in the reality defined by the discourse. A discourse speaks to readers in a certain manner, thereby opening up positions for readers to occupy. In this way discourse constructs subjects. Researchers need to examine the ways in which the discourse addresses potential readers. Discourse constructs ways of relating within relationships and offers people a perception of themselves. In order to explore these constructions

researchers should query the relationship between addressor (text) and addressee (reader) (Parker, 2002). In addition, researchers need to investigate the role required of the addressee in order to attend to the discourse and the right to speak that the discourse offers the addressee. Parker (2002) also suggests that researchers explore the positions of readers relative to the discourse by considering the position of power one reader may have in comparison to another. For example, a menopausal woman who can afford to take HRT medicine and a menopausal woman who cannot afford HRT have different positions of power in relation to the medical discourse.

The final criterion states: "a discourse is historically located" (Parker, 2002, p. 153). Discourses are dynamic; they change across time and place. An analysis of discourse requires locating the objects described in history. Although it is not set out as a specific criterion, Parker (2002) encourages researchers to also explore possible moral and political influences as agents of discourse within the text.

Methodology

In this research study the researcher aimed to adapt Parker's approach to discourse analysis to a broad sample of text. The sample in this study consisted of 37 text articles. During the research review other methods of analysis, suitable for a broader exploration of discourses in the media, were investigated. The study by Lyons and Griffin (2003) offered a more suitable approach to the analysis of the sample texts. Lyons and Griffin (2003) made use of an approach to discourse analysis that involved a modification of the approach used by Parker and the Bolton Group. This modified approach allowed for a broader analysis of a wider scope of text. Lyons and Griffin (2003) relied on Parker's guidelines contained in his '*Critical Textwork*' to perform an analysis of discourses operating in self-help books. In the section below the guidelines provided by Parker (1999) are summarised. The basic approach followed by Lyons and Griffin (2003) is then outlined.

Parker provides different and innovative approaches to exploring a variety of different texts, such as letters, visual advertisements and even work environments. Although he provides certain methodological principles that can be followed while reading texts he also notes that any rigid dependence on a set method of analysis is likely

to restrict the understanding and exploration of the intricacy and diversity of meanings (Parker, 1999). The approaches he recommends for analysis are thus flexible and adaptable and allow the researcher to remain true to the text chosen for analysis. In this way a flexible and creative approach to discourse analysis is encouraged. Parker (1999) reminds researchers that language is always set against a cultural backdrop, which he explains as the social world the text describes, that includes families and groups. This cultural backdrop provides shared communicated forms of meaning that may be drawn upon by the reader. In addition, Parker (1999) emphasises that the process of reading a text is itself a form of translation and therefore, produces the object that is subjected to analysis. Analysis is always framed by a researcher's background, their paradigm and theoretical underpinnings.

Parker (1999) highlights three characteristics of language that should be explored while reading a text: contradiction, construction and practice. When exploring the different contradictions in text researchers should focus on the different meaning operating within the text (Parker, 1999). Researchers should then identify the various dominant meanings that may be supported by ideology or cultural myth. It is important to explore the contradictions between different ways of viewing the world and to identify points of alternative meanings and possible sources of resistance. In order to explore construction in the text researchers should focus on how meaning is constructed within the text and explore aspects of socially constructed meaning (Parker, 1999). Researchers must be careful to not take anything for granted. The third characteristic of language involves the practice of discourses within the texts. Researchers should ask themselves what the contradictory systems of meaning do and how they operate (Parker, 1999). It is helpful to reflect on the way in which discourses operate to serve political functions or to communicate political conflicts. Researchers must explore issues of power and look for spaces opening up for resistance and alternative constructions. Parker (1999) also reminds researchers of the importance of reflexivity. Researchers should reflect on their own subjectivity and be aware of their part in the cultural context and the stance that they take in reading a text.

Lyons and Griffin (2003) adapted the guidelines provided by Parker and the Bolton Group to conduct a discourse analysis of self-help literature. This study made use

of aspects of Lyons and Griffin's (2003) adapted methodology as well as Parker's guidelines. The steps adapted from Lyon and Griffin's (2003) study of menopausal discourses in self-help books are discussed below.

Lyon and Griffin (2003) read Parker and the Bolton Group's work on adapting Parker's ways of reading to meet the selected text. They then read and re-read the texts they had selected and drew out salient ways of speaking about menopause and women at midlife. The language used to describe them was explored. Lyons and Griffin (2003) focused on discourses concerning menopause and women and systematically extracted and coded relevant quotes and pictures. They then considered the similarities, differences and contradictions in texts regarding the various descriptions of menopause and women. They continued to explore the ways in which contradictions were smoothed over. They then highlighted certain discourses and explored the possible ways of functioning that the discourses provided for women readers. Finally, they identified five main discourses to focus on in their study. Although the researchers specified a pathway for their analysis, their study did not follow an inflexible step-by-step approach but instead took the form of a structured discussion of their revealing explorations and possible conclusions.

Method for Analysis

The literature concerning Parker's criteria, discussed in his book '*Critical Discursive Psychology*' (Parker, 2002), his proposed 'ways of reading' a text contained in his book '*Critical Textwork*' (Parker, 1999) and the adapted approach used by Lyons and Griffin (2003) were compared and reviewed for similarities. Similarities as well as complementary steps across all three summaries were identified and an adapted approach was formulated. Thus, the method of analysis was tailored to suit the texts selected. The ways of reading, analysis and guides for discussion that were used in this research study are discussed below. The texts selected are contained in appendix A. The analysis is discussed in chapter five and a discussion concerning reflexivity is included in chapter six.

Ways of reading the texts

1. The first step involved reading and re-reading the articles. Articles that were found to not be appropriate or relevant to the study were excluded from the sample. However, these articles are included in appendix A. Articles that were verbatim repeats of previous articles or were not actually related to menopause (despite containing the key word 'menopause') were also excluded from the sample.
2. Interesting sections in the articles were highlighted. These sections related to the ways in which women, mid-life and menopause are discussed.
3. The various highlighted sections were read and re-read and the articles were systematically reviewed in order to identify specific discourses.
4. The highlighted quotes were then coded in accordance with the different discourses identified. This was done by making notes concerning the various descriptions of women, midlife and menopause in the texts. Discourses were identified based on the coherent descriptions of objects and the repetitive and frequent use of words, terms and systems of language to construct objects.
5. Finally salient quotes were identified for analysis. These quotes were related to the various discourses identified in the previous steps.

Analysis

1. Following the completion of the 'ways of reading stage' the identified discourses were given names.
2. Some of the identified salient quotes were used to discuss the various constructions.
3. The objects constructed through discourse and the ways in which objects are brought into being were explored. The researcher explored how discourse constructs an object through and by language. This was done through exploring the use of metaphors, similes and word choice. Possible alternative meanings of menopause, women and midlife were explored as possible sources of resistance.
4. The ways in which discourse operates to construct subject positions were considered. The researcher explored how subject positions could differ for different readers.
5. The researcher explored the ways in which the text addresses the reader and different audiences in order to make them attend to the text and evoke possible responses. The different rights to speak and roles constructed by the text were reviewed.

Discussion

1. The researcher reviewed similarities and differences between some of the identified discourses. This step was based on Parker's statement that the ways in which contradictions between different discourses are smoothed over and the interrelationships between different discourses should be explored.

2. The discourses were located in history through considering how different meanings are constructed across time. The possible temporary impact of dominance of one discourse on another discourse was explored.

3. The various possible institutional and ideological influences on these constructions were brought into question. The researcher explored the interconnections between myth, institutions and power. The influence of these power relations on dominant and resistant discourses was explored.

4. The final step involved reflexivity. Parker (1999) encourages researchers to be aware of the value of reflexivity. The analyst should make use of him/herself as a source for exploring his/her own cultural and historical influence on the different discourses evoked when reading the texts. This is an important part of ethical research in qualitative studies. Additional ethical implications are discussed later in this chapter. Reflexivity allows subjectivity to be addressed as part of the research process.

Although the methodological approach was presented in a step-wise approach in this section, the researcher followed Parker and the Bolton Group's (1999) guidelines suggesting that methodology should be flexible and adaptable. Thus, the texts are discussed in accordance with the guidelines provided above rather than systematically analysed.

Text Sources for Analysis.

The researcher initially intended to analyse magazine articles concerning menopause as many women read magazines for information on female health related issues (North American Menopause Society, 2010). However, due to various practical considerations it was decided that newspaper articles would be used in this study. This decision was taken based on the fact that there are no magazine articles publically available on the University of Pretoria's database, the magazine websites themselves do

not provide previously published articles for public access and there were insufficient articles available on the shelves at local supermarkets to support the research aims. Thus, newspapers were seen as a logical alternative form of media. This decision was taken based on the availability of articles and was discussed with the researcher's supervisors.

Newspapers provide a wealth of information. For example, *The Citizen* has a section dedicated to health that can also be reviewed on their website (http://www.citizen.co.za). Many women make use of newspaper articles when gathering information on health related topics such as menopause. Unlike magazines, newspapers target both male and female readers and are often depicted as objective and reliable sources of information, knowledge and well researched journalism. The texts in newspapers may thus influence a wider audience and be taken more seriously than the information contained in magazines. The articles in newspapers thus circulate and perpetuate discourses operating in texts within society. This study made use of articles concerning menopause published in publically accessible (either through electronic databases or internet sites) South African newspapers. In accordance with the limitations of a mini-dissertation the selection of articles was influenced by practical concerns. For example, only English articles were selected because the researcher is English speaking and all the articles used were publically accessible.

The articles were also all published between 2006 and 2011. This time frame was used because the database only contained menopause related articles dating from this period.

The study made use of the SA Media database, which contains over 120 South African newspapers. This database offers a sample of newspapers that are distributed throughout the country and was thus considered to contain a representative sample of the various articles related to menopause published in South Africa. A search using the keyword 'menopause' found 37 articles published during the last six years. Articles were included in the study based on their use of the keyword 'menopause' and their availability. The 37 articles used in this research are provided in appendix A of the research report.

Ethical Considerations

The text samples were collected from various publically accessible South African newspaper articles and therefore no human or animal participants were involved. However, in conjunction with postmodernism and discourse analysis principles analysis was conducted from a reflexive standpoint. The researcher thus acknowledged her own cultural and historical position and influence in analysing the texts. Thus, the researcher did not seek to find objective truths but instead remained aware that her analysis was influenced by her own ideals and cultural background (Schiffrin, Tannen & Hamilton, 2003). Discourse analysis does not claim to provide an absolute representation of reality, instead the thinking and emotional processes with which the researcher approaches the analysis form part of the research (Powers, 2001). No version of 'truth' is taken to be superior or absolute over other 'truths' that are uncovered through analysis. Through the process of reflexivity researchers are encouraged to be aware of the way in which their own socio-cultural background can and does influence their interpretation of text.

Reflexivity allows researchers to separate from the self-referential circle that can sometimes typify research work (Parker, 2005). Reflexivity also tempers the certainty of the researcher's interpretations by remaining sensitive to how the researcher is situated *vis-à-vis* the text (Gergen, Chrisler & LoCicero, 1999). An attitude of openness to the possibility and exploration of different interpretations of the text is encouraged (Gergen et al., 1999).

In chapter six the researcher's assumptions and reflective thoughts during the research process are discussed. This purpose of this discussion is to ensure transparency regarding the researcher's role in the analysis. The texts selected are provided in appendix A of the research report. This facilitates an ethical and honest approach to qualitative research by dealing with the institutional position of historical and individual characteristics of the research relationship (Parker, 2005).

In this chapter the use of discourse analysis as a method for the exploration of menopause discourses within South African media was discussed. Parker's valuable guidance and ideas were discussed. The process through which the researcher formed her own adapted method of analysis was discussed. Finally, the approach used to select the texts was explained and ethical considerations related to the research were clarified.

Chapter Five: Analysis

In this chapter the process followed by the researcher prior to the analysis of the texts is discussed. The various discourses identified during this process are then discussed.

A Review of 'Ways of Reading'.

The researcher followed the approach to 'ways of reading' that was outlined in the methodology section of this study. She read and then re-read the 37 articles for analysis. During this process the researcher identified several articles that were not appropriate for the study. Some of these articles were not related to women, menopause or midlife while other articles were replicates of previous newspaper articles.

The researcher then highlighted interesting parts of the articles, such as parts relating to menopause, midlife and women in different colours. Following this initial categorisation the researcher re-read each article and provided names for the possible discourses identified in the highlighted sections. During this process the possible discourses were also noted and numbered so that the researcher could ensure that the discourses were assigned to the appropriate highlighted sections. Through this process the researcher identified 10 discourses operating through the media texts. The researcher also used a code for each discourse and where it appeared (i.e. article number and date). This allowed the researcher to observe discourse patterns across time (over the six year period) and note possible interrelationships between discourses. Once this process was complete the researcher proceeded to analyse the highlighted sections of the articles. These highlighted sections were coded according to the related discourse. A summary of the way in which discourses were coded according to year and article number are available in appendix B section of this study.

Analysis

Eight main dominant discourses and two supplementary discourses were identified. These discourses were identified based on repetitive descriptions, frequent words and the use of terms used and systems of language such as metaphors in the

construction of various objects and subject positions. The dominant discourses identified were labelled: (1) menopause as a disease, (2) treatment of menopause as dangerous gamble, (3) menopause as old-age, (4) menopause as natural progression, (5) menopause as loss, (6) menopause as responsibility, (7) menopause as confusion and (8) female object as biological being. The supplementary, resistant discourses identified were labelled (1) menopause as rejuvenation and (2) midlife as rejuvenation.

In the sections below these discourses are each discussed separately. Specific attention is paid to the power relations within the discourses. In the following chapter the possible interrelationships between the discourse and the changes in the discourses over time are discussed. In addition possible political and moral influences are questioned.

Menopause as disease

1.1. Menopause as Disease. The discourse menopause of disease was located within various newspaper texts.

1.2.Some of the salient quotes used to identify this discourse are provided below:

The official medical definition of menopause is when menstruation stops for 12 months……symptoms can include headache, palpitations, night sweats, insomnia, hot flashes, vaginal dryness, pain during intercourse, vaginal itching or burning, urinary infrequency or pain, fatigue. That's not all. This period may also include reduced sexual desire and arousal, anxiety, depression, irritability, weight changes, cognitive issues, back pain and stiffness, hair/skin changes and joint pain. Conventional medicine involves synthetic HRT…

Dr. Benita Perch, article number 5; 06 October 2010.

Although generations of doctors have prescribed hormones to reduce these symptoms, very little research has focused on the underlying causes.

Marika Sboros, article number 7; 30 May 2007.

The menopausal woman will most often experience the following symptoms: hot flushes, night sweats, palpitations, insomnia, irritability, anxiety, diminished energy, a low libido

and even depression..... About 80% of women have symptoms and will need some form of treatment.
Jabulile Ngwenya, article number 8; 19 June 2007.

... You don't have to wait until you have a full-blown case of anxiety or depression to take action. Increasing your exercise level, exposing yourself to more light and even making a concerted effort to be happy can make a difference. If that's not enough, talk to your doctor about whether a short course of low-dose antidepressants or talk therapy (or both) could get you back on track.
Pat Wingert and Barbara Kantrowitz, article number 1; 22 January 2007.

...the growing popularity of bio-identical hormones means women can test the waters of a possibly safer, more effective alternative to conventional (synthetic) hormone replacement therapy...this emerged at a recent Demystifying Hormones seminar, held for doctors at the University of the Witwatersrand Medical School and presented by Johannesburg endocrinologist Dr Sindeep Bhana. .... He also says the accurate assessment of hormone levels is essential, as all women will react differently to hormone therapy. A new saliva test will be available in SA later this year, which he says will be more accurate and convenient than conventional blood tests.
Glenda Daniels and Marika Sboros, article number 3; 30 August 2006.

About three out of four women who suffered night sweats and hot flushes said the symptoms vanished after a year of hormone replacement therapy (HRT) use, the researchers reported in a paper in the British Medical Journal.
Reuters, article number 6; 25 August 2008.

1.3 Menopause is constructed as a disease. Disease is defined as an "unhealthy condition of the body or mind, plants, society" (Thompson, 1996, p. 246). This view of menopause can be seen in the quotes listed above. This discourse constructs menopause as an object, through language it becomes an object which is defined, has an underlying cause, manifests symptoms and requires treatment by medical

professionals in accordance with medical research. This discourse links to the broader, dominant scientific bio-medical discourse, which places medical and scientific research in a position of power relative to patients.

When menopause is defined within a medical framework it is constructed as a disease requiring medical attention and medical professional's knowledge. The first quote provided above lists the symptoms of menopause. The *Pocket Oxford Dictionary* defines a symptom as "1. Physical or mental sign of disease. 2. Sign of the existence of something." (Thompson, 1996, p. 924). The language used thus acts to construct menopause as disease, which is characterised by symptoms such as headaches, depression and joint pain, which by definition require medical attention. Experiencing any of these signs at midlife proves that an individual is diseased. In this way symptoms are constructed as being under the medical domain's control and women who experience symptoms are seen as having lost control over their bodies and requiring medical attention.

In line with scientific ideology, medical researchers aim to identify an '*underlying cause*' reflective of a linear relationship between symptoms and aetiological factors. Menopause as disease thus requires much medical research and is both constructed and explained by medical professionals and thereafter is only treatable according to medical expert's knowledge and prescribed medication. According to the quotes provided above, both the '*British Medical Journals*' and '*generations of doctors*' have conducted extensive research on menopause. The knowledge presented in the articles is thus legitimised by being linked to the opinion of 'experts,' which operates to justify this knowledge as an 'objective truth' according to modernist principles. The discourse suggests to individuals who are not experts and/or knowledgeable about medical terminology and medical research, that doctors know what is wrong with them and understand why and how to cure the disease. Finally quote five states that '*Witwatersrand Medical School' has* dedicated time to the study of menopause as a disease. The quotation proudly states that '*a new saliva test will be available*' to identify diseased patients requiring medical help. Thus, according to this quotation menopause as disease can be located and even '*cured*' by medical experts with methods such as 'c*onventional medicine… synthetic HRT*', and '*antidepressants or*

talk therapy (or both)'. Regardless of the treatment chosen, the discourse constructs menopause as a time where '*About 80% of women have symptoms and will need some form of treatment.'* This statement suggests that almost all women will be diseased at some stage of menopause, which is constructed as a universal, unavoidable disease.

1.4 The discourse of menopause as disease operates to construct certain subject positions, these positions may differ for various readers addressed by the text. Menopausal women reading the text are addressed as diseased and requiring medical help. Within the dominant bio-medical discourse women are constructed as patients and thus subservient to medical experts' knowledge and dependent on their help. In this way women are encouraged to assume that they will manifest and are expected to manifest the symptoms listed by medical terminology. Women require treatment if they wish to be '*cured*' of menopause, or at least wish to avoid the onset of severe depression and anxiety. Menopause is constructed as a universal disease, and thus even women who do not experience symptoms may feel as though they are abnormal.

Likewise, women who are pre-menopausal may assume that at some point they will become '*diseased*' and should therefore anticipate that they will need doctors' assistance. The anticipation of becoming diseased may require them to acquire more medical knowledge concerning the disease in order to better prepare themselves for the *'inevitable'*. In this way pre-menopausal women are positioned in an assumedly unavoidable position. This position may evoke further anxiety as disease is anticipated. The possibility of different experiences of menopause and midlife are not allowed for within the reality constructed by this dominant discourse and choices for women before and during midlife are portrayed as limited.

Women who can afford medical insurance or treatment may be in a superior position relative to women who cannot afford this treatment. The menopause as disease discourse assumes that all women will require treatment during menopause, and thus both the disease and its prescribed treatment are seen as unavoidable. Women who are unable to pay for hormone therapy are therefore positioned as disadvantaged, as they are not able to treat the 'inevitable' symptoms of menopause. Thus, the female body's innate disposition to be diseased during midlife creates a

victim position as it is assumed that these women will require treatment that they cannot access.

Medical experts reading the text may be placed in an advantaged position as their knowledge and qualifications construct them as superior. In contrast health workers that work outside of a predominantly medically and scientifically focused domain may feel subjugated by this discourse as it assumes that only medicine that has been researched for '*generations*' can '*cure*' menopausal symptoms.

1.5 The reader is addressed as an individual who requires medical information from experts. The reader is assumed to be female and middle aged. She is urged to seek medical advice due to the seriousness and inevitability of her condition. The text functions to position women as dependent on medical professionals for expert advice and a '*cure*' for their symptoms. Women are urged to seek medical help and to present their dysfunctional bodies for medical scrutiny. Menopausal women are thus expected to rely on medical exerts for help, as these experts have the knowledge and power to understand menopause and show women how to '*survive it*.' Through this discourse women are constructed as patients. The discourse also encourages them to visit their general practitioner as soon as possible to enquire about menopause and to receive medical treatment to avoid depression, anxiety and other symptoms. The medical discourse thus constructs menopausal women as unavoidably diseased while simultaneously constructing medical experts as having the knowledge/power to cure the symptoms of this disease. In this way the text creates a sense of urgency for both menopausal women and medical doctors. In this discourse doctors are required to assess patients according to various tests, diagnose their disease and prescribe necessary treatment. Definitions reflect the power of ideology, and it can therefore be assumed that due to menopause's definition within and by medical terminology, medical knowledge has power over other forms of knowledge concerning menopause. Thus, medical experts hold a superior role in health departments relative to other alternative medical professionals outside the scientific discourse.

Treatment of Menopause as Dangerous Gamble

2.1 Menopause is also constructed as a dangerous gamble.

2.2 Some of the salient quotes reflecting this discourse are provided below.

Menopause is the time when there are no more eggs in the ovaries and the ovaries stop producing oestrogen, thus throwing the menopausal woman's system into chaos…. The benefits of HRT outweigh the risk and it is the best thing to reduce the symptoms.
Jabulile Ngwenya, article number 8; 19 June 2007.

… hormone therapy relieves hot flashes, night sweats and vaginal dryness, and it may improve sleep, mood and concentration. It also preserves bone density and protects against fractures. But there also are risks, including higher rates of breast cancer, stroke, blood clots in legs and lungs and, for older women, coronary heart disease.
Joanne Manson and Shari Bassuk, article number 3; 22 January 2007.

About a million women in Britain are on HRT, which provides synthetic oestrogen in tablet form, and can help alleviate menopausal symptoms. It also protects against osteoporosis and reduces the risk of colon and rectal cancer. But the latest study, by experts at Leiden University in the Netherlands, found those who were on HRT for more than six months at a time were twice as likely to develop a malignant melanoma, the most deadly form of skin cancer.
The Daily Mail, article number 1; 13 April 2009.

Meanwhile, HRT has been linked to an increased risk of breast cancer, heart attacks, stroke, dementia and perhaps even asthma. …… Right now, most doctors are recommending only short-term use of HRT for women who have severe symptoms of menopause.
Amanda Gardner, article number 6; 6 December 2006.

Some women lost faith in conventional medicine and turned to so-called natural remedies for menopausal symptoms. But the safety and effectiveness of many of these alternative therapies have not been closely studied. You should assume that they carry the same risks

as FDA-approved hormone therapy…. Don't ignore these problems. Depressive symptoms put you at higher risk for many long-term health problems, including cardiovascular disease, dementia, stroke and osteoporosis….. After menopause, women are much more vulnerable to osteoporosis, a thinning of bones that leaves them susceptible to fracture.
Pat Wingert and Barbara Kantrowitz, article number 1; 22 January 2007.

Many women are attracted to "all natural" supplements for menopausal symptoms…. Not regulated by the United States Food and Drug Administration. That means they are not checked for purity, safety or effectiveness.
Harvard Health Publications, article number 4; 7 November 2006.

2.3 According to these extracts from the texts the treatment of menopause is a dangerous gamble. Thus, the choice of treatment for menopause is seen as both unavoidable and risky. The discourse operates by constructing choice as an object. This object is brought into being by the repetitive use of words that serve to support alternative and contradictory arguments regarding hormone replacement therapy. Words such as, '*preserves', 'protects', 'alleviates', 'reduces', 'recommended'* serve to construct HRT as beneficial. However, the repetitive use of words such as '*disease', 'deadly', 'risks', 'vulnerable', 'safety and effectiveness not studied', 'problems*' and '*susceptible'* operates to construct HRT as detrimental to women's health.

According to this discourse all women must choose between taking HRT and taking natural remedies. Thus, no alternative choices are created. This discourse is strongly linked to the menopause as disease discourse as it also assumes that menopause inevitably requires treatment. The discourse is also linked to the current dominant bio-medical discourse, as it constructs medical knowledge as superior to the knowledge contained in alternative, natural approaches. In order to become widely accepted by this discourse alternative medicines would have to undergo more research and prove that they adhere to the standards governed by scientific discourse.

Both choices, provided within the discourse of menopause treatment as dangerous gamble stem from a reality defined by the menopause as disease discourse. In

addition, both these choices are constructed as offering possible danger. Both choices involve risks and thus the treatment of menopause is constructed as a gamble, with both alternatives offering risks and benefits but neither alternative providing a completely safe and favourable outcome. This creates a dilemma for the consumers (readers) of the texts. Although natural remedies offer a source of resistance of the dominant medical discourse, they are still confined by its standards and requirements.

Choosing to take HRT is constructed as the optimal treatment approach as '*the benefits of HRT outweigh the risk and it is the best thing to reduce the symptoms*' and this form of treatment is seen to alleviate menopausal symptoms and protect against diseases such as '*osteoporosis and colon cancer'*. Within this discourse, choosing to not take HRT treatment is constructed as reckless behaviour. However, the discourse also highlights the risk of HRT treatment, such as its relationship to increased risk of developing breast cancer and cardiovascular disorders.

Choosing to take natural medicine is constructed as beneficial as it is associated with less risk of disease than HRT. However, the efficacy and safety of natural medicine have not been proven within a dominantly scientific discourse that values validated medical studies. Natural medicine thus fails to meet the standards governed by the wider dominant bio-medical scientific discourse.

This discourse thus constructs the treatment of menopause as a dangerous gamble, as treatment is assumed to be unavoidable and necessary, but is simultaneously constructed as risky regardless of the treatment chosen.

2.4 The discourse constructs different subject positions for different readers. Menopausal women reading the text may be placed in a dilemma, as they feel compelled to choose a treatment approach and attend to the linking discourse of menopause as disease. These two discourses operate in tandem to position menopausal women as dependent upon their doctors to provide them with aid in making a decision and weighing up the benefits and risks of treatment. Menopausal women are forced into a gamble whereby each decision places them in a risky dilemma. Both medical experts and natural therapists are also placed in a predicament as they are not able to fully

endorse their approach. These 'experts' are therefore in an uncomfortable position, although they remain in a position of power relative to women seeking their advice.

2.5 The subject positions constructed by this discourse place individuals in different roles and provide individuals with different rights to speak. Women may feel that they are unable to choose not to take treatment or to look for an alternative to the two treatment approaches constructed by this discourse. Although women are offered a voice within this discourse they remain constrained as they are only permitted to choose between two risky options. They may feel compelled to seek advice from health experts and yet may simultaneously doubt the approaches offered by the experts. The discourse acts to create a sense of risk and danger for women taking treatment and yet urges women to take treatment.

Menopause as Old-Age

3.1 In this discourse menopause is constructed as old-age.

3.2. Some of the salient quotes reflecting this discourse are provided below.

With a pull of sadness, she acknowledges her greying hair, useless uterus, and failing eyesight. She notes the way she cannot quite find the right word, and keeps checking her handbag to make sure she has the remote. The children have left home so she waters the pot plants. She becomes overly watchful of her body and – as legs, belly and breasts-sag and her skin gets crepey – she becomes fearful. It is just like becoming an adolescent all over again but without the youthful promise.

Mary Jordan, article number 5; 14 November 2006.

Dr. Craige Golding, a Johannesburg physician who specializes in anti-ageing medicine, believes that declining hormone levels in ageing men and women fuel disease.

Claire Keeton, article number 12; 5 August 2007.

Postmenopausal women are particularly susceptible to fractures due to osteoporotic bone loss – and up to 20% of that loss can occur within just five to seven years after menopause.
Science Daily, article 4; 24 January 2007.

Some physicians still believe that scientists will someday prove that oestrogen (or some synthetic version of it) is indeed the elixir of youth. … It's also important to realize that both men and women tend to feel less sexual desire as they get older.
Pat Wingert and Barbara Kantrowitz, article number 1; 22 January 2007.

The balance between bone resorption and deposition changes as people age. During childhood there is a higher amount of bone formation and less breakdown. In early and middle adulthood, these processes are equal. In aging adults, particularly among postmenopausal women, bone breakdown exceeds its formation, resulting in bone loss, which increases the risk for osteoporosis...
Amanda Gardner, article number 1; 23 January 2008.

Your brain may work less well when you approach the menopause, but deficits, if they can be called that, are temporary. Learning capacity bounces back after menopause. … Science is now backing up what women have long claimed: memory and learning take a hit during menopause.
Amanda Gardner, article number 2; 10 June 2009.

Hormones may not be able to stop ageing clock. … Postmenopausal women may notice that their skin does not have the same elasticity as it once did and that it is drier than normal. … The jury is still out as to whether oestogens can be effective for ageing skin.
Newswise, article number 3; 2 September 2009.

"It's a useful enough test, but I don't think it provides enough information. Is it actually going to help society and women in some way?" Grudsinskas pauses, witheringly. "What worries me is that a 'normal' result (a prediction of menopause around early 50s) may

encourage people to wait to conceive. It's far more useful to use age as an indicator of fertility."
Viv Groskop, article number 4; 19 August 2010.

Women often do not realise how seriously ovarian reserve declines after the age of 35. Every year that goes by you are losing a big proportion of your ovarian reserve.
Fiona Macrae, article number 1; 6 February 2010.

Of course, menopause is not the end of the world; nor is it a disease. It is merely a natural life progression. ….'She adds that the thinner body "ideal" is detrimental, as most women, as they get older, gain weight and need to feel comfortable in their own skin. They also have to deal with greying hair; the thinning of pubic hair; and a gradual decline in skin elasticity and structure as the skin becomes thinner with age.
Jabulile Ngwenya, article number 8; 19 June 2007.

3.3. In this discourse the ages of 50 to 60 are constructed as a time of deterioration. This construction is achieved through the use of words and phrases such as '*greying hair,' 'failing eyesight,' 'cannot quite find the right word,' 'legs, belly and breasts – sag and her skin gets crepey,'* and *'skin becomes thinner with age.'* This deterioration is constructed as inevitable and as universal, menopause is viewed as '*a natural life progression*' that all women must endure. In this discourse a certain reality is created in relation to menopause, which is seen as a time of unpreventable deterioration and decay.

According to *The Pocket Oxford Dictionary* age is "a condition" (Thompson, 1996, p. 15) and old is defined as "worn, dilapidated, or shabby from the passage of time" (Thompson, 1996, p. 618). The menopause as old age discourse thus characterises menopause as a pathway leading towards impending death, something of which women are '*fearful*.' The menopause as old age discourse thus operates to construct a time of deterioration. Words and phrases operating to construct this discourse include, '*without youthful promise,' 'less sexual desire,' 'breakdown', 'bone loss', 'deficits'* and '*ageing skin.*' In addition to physical deterioration this

discourse also constructs aging as related to decreased usefulness and decreased social worth. During this time women's reproductive role ends and they become infertile: '*useless uterus,' 'age as an indicator of fertility*,' and *'ovarian reserves decline after the age of 35. Every year that goes by you are losing a big portion of your ovarian reserve.'* This links to a discourse of reproduction, which constructs women who can bear children as useful members of society and as mothering agents. Menopause marks the end of these roles.

In addition to constructing menopause and old age as deterioration, the discourse also serves to pathologise the aging process and thus to strengthen the construction of menopause as a time of disease. Words and phrases constructing this reality of menopause include, *'anti-aging medicine,' 'declining hormone levels in ageing men and women fuel disease,' 'susceptible to fractures,' 'risk of osteoporosis,' 'brain may work less well'* and *'stop the ageing clock.'*

This discourse is linked to other western discourses concerning the beauty and value of youth. According to these discourses younger women are more valuable than the older, less aesthetically attractive population. These discourses surrounding youth were discussed in the research review. Menopause as aging thus becomes a time of subjugation and disregard by society. Menopausal women's '*children have left the home'* and they are left alone to '*water the pot plants*,' and are lacking in '*the youthful promise.*' In addition, as these women's fertility decreases they are less able to fulfil their role and '*help society'* by reproducing. Thus, menopause as old age is brought into reality and constructed as deterioration, uselessness and disease.

3.4 This discourse also constructs various subject positions for women. Younger women, who are not yet approaching menopause, are constructed as useful to society due to their ability to bear children. Their youthful, healthy appearance brings joy to society. However, their construction in this role simultaneously positions them as servants to society, as they hold value only if they take on the mothering role and are aesthetically pleasing to others. This discourse does not allow women to choose not to have children and still retain value within society. The idea that menopause may be a natural way of supporting women by limiting the number of children they are able to

have is disallowed within this discourse. This discourse positions menopausal women as useless as they are no longer fertile. In addition, menopausal women are also no longer able to fulfil the mothering role as their children are old enough to leave home. This constructs a position of worthlessness for menopausal and postmenopausal women. The text may also operate to encourage men to consider women's value in accordance with these terms.

The discourse simultaneously positions all women as inevitably waiting for menopause. Each woman is seen as having a biological clock that ticks away up until her time until menopause, signalling the end of her '*youthful promise'* and the beginning of disease and deterioration. Much like Cinderella at twelve o'clock, the menopausal woman is destined to deteriorate. This discourse thus positions women as biological agents. The discourse of women as biological agents is discussed later in this chapter.

This discourse positions men, who do not have to go through this '*natural life progression*,' as unconfined to the discourse. Men do not have to be '*fearful*' as they are positioned outside the discourse and are therefore free of its confinements. It may be assumed that aging in men is constructed differently and that it is not so closely linked to positions of worthlessness and disease. In relation to the discourse of reproduction, men are able to reproduce until death and thus do not become 'useless' with age. Men are in a superior position of power within society, given their limitless reproductive status. Men hold more power within the discourse as they hold more flexible positions in terms of family and career planning.

3.5 Younger women are in a superior position of power relative to menopausal women, as they are still '*useful*' within the discourse. However, this power is conditional on their willingness to fulfil their role as mothering agents and '*serve society'*. Young women are thus placed in a double bind situation, where they can either comply with the discourse and fulfil their obligatory role of reproduction, or they can choose to reject this role and risk being defined as useless.

Menopausal women have less power within this discourse because they have lost the reproductive role and their value as youthful beauties. Discourses such as the

fertility discourse and the family discourse construct menopausal women as outsiders and subjugated subjects due to their increasing infertility and the loss of their care taking roles. Within western societies these women may be subjugated and have less right to speak within the discourse than younger women and men. This discourse also positions men as powerful because they do not experience menopause and therefore are not seen as aging as dramatically as women. This discourse thus constructs menopausal and post-menopausal women as old and therefore useless, worn out and deteriorated.

Menopause as Natural Progression

4.1 The fourth discourse identified in the texts relates to menopause as natural progression.

4.2 Some of the salient quotes relating to this discourse are presented below.

Doctors at the Demiral University Medical School in Turkey also found that sun exposure, physical activity and blood pressure all had an effect on the timing of menopause.

Daily Mail, article number 2, 23 August 2006.

Bio-identical hormone therapy is not new and has been available in SA for many years. It has been described by international specialists as a form of therapy that "respects the rhythm of nature".

Glenda Daniels and Marika Sboros, article number 3; 20 August 2006.

Of course, menopause is not the end of the world; nor is it a disease. It is merely a natural life progression … This stage in life is inevitable. "It is a natural part of aging" says Becker.

Jabulile Ngwenya, article number 8; 19 June 2007.

The Victorians thought it drove women mad, while the early Greeks believed it could be cured by applying leeches, but the menopause is a natural part of every women's life cycle. Even so, each woman's experience will be different.
Cherrill Hicks, article number 2; 25 February 2010.

Menopause is a natural transition in life, one that all women from all cultures experience.
Benita Perch, article number 5; 6 October 2010.

Is not inevitable or universal like the female menopause.
Phil Daoust, article number 6; 14 October 2010.

4.3. Similar to the menopause as disease discourse the discourse of menopause as natural progression constructs menopause as a universal phenomenon that is assumed to be common to all women and inevitable. *The Pocket Oxford Dictionary* defines nature as "thing's or person's innate or essential qualities or character" (Thompson, 1996, p. 592) and defines progression as: "forward or onward movement towards a destination" (Thompson, 1996, p. 715). This discourse actively constructs a reality in which women are innately predetermined to be menopausal during midlife. Thus, menopause is seen as an inevitable life stage for all women. The discourse also simultaneously excludes men as they do not experience this life stage. The discourse of menopause as natural progression is constructed though language and it is linked to wider discourses that confine women to a certain pre-defined life cycle. This discourse is also linked to the discourse of women as biological agents, which is discussed later in this chapter.

The words and phrases operating in the text that construct the menopause as a natural progression discourse include: '*rhythm of nature,' 'natural life progression,' 'natural part of every woman's life cycle'* and *'natural transition in life, one that all women from all cultures experience.'* Menopause is thus constructed as a natural life stage that is experienced cross-culturally. This discourse is also linked with the discourse of menopause as old age, which was discussed previously.

The discourse of menopause as disease is in direct opposition to the natural progression discourse, as this discourse constructs menopause as normal and expected, not as a disease and a manifestation reflecting abnormality, '*menopause is not the end of the world; nor is it a disease. It is merely a natural life progression*.' However, although menopause is seen as natural it is still confined by the wider dominant bio-medical discourse, as it is seen as a condition that should be under medical control and requires treatment, *'…described by international specialists as a form of therapy that "respects the rhythm of nature".'* Although menopause may require specialist attention, this discourse also states that menopause may be managed by exposure to natural resources such as '*sun exposure, physical activity*.' This actively links to the discourse of responsibility, discussed later in the chapter, as it constructs the timing of menopause as dependent upon a responsible lifestyle and women making responsible health choices.

4.4. The discourse of menopause as natural progression constructs various subject positions for readers of the texts. Although the discourse constructs menopause as a normal life stage, menopausal subjects are still constructed as abnormal within the wider, dominant bio-medical scientific discourse. The scientific discourse positions all women as submissive, passive and compliant patients. Within this discourse women are positioned as subservient due to the inevitability of menopause. If women do not manifest symptoms as defined by and within the menopause as disease discourse, they are constructed as failing to go through a natural stage in life and are viewed as 'abnormal'. In this way women who do not manifest menopausal symptoms are positioned as not worthy of medical attention or research and are side lined by silence. However, when women do manifest symptoms of menopause they are required to seek medical attention, assessment and treatment in order to survive these symptoms. Thus, this discourse positions women as abnormal subjects who are dependent on medical experts to guide them through midlife.

This discourse also constructs positions of responsibility for women. Women are expected to be compliant subjects who must make use of natural resources, such as opting for a healthy lifestyle including sun light and physical activity, as well as

visiting their doctors for hormone therapy. The discourse of responsibility is discussed in more detail later in this chapter.

4.5. Women at midlife hold fewer rights to speak against this discourse than men and younger women. Menopausal women are also confined within a wider bio-medical discourse. They are constructed as patients and are therefore seen as inferior relative to medical experts who can conduct research and testing on them. Unlike men, women are also positioned as innately pre-determined to progress through menopause, and thus are simultaneously confined by the menopause as old age and menopause as disease discourses. These discourses act to subjugate women and define their reality and experience at midlife. Additionally, these discourses place women within a discourse of responsibility, which expects women to be accountable for their health as they invariably progress towards midlife and menopause.

Confusion

5.1. The discourse menopause as confusion constructs the phenomenon of menopause according to a certain definition of reality constructed within and by the discourse.
5.2. Some of the salient quotes reflecting this construction of confusion as an object for analysis are provided below.

But the fact is that the mechanisms that cause some women to suffer from severe (frequent and intense) hot flushes have remained a mystery.
Marika Sboros, article number 7; 20 May 2007.

Some women lost faith in conventional medicine and turned to so-called natural remedies for menopausal symptoms. But the safety and effectiveness of many of these alternative therapies have not been closely studied. You should assume that they carry the same risks as FDA-approved hormone therapy.… After menopause, women are much more vulnerable to osteoporosis, a thinning of bones that leaves them susceptible to fracture.
Pat Wingert and Barbara Kantrowitz, article number 1; 22 January 2007.

What's a woman of a certain age to do? Now New Zealand research suggests calcium tablets taken by millions of postmenopausal women the world over to reduce their risk of osteoporosis may be contributing to an increase in heart attack and other cardiovascular problems. … The study may not be large enough to justify taking women off calcium supplements just yet. "Preventative medicine is not something that can be standardized per person," she says "it needs to be individualized".
Amanda Gardner, article number 1; 23 January 2008.

Just how eating fish could delay menopause is not known. One theory is that diets with higher levels of protein and B complex foods, which include fish, may have an effect on the pituitary gland, and the regulation of ovaries and the female cycle.
Daily Mail, article number 2; 23 August 2006.

It is difficult enough growing older and having to cope with wildly fluctuating hormones, without all the confusion and controversy surrounding treatment for menopause. … The reality is there are as many views on HRT in and out of medical circles as there are hormones coursing through women's bodies. Women can be forgiven for still being confused about what therapy to take, when to take it or whether to take any of it at all. … Bhana says HRT is not a one-size-fits-all approach. "No two women are the same, and neither are their hormonal profiles". … Prof Derrick Raal, head of the University of the Witwatersrand's endocrinology department, says when it comes to HRT the "answers are not straightforward".'
Glenda Daniels and Marika Sboros, article number 3; 30 August 2006.

HRT is the most effective treatment for menopausal symptoms and improving a woman's quality of life, yet misperceptions about the risks and benefits have caused anxiety and confusion … The South African Menopause Society (SAMS) recommends that each woman's case should be treated individually and that women should discuss HRT use with their doctors.
Jenny Hope, article number 4; 1 July 2008.

That's more than 500 million women and many of them, like our friend, have only a limited understanding of what's happening to their bodies. Although this is the best-educated generation of women in human history, menopause remains a mystery to most of us. We tend to know very little about how out changing hormone levels affect our brains, our bones, our hearts and our vulnerability to many diseases – and what we should be doing about it. As science provides new insights into women's health, menopause is coming out of the shadows…… There's still a lot researchers don't know about hormones, including potential benefits and risks for each woman.
Pat Wingert and Barbara Kantrowitz, article number 1; 22 January 2007.

"Since menopausal symptoms are not life-threatening and do not cause serious illness, a woman has time to experiment with different herbs or combinations to see what works best," Sahelian says.
Amy Sutton, article number 1; 2 August 2006.

Some may cruise through it with few problems; others have symptoms so dire as to make life intolerable. Some may feel liberated by stopping having periods; others may be sad that they can no longer get pregnant.
Cherrill Hicks, article number 2; 25 February 2010.

5.3. The menopause as confusion discourse creates confusion as an object. It constructs confusion in the text and locates it within a wider socio-cultural discourse. Language constructs and is constructed by discourse, the words and phrases used within the text to draw on the discourse and construct confusion include: *'not known,' 'confusion and controversy,' 'are as many views on HRT in and out of medical circles as there are hormones coursing through women's bodies,' 'answers are not straight forward,' 'HRT is the most effective treatment for menopausal symptoms… yet misperceptions about risks and benefits have caused anxiety and confusion,' 'researchers still don't know about hormones'* and *'mechanisms that cause… hot flushes have remained a mystery.'* The content of these quotes suggests that the menopause as confusion discourse may have developed as a result of three conflicting but complementary discourses. These discourses

are the menopause as disease discourse, which describes menopause as an abnormal disease that requires medical treatment in order to be cured, the menopause as natural progression discourse, which constructs menopause as normal and a healthy life stage while still requiring responsible decision making with doctors and a choice of treatment, and the treatment of menopause as a dangerous gamble discourse, which constructs the choice of treatment as a risky but unavoidable gamble. Menopause is thus constructed as confusing, as it does '*not cause serious illness*,' however some symptoms are '*so dire as to make life intolerable*' and cause some '*women to suffer severe hot flushes*.'

Although women are encouraged to turn to medical experts for advice, the discourse also states that '*answers are not straight forward*' and '*there's still a lot researchers don't know about hormones*.' HRT is recommended as the best treatment for menopausal symptoms and yet women are warned that it creates an increased risk of disease. Menopause makes women '*much more vulnerable to osteoporosis'* and yet taking calcium to prevent bone loss causes an '*increase in heart attack and other cardiovascular problems.*' This uncertainty based on the existence of various strong conflicting messages, constructs menopause as a mystery and creates confusion as an object.

The Pocket Oxford Dictionary defines confusion as "throw into disorder" (Thompson, 1996, p. 175). The discourse of menopause as confusion is the result of the existence of conflicting discourses surrounding menopause. The menopause as dangerous gamble discourse sets up a reality whereby treatment of menopause is seen as risky and potentially dangerous. The menopause as disease discourse and the menopause as natural progression discourse are in conflict with each other, although both discourses position women as confined within the wider dominant bio-medical discourse. Women are thus forced to choose between these two discourses. The confusion discourse results as women are 'thrown into disorder' as they try to pass through midlife unscathed. Confusion is constructed as an inevitable obstacle of the reality defined by the discourses that women face during their 50s and 60s.

5.4. The discourse of confusion constructs various subject positions for menopausal women, medical doctors and researchers. Within this discourse menopausal women as

constructed as confused subjects. They are viewed as both difficult to predict and treat: '*no two women are the same, and neither are their hormonal profiles*'. According to this discourse even professors, medical experts and researches battle to understand how to help women during menopause, '*there are as many views on HRT… as there are hormones coursing through women's bodies*.' The discourse thus excuses medical professionals for struggling to help women during menopause. However, despite medical professionals' confusion, women are still encouraged to visit their doctors and heed the advice they receive, '*women should discuss HRT use with their doctors*.' This discourse is strongly linked to the treatment of menopause as a dangerous gamble discourse. The discourse is also linked to the bio-medical discourse, which constructs scientific knowledge as superior and in a position to provide answers to confused women who are unable to know anything about their own bodies, '*science provides new insights into women's health, menopause is coming out of the shadows.*'

Women are placed in a patient position and are assumed to be compliant and dependent on a doctor's advice. Women '*can be forgiven for still being confused*,' as even medical professionals are confused. The discourse thus suggests that the medical profession is responsible for forgiving women for being unable to understand their own health. According to the extract, '*although this is the best educated generation of women in human history, menopause remains a mystery to most of us,*' it is impossible for most women to understand menopause, regardless of their intelligence or education. Within this discourse women are placed in a position of assumed nativity and ignorance about their bodies, while simultaneously being constructed as complex subjects that are incomprehensible to researchers. This discourse thus allows researchers and medical experts to maintain their superior position as having more knowledge than their patients, while simultaneously exempting doctors from responsibility for decisions. It is assumed that unless a woman knows which treatment approach, as defined by the medical profession, will be best for her '*hormone profile'* she will be confused and have a *'limited understanding of what's happening to their* (her) *bodies* (body)*.'*

5.5. This discourse addresses midlife women; it demands their attention due to the inevitable biological progression it forces women to acknowledge as females. The

discourse also places medical professionals and researchers in a position of power, while menopausal women are constructed as confused and lacking knowledge. Menopausal women have fewer rights to speak up against the discourse than men and younger women and are encouraged to seek advice from doctors regarding how best to live their lives leading up to menopause.

Responsibility

6.1 A discourse of responsibility operates within the texts.

6.2 Some of the salient quotes that reflect this construction of responsibility are provided below.

Women who eat fish regularly are 40% less likely to have an early menopause than those who do not, according to new research.

Daily Mail, article number 2; 23 August 2006.

Before women decide on any treatment, though, accurate hormonal assessment is critical say specialists.

Glenda Daniels and Marika Sboros, article number 3; 30 August 2006.

The first tip for avoiding them is to keep cool. Drink cold beverages and avoid hot ones, use fans and air conditioners and dress in layers….. Some women find that caffeine, alcohol, spicy food and stressful situations trigger hot flushes. Make a note of things that seem to trigger your flushes in a daily diary. … if, after trying the self-help techniques, you still find yourself sweaty and sleepless, consult your clinician about trying one of the prescription medications.

Harvard College, article number 4; 7 November 2006.

When boomers were toddlers, menopause was seen as the end of a woman's vital years. But scientists now understand that this is a critical juncture, and what you do during menopause can shape your physical and emotional lives for years to come. … Women who make smart choices in menopause are more likely to live longer, healthier lives.

Becoming more physically active, for example, can strengthen your bones, protect you from heart disease, boost your mood and reduce hot flashes, and may even lower your risk of dementia. … Learning more about menopause will help you weigh some health choices you'll have to make … doctors say women should make every effort to avoid medication by making lifestyle changes that have been shown to help – stepping up physical activity, reducing stress, losing weight, stopping smoking. If you choose hormones, the current recommendation is to take the lowest effective dose for the shortest possible time.
Pat Wingert and Barbara Kantrowitz, article number 1; 22 January 2007.

What questions do you and your doctor need to answer to make an informed decision about hormone therapy? And if you choose hormone therapy, how can you minimize the risks? Here are the key elements of that conversation.
Joann Manson, M.D. DR.PH., and Shari Bassuk, SC.D., article number 3; 22 January 2007.

Dr Patricia Okeyo, a specialist, notes that, as more and more women are educating themselves through the internet, reading magazines and having conversations with their friends, "the modern woman is taking charge of her sex life" …Okeyo says menopausal women should for regular medical check-ups –pap smears, mammograms and so on; smoke less or stop altogether; reduce alcohol intake; exercise; eat a healthy diet; and take calcium supplements to build up the bones to stay healthy.
Jabulile Ngwenya, article number 8; 19 June 2007.

Jaff advises women who are peri- and postmenopausal to have a daily minimum of omega-3 fatty acids in their diet.
Sue Grant Marshall, article number 3; 19 Mach 2008.

There are still many unanswered questions but, Kramer says: "we can argue an active lifestyle with moderate amounts of aerobic activity will likely improve cognitive and brain function, and reverse the neural decay frequently observed in older adults."

Amanda Gardner, article number 2; 10 June 2009

Women should avoid delaying starting a family until their 30s…. "we need more babies to sustain the economy. As it is, we are not going to have enough people to support the ageing population"… "There are many more limitations to women's fertility than to a man's" … encouraging earlier childbirth should be our prime concern he adds. "This really is an issue for the whole of society..".
Viv Groskop, article number 4; 19 August 2010.

6.3. The menopause as a responsibility discourse constructs responsibility as an object. The text draws on wider socio-cultural discourses by being used by and using certain repetitive words and phrases. Societal responsibility is constructed as behavioural choices women are obligated to make in order to look after their health and support the community by fulfilling their roles as good menopausal patients. Women are expected to follow medical advice, make informed decisions, avoid the risks associated with medications and ensure they bear children. The discourse also holds women responsible and accountable for their ill health if they do not educate themselves sufficiently concerning their roles.

This may be seen in the following quotes: *'menopause… critical juncture,' 'what you do… shape your physical and emotional lives for years to come,' 'make smart choices,' 'become more physically active … strengthened bones… reduce hot flashes,' 'learning more about menopause… weigh some health choices you'll have to make,' 'make every effort to avoid medication by making lifestyle changes.'* In addition, when making choices women should follow the '*current recommendations*,' but first they must go through '*accurate hormonal assessment,' 'educate themselves'* and ask their doctors smart questions in order to make an '*informed decision about hormone therapy*.' Menopausal women are also expected to '*go for regular medical check-ups…*' and make healthy lifestyle choices in accordance with the tips provided by medical professionals. For menopausal women responsibility is thus constructed as behaviour that follows the stipulations and recommendations governed by medical experts.

This discourse also impacts pre-menopausal women as it links to the discourses of reproduction and menopause as deterioration. These pre-menopausal women are constructed as useful participants in and therefore the discourse positions them as having an obligation to fulfil their societal responsibility by having children before the age of 30 in order to '*sustain the economy*' and serve '*the whole of society'*. The discourse of responsibility connects to wider socio-cultural gender discourses that construct women as caretaking subjects who are responsible for the welfare of society. Women are thus encouraged to act for the good of society and may feel guilty if they fail to meet these obligations. Women are expected to fulfil their role by subordinating their own needs to the needs of society at large. Women are expected to sacrifice their careers and dreams to take care of their families. Women must be responsible for their own health and fertility in order to look after their husband, parents and children. Responsibility involves informed decision making, healthy lifestyle choices and starting a family before turning thirty.

6.4. The discourse of responsibility constructs various subject positions. In order to comply with rules defined by the discourse a woman is positioned in the framework of what a responsible subject should do to have value within her community. Responsible women follow the guidelines of the discourse, such as by having children. They are therefore positioned in caretaking roles, which are seen as less important than the men's roles, which involve being the breadwinner. In addition, women are also constructed as dependent on medical doctors for advice. In the role of patient a woman's responsibility is to be compliant and submissive. However, women are also expected to be knowledgeable about menopause. This discourse does not construct a superior position of power for women relative to men and medical experts. Women who do not follow the guidelines defined by the discourse are constructed as irresponsible subjects. Thus, these women are still governed by the discourse but hold a less powerful position within society due to their limited and unfulfilled role. They are assumed to be unable or reluctant to listen, do the right thing and serve their community. The discourse creates subject positions that allow medical doctors to take the role of advisors and to be judges of woman's level of responsibility. Medical professionals are in a superior position of

power relative to women. Fertility and menopausal symptoms are constructed as issues to be controlled by medical professionals, and thus women are not seen as having control over their own bodies and lifestyles.

6.5. Within this discourse medical practitioners are positioned as the judges of women's levels of responsibility. If women do develop symptoms or disease it is assumed that they have not taken the necessary steps in terms of education or lifestyle changes. Doctors are thus placed in the superior, evaluative position while women must take the role of compliant, dependent patients. Doctors are thus able to set the guidelines for how women should live their lives. Although this discourse requires women to be responsible for their own decisions, the discourse also undermines women's power by suggesting that their decisions need to be approved by medical doctors. The discourse thus simultaneously positions women as accountable for their choices and dependent on doctors' approval for their decisions. It is clear that doctors are not to be blamed if their patients become ill. Women are dependent on medical professionals for help yet remain accountable for any errors in judgment concerning their treatment.

Biological Beings.

7.1 The text draws on the wider socio-cultural discourse of women as biological beings.
7.2 Some of the salient quotes related to this discourse are presented below.

Before women decide on treatment, though, accurate hormonal assessment is critical say specialists. … Powerful drugs are based on this concept, and it increases the risk of serious side effects. It also allows drug companies to hold a patent for 16 years and reap the profits (not necessarily a bad thing as it lets the companies to do more research). … Accurate assessment of hormone levels is essential, as all women will react differently to hormonal therapy. A new saliva test will be available in SA later this year, which he says will be more accurate and convenient than conventional blood tests. … They advise women to do the following: do not delay childbirth into their 30s, when reproductively they are considered "geriatric".
Glenda Daniels and Marika Sboros, article number 3; 30 August 2006.

As science provides new insights into women's health, menopause is coming out of the shadows – a result, we believe, of the boomer culture of openness and the nation's growing awareness of the importance of good health at every life stage. Ignoring menopause and hoping it goes away won't make the transition any easier. In fact, research indicates that women who know what to expect navigate their way through midlife the most successfully. ... The hypothalamus gets input from all parts of your body as it goes about the job of keeping you running efficiently… it may be during a hot flash, fluctuating oestrogen levels and hormones form the pituitary gland confuse the hypothalamus. ... More recent research studies suggest another mechanism. Dr. Robert R. Freedman and his colleagues at Wayne State University in Detroit have used functional magnetic resonance imaging (fMRI) to observe women's brains during a hot flash. ... Most doctors urge women to begin getting yearly mammograms in their 40s.
Pat Wingert and Barbara Kantrowitz, article number 1; 22 January 2007.

If you are not getting enough relief from your symptoms, work with your doctor to gradually adjust the dose upward until you do.
Joann Manson, M.D. DR.PH., and Shari Bassuk, SC.D., article number 3; 22 January 2007.

Each woman is born with about 1 million eggs in her ovaries, which are used to produce babies and hormones. … Menopausal women should go for regular medical check-ups.
Jabulile Ngwenya, article number 8; 19 June 2007.

South African author and consultant, Nicole Jaff… wrote a book, Menopause The Complete Guide… it's an easy to read and highly professional, with 800 medical references that leave the reader in no doubt about its authenticity.
Sue Grant Marshall, article number 3; 19 March 2008.

Using hormone replacement therapy is safe for most women going through menopause, according to an international panel of experts.

Jenny Hope, article number 4; 1 July 2008.

Tracking a woman's fertility… the speed at which female fertility declines has been highlighted by the first study to track a woman's supply of eggs from conception to menopause. The average 30-year old will have just 12 percent or barely an eighth of her eggs left, the research shows. ….. Unlocking the workings of female biological clocks could help doctors better advise young cancer patients about how to persevere their fertility.
Fiona Macrae, article number 1; 6 February 2010.

Doctors in Iran have developed what they believe is accurate and simple blood tests to establish when a woman will hit the menopause… the results from our study could enable us to make a more realistic assessment of women's reproductive status many years before they reach menopause … we believe that our estimates of ages at menopause based on AMH levels are of sufficient validity to guide medical practitioners in their day-to-day practice so that they can help women with their family planning.
Sarah Boseley, article number 3; 8 July 2010.

Dr Gedis Grudzinskas is one of the most respected names in fertility. He is angry. Fed up with potential patients being given false hope by the baby-making-industry, he is distinctly unimpressed by the recent findings that it may soon be possible to predict to within four months when a woman is likely to go into menopause – and, by extension, whether she can afford to put off having children. … He fears it may be linked to a misplaced trust in medical advances. … "Women should be given adequate time to have the child without losing opportunities for career development. At the moment, we are seeing women who tend to do better in the workplace behaving like men (postponing childbirth or not bothering at all). Is that what we want?" … "Encouraging earlier childbirth should be our prime concern," he adds. "This really is an issue for the whole of society".
Viv Groskop, article number 4; 19 August 2010.

7.3. The discourse of women as biological beings is closely connected to the menopause as disease discourse. Both discourses are constructed and operate within wider bio-medical and scientific discourses that hold certain assumptions. These assumptions were discussed in the research review chapter and include reductionism and determinism. Reductionism assumes that subjects may be explained according to sets of objective, universal criteria that are independent of social contexts (Powers, 2001). Determinism reflects the linear view used by scientific models to attempt to control and predict disease. Subjects' experiences are defined and assessed according to medical terminology, which is often not understood by the subjects. The medical discourse is therefore assumed to be superior to the subjects' own knowledge. Medical terminology is specified and used to construct the criteria according to which subjects are diagnosed and subsequently treated. The reality defined by the dominant scientific discourse frames the reality of its sub-discourses, such as the discourses that produce menopause as a disease and position women as biological beings under medical observation. The biological beings discourse encourages both medical experts and women to objectify the female body and to scrutinise it based on its functionality and efficiency.

The biological beings discourse is related to the assumptions discussed above. The biological being discourse is constructed through the use of language, including the quotes provided above. Within the biological being discourse the female body is positioned as an object which can be diagnosed within the menopause as a disease discourse in accordance with various tests and symptoms. Thus, as the female object's biological clock ticks away the female body runs less efficiently and requires medical attention and an expert's supervision. When menopause as disease manifests the female object is required to undergo medical evaluation in order to assess and treat the pathology behind its dysfunction, as well as to allow for further research aimed at predicting and controlling symptoms. Female objects who have not yet manifested pathology are expected to subject themselves to medical scrutiny in order to determine when their pathology will manifest. Prior to menopause the female object's status is assessed as fertile and therefore useful. The object functions to start a family, bear children and serve society.

Words and phrases that are salient to the identification of this discourse include: '*accurate and simple blood tests to establish when a woman will hit the menopause,' 'predict within four months when a woman is likely to go into menopause,' 'a new saliva test,' 'accurate assessment of hormone levels is essential,' 'lets companies do more research,' 'a panel of experts,' '800 medical references,' 'no doubt about it's (menopause book's advice) authenticity,'* and *'work with your doctor to gradually adjust your dose.'* Medical experts suggest that women should ensure that they are prepared for menopause, as '*research indicates that women who know what to expect navigate their way through midlife the most successfully.*' Thus, in order to be successful in menopause women must comply and be tested. The texts also quote experts, thus confirming their status as objective and scientific and thus superior to the average menopausal woman who is likely to be reading the text.

The biological beings discourse constructs the pre-menopausal female as functioning within society as a reproductive object, whose functionality may be assessed according to her fertility level. Women are also expected to accept advice from medical doctors regarding how to best serve society at large through their reproductive capabilities. In order to fulfil her pre-determined role the female object must bear children and fulfil her maternal responsibilities. These discourses of biological beings and reproduction, are constructed through words and phrases such as: '*each woman is born with about 1 million eggs in her ovaries, which are used to produce babies,' women must not 'delay childbirth into their 30s when … considered "geriatric," 'tracking a woman's fertility,' 'unlocking the workings of female biological clocks could help doctors better advice… how to preserve their fertility,' 'assessment of women's reproductive status… to guide medical practitioners in their day-today practice … help women with their family planning,'* and *'we are seeing women who tend to do better in the workplace behaving like men (postponing childbirth or not bothering at all)… as issue for the whole of society.'*

The biological being is constructed as rightfully under medical control, which is able to predict menopause and guide family planning to ensure the survival of the species.

7.4. This discourse encourages both medical experts and women to objectify the female body. The discourse of biological beings positions menopausal women reading the text as biological subjects that are expected to submit to the power of scientific models. Within this discourse women are required to be subjects for assessment, diagnosis, research and treatment. Women are thus primarily viewed as biological beings, and are seen as driven by erratic hormones that lead to dysfunctional behaviour. The discourse negates the role of emotional, cognitive and interpersonal factors in determining women's experiences. The text speaks of a female body, not of embodied women. It is assumed that women confined within the reality of the discourse pass through pre-defined life cycles, and that these cycles occur in the same manner regardless of cultural contexts or life circumstances. Thus, any difficulties menopausal women experience must be treated with hormone therapy.

Within this discourse pre-menopausal women are forced to either choose to comply with the discourse and go for testing in order to predict menopause, plan families, have children and serve society or to dismiss these expectations and be non-complicit. Thus the only two options this discourse makes available to women are both extreme and life changing. Women who choose to postpone having a family are constructed as '*behaving like men*.' The discourse therefore also constructs a subject position for men. According to this discourse men should expect women to leave their careers to bear children, while they (the men) function as the bread winners within the families. Men are not allowed to postpone their careers within the discourse. This discourse perpetuates and supports wider socio-cultural gender discourses and gender stereotypes. The biological beings discourse operates as a sub-discourse within wider socio-cultural gender discourses and functions to limit choices for both men and women.

7.5. Women who take up subject positions within this discourse are expected to fulfil the mothering role and postpone their careers. In addition, they are expected to submit their bodies for medical testing and research as diseased subjects prior to and during menopause. The text addresses women's bodies, not women. Women are expected to take their bodies to medical experts. Within the discourse women as subjects may speak

only if they communicate through medical terms and through laboratory test results. They are expected to take on the patient role and follow the instructions provided by doctors.

Menopause as Loss (linked to the wider discourse of midlife as loss)

8.1 The researcher identified two closely related discourses, labelled menopause as loss and midlife as loss. These two discourses are discussed together in the section below.

8.2 Some of the salient quotes reflecting the construction of these discourses are presented below.

Women often complain of menopausal symptoms that include low libido, and doctors are quick to say these require treatment, Jaff says. But it could just be that the woman's partner is not being romantic enough.

Glenda Daniels and Marika Sboros, article number 3; 30 August 2006.

The play MENOPAUSE THE MUSICAL (Pieter Toerien's Montecasino theatre) is about loss. It defines a period of awkward and painful transition, when a women is neither old nor young, and dropping levels of hormones cause damage. She feels as though she is drowning and somehow diminished and constantly regrets the slow disappearance of what she perceives to be her prime.

Mary Jordan, article number 5; 14 November 2006.

Add another time to the loss of ailments linked with midlife hormone replacement therapy (HRT): hearing loss.

Amanda Gardner, article number 6; 6 December 2006.

Hot flashes, night sweats an insomnia have been known to leave more than a few women moody and depressed. Side effects of medications or an undiagnosed thyroid problem could be the culprits. Or maybe the stresses that many of us are dealing with at midlife are just too much – work, coping with kids or teenagers, caring for elderly parents.

Pat Wingert and Barbara Kantrowitz, article number 1; 22 January 2007.

Hot flushes irritated her endlessly. But she refuses to take her jacket off, as that will be a sign of her losing control and even admitting that she has given in to the big M. … one anticipated side-effect of "the change of life" is a total loss of libido.
Jabulile Ngwenya, article number 8; 19 June 2007.

A vanishing waistline, hot flushes and mood swings – most women associate the menopause and its symptoms with dread and confusion.
Daily Mail, article number 1; 13 April 2009.

Memory and learning take a hit during menopause.
Amanda Gardner, article number 2; 10 June 2009.

Menopausal symptoms can be demoralizing. Hot flushes, night sweats, a dry vagina… and urinary problems are directly caused by the decline in oestrogen levels. But many women report myriad other symptoms, including weight gain, loss of libido, low energy, mood swings and forgetfulness. Researchers aren't certain if these are also caused by hormonal changes, or are linked to more general health and lifestyle factors and the emotional upheavals that are common at this time of life – from empty-nest syndrome to caring for elderly parents.
Cherrill Hicks, article number 2; 25 February 2010.

8.3. The discourse of menopause as loss is located within the text through the repetition of certain words and phrases. Language serves to construct loss as an object and bring it into being within the discourse. The words and phrases used within the text to construct menopause as loss include: '*loss,' 'awkward and painful transition', 'dropping levels of hormones cause damage', 'diminished', 'slow disappearance of what she perceives to be her prime', 'loss of ailments', 'hearing loss', 'hormone replacement', 'sign of her losing control', 'total loss of libido', 'vanishing waistline', 'dread', 'memory and learning take a hit', 'demoralizing'* and *'decline in oestrogen levels'*. This discourse abides by the assumptions of wider dominant scientific, bio-medical discourses that operate to support

the discourse of menopause as disease. The menopause as loss discourse therefore assumes a linear view of reality. In this discourse menopause is constructed as having an underlying cause, declining hormones, which manifest in the loss of certain body functions, health and control.

However, the menopause as loss discourse is resisted by an alternative discourse, the midlife as loss discourse, which is not confined to the limitations of the menopause as loss discourse. The midlife as loss discourse does not follow scientific views of 'truth' in relation to viewing disease as having a specific biological underlying cause. Instead, this discourse considers contextual factors that may impact on the experience of midlife. Within the reality defined by the midlife as loss discourse it is acknowledged that hormones during menopause may cause women to suffer symptoms however the discourse also states that these symptoms could also be the result of other factors. Thus, the discourse contains a level of uncertainty regarding the origin of various symptoms. The discourse brings midlife as loss into being and constructs it as an object for analysis. The words and phrases used within the text to portray the midlife as loss discourse include, *'but it could just be that the woman's partner is not being romantic enough,' 'side effects of medications or an undiagnosed thyroid problem could be culprits', 'stresses that many of us are dealing with at midlife are just too much', 'work coping with kids or teenagers', 'caring for elderly parents, researchers aren't certain'* and *'emotional upheavals that are common at this time of life – from empty-nest syndrome to caring for elderly parents.'* Although the menopause as loss and midlife as loss discourses follow different, conflicting assumptions of reality they both construct loss as an inevitable aspect of women's lives. These discourses are closely linked to wider socio-cultural gender discourses. Within these wider gender discourses certain assumptions are constructed by and within society concerning men and women and masculine and feminine roles. These roles govern the type of subject behaviour that is considered to be acceptable and useful within society. Chapter two illustrated how gender stereotypes and roles are reinforced throughout childhood to such an extent that adult men and women have internalised models of correct gender behaviour. In this way, women are more likely than men to feel that they should stay at home and look after their children. The roles of

mother, wife and caretaker of the family hold value and power within society and the loss of these roles can lead to a woman being less valued by society.

8.4 The discourse operates to construct subject positions for various readers. It positions women in their 50 and 60s as menopausal and middle-aged. It sets up a position of deprivation as these subjects are positioned in a state of or in anticipation of loss. It also creates a subject position of caretaker for women, as they are expected to care for children and grandparents. This subject position is linked to the experience of emotional upheavals.

Within this discourse men are positioned as being responsible for women's libido. The texts suggest that if men are not romantic then they should expect their female partner's libido to drop. Thus, the discourse places men in a position of responsibility in relation to their partner's health and well-being.

8.5 The two discourses described in this section position middle aged women as symptomatic in relation to menopause. In addition, these discourses see middle aged women as plagued by various difficulties, such as the need to care for others and the loss of youth. Women are expected to respond to emotional upheavals, such as the empty-nest syndrome, by manifesting menopausal symptoms.

Menopause as Rejuvenation

9.1. The final discourse identified in the texts concerned menopause as rejuvenation.
9.2. Some of the salient quotes relating to this discourse are provided below.

Menopause is perceived as a time for a woman to come into her own.
Mary Jordan, article number 5; 14 November 2006.

Often she sees couples storming into her office, hating each other, blaming their difficulties on menopause when communication could actually be the problem. Real, honest communication between both partners is key to a more satisfying, fulfilling relationship. … McIntosh, who has experienced menopause, says "it is not the end but

the beginning of a whole new relationship, not only with yourself, but also with your partner"…. McIntosh gets a sparkle in her eye as she declares: "it is very liberating!"
Jabulile Ngwenya, article number 8; 19 June 2007.

But scientists now understand that what you do during menopause can shape your physical and emotional lives for years to come. … If you are like most women, you've probably spent much of your life up to this point focusing on the people who need you: your spouse or partner, your children, your aging parents, your friends, your co-workers. Meanwhile, you have a list of things you want to accomplish for yourself, like learning another language or starting a new career. Whatever your goals, chances are you've put them off until tomorrow. What have we learned from reporting about midlife? Tomorrow is here.
Pat Wingert and Barbara Kantrowitz, article number 1; 22 January 2007.

9.3. The discourse of menopause as rejuvenation is constructed through language through the repetition of certain words and phrases. Language constructs menopause as rejuvenation into an object and brings it into being. The words and phrases used within the text to develop the discourse and construct menopause as rejuvenation include: *'time for a woman to come into her own,' 'not the end but the beginning of a whole new relationship, not only with yourself, but also with your partner,' 'it is very liberating'* and *'Whatever your goals, chances are you've put them off until tomorrow. What have we learned from reporting about midlife? Tomorrow is here.'* These phrases actively construct menopause as liberation from various roles and obligations. In this discourse, menopause is seen as the beginning of a new stage in a woman's life. This discourse, similar to the menopause as loss discourse, is based on the wider socio-cultural gender discourses discussed above. *The Pocket Oxford Dictionary* defines rejuvenation as "make (as if) young again" (Thompson, 1996, p. 763). Menopause is a time for women to re-experience the freedom and energy of their youth, to regain their independence and to shake off old stresses.

This discourse actively resists the menopause as disease and menopause as aging discourses by constructing menopause as a time of enjoyment and empowerment. In this

discourse women are not viewed as being subjected to and dependent on medical professionals. In contrast to the menopause as old age discourse, which anticipates deterioration for menopausal women, this discourse opens up possibilities for new growth and transformation.

9.4. The discourse constructs different subject positions for menopausal and pre-menopausal women. Within the reality defined by the discourse, pre-menopausal women are positioned as care-taking subjects. However, menopausal women are liberated from this subject position. The discourse therefore assumes that all pre-menopausal women are married, have children and want to be care-takers. In this way it supports the midlife as loss discourse as it views midlife as a time of letting go of the care-taking role. However, although it does see midlife as a time of change, in contrast to the menopause as loss and midlife as loss discourses within this discourse the changes are framed positively.

9.5. Within this discourse pre-menopausal women are positioned as '*focusing on the people*' such as their '*partner, your children, your aging parents, your friends, your co-workers.*' In order to fulfil this subject position these women are expected to delay the '*list of things'* that they '*want to accomplish,'* such as *'starting a new career'*. In contrast, menopausal women are positioned as liberated subjects who may stop their care-taking role and begin to take time '*to come into her own'* and accomplish personal goals. The discourse encourages women to speak for themselves and focus on their own desires. However, this discourse does not allow menopausal women to need to mourn the loss of care-taking and child-bearing roles; instead it assumes that women will welcome the loss of these roles.

In this chapter the process followed prior to the analysis of the texts was discussed. The analysis of the newspaper texts was discussed in relation to the identification of ten discourses. The chapter then discussed the eight main dominant discourses and two supplementary discourses in detail. The dominant discourses identified were menopause as a disease, treatment of menopause as dangerous gamble, menopause as old age, menopause as natural progression, menopause as loss, menopause

as responsibility, menopause as confusion and female object as biological being. The supplementary discourses that were identified were menopause as rejuvenation and midlife as loss. In the following chapter the similarities and differences between the discourses are discussed and the changes in menopause discourses over time and the possible influence of ideology and institutions are highlighted. The reflexive stand point used by the researcher is discussed at the end of the chapter.

Chapter Six: Discussion and Reflexivity

In this chapter the interrelationships between the discourses identified in the previous chapter are discussed. The similarities and differences between the discourses are explored and possible pattern changes over time are noted. The chapter ends with a discussion of the researcher's reflexive stand during the research process.

Process Thus Far

The researcher followed the approach to 'ways of reading' texts outlined in chapter four. The 37 articles selected for analysis were read and re-read and only appropriate articles were included in the study. Sections of the articles relating to menopause, midlife and women were highlighted and systematically coded to make analysis more manageable. As a result of this process 10 discourses operating within the media texts were identified. The discourses were coded and these codes were linked to article number and year of publication, in order to facilitate comparisons between the discourses. This coding system is outlined in appendix B.

In chapter five an adapted version of Parker's method of discourse analysis was used to analyse the texts. The analysis focused on 8 dominant discourses identified during the coding process: menopause as disease; treatment of menopause as dangerous gamble; menopause as old age; menopause as natural progression; menopause as responsibility; menopause as confusion; female as biological being and menopause as loss. In addition, two other supplementary discourses, midlife as loss and menopause as rejuvenation, were discussed. These discourses were seen as supplementary because they hold less power within the scientific discourse dominated context of menopause. The supplementary discourses were less well represented in the media than the other discourses and did not seem to have as many 'rights to speak' as the other discourses.

This chapter contains the final four steps of the data analysis:

1. A review of the similarities and differences between the identified discourses. This includes an exploration of the ways in which contradictions between different discourses are smoothed over and the interrelationships between some of the different discourses.

2. The discourses are located in history and different menopausal discourses are constructed over time. The interrelationships between different discourses over time in terms of dominance and resistance are explored.
3. The various possible institutional and ideological influences on these constructions are questioned. The interconnections between myth, institutions and power are explored. The influence of these power relations on dominant and resistant discourses was explored.
4. The reflexivity process is discussed. In this section the researcher explores her own readings of the texts and attempts to understand the ways in which her interpretations may have been influenced by her particular cultural and historical background. Ethical implications are also addressed as the researcher discusses the subjectivity involved in the process of analysis and discussion of discourses.

Step One

The various discourses identified are similar in many ways. Many of the identified discourses contain similar definitions of reality and conform to the wider dominant socio-cultural bio-medical scientific and gender discourses. Some of the identified discourses actively resist other discourses and follow different assumptions. However, the resistant alternative discourses are still confined within the parameters of the dominant discourses and thus set themselves against definitions and standards constructed by the dominant discourses. Thus, many of the discourses identified in this study are based on the dominant discourses and thus follow the assumptions of the scientific paradigm. These discourses occupy a higher position of power/knowledge relative to other sub-discourses. Discourses that construct menopause and the treatment of menopause differently are still bound by the parameters of the dominant socio-cultural discourses. Interrelationships can be observed by reviewing the menopause as disease, treatment of menopause as a dangerous gamble and menopause as natural progression discourses.

The menopause as disease discourse is based on the wider socio-cultural bio-medical scientific discourse. This discourse describes menopause as a disease and views the presence of symptoms at midlife as normal. These symptoms are believed to be caused by erratic hormonal changes in the dysfunctional female body and menopause is

therefore constructed as a phenomenon for medical attention, research and control. The treatment of menopause as dangerous gamble discourse is linked to the construction of menopause as a disease discourse and thus also states that menopause requires medical treatment and cure.

At first glance menopause as natural progression discourse appears to hold different assumptions concerning menopause from those assumptions held by the menopause as disease and menopause as a dangerous gamble discourses. This discourse constructs menopause as an object that is natural and a sign of healthy transition. Symptoms associated with menopause are thus constructed as normal and appropriate. However, this discourse is similar to the other two discourses in that it views menopausal symptoms as requiring management either through medical or alternative treatment. Failure to manifest symptoms is considered abnormal and therefore also requires treatment. These discourses all construct women as requiring intervention during midlife. Women's bodies are constructed as out of their control. Women's bodies need to be controlled by medical professionals, who hold superior knowledge and are therefore able to take better care of the bodies. Control over the female body is given to those who hold scientific knowledge about its functioning and understand how to treat its increasing level of dysfunction.

These discourses define proper treatment as medically researched and validated HRT or other medicines prescribed by doctors. Alternative medicines are constructed as unsafe and ineffective because they do not adhere to the standards and requirements of the medical paradigm. Through this process the wider socio-cultural biomedical scientific discourse effectively side-lines alternative natural medicines. Approaches that uphold scientific requirements gain superiority, power and legitimacy to talk. Although the menopause as natural progression discourse differs slightly from the two other discourses in that menopause is constructed as normal, it is still similar to the menopause as disease discourse in that it treats menopause as an abnormal occurrence that needs to be monitored and treated by medical experts.

These discourses are all linked to the development of the female object as biological being discourse. The menopause as disease, treatment of menopause as dangerous gamble and menopause as natural progression discourses all construct the

female body as innately pre-determined to become diseased and/or requiring treatment during midlife. The female body is objectified as a dysfunctional mechanism that inevitable leads to midlife, a period during which fertility and usefulness deteriorate. Fertility is constructed as a societal concern (seen in the menopause as responsibility discourse) and the female body is therefore constructed as an object for research, assessment, treatment and control. Women are constructed as biological beings, independent of contextual variables. Thus, a woman's anxiety or depressive symptoms are not seen as related to family, occupational or other contextual factors but instead are explained as being completely related to biological factors. Women are reduced to objects explained and controlled by hormones and bodily functions. All of these discourses construct women's bodies as dysfunctional during menopause.

The menopause as disease and menopause as natural progression discourses both hold that women at midlife require treatment of some description. This results in the objectification of women's bodies through the creation of the female object as biological being discourse. This discourse holds that women are obligated to subject themselves to experimentation, assessment and research. This subject position is constructed as being for women's own good, for the good of society at large and for the advancement of science. Women are defined as patients requiring treatment if they wish to survive midlife, as seen in the treatment of menopause as dangerous gamble discourse. However, these discourses also contain conflicting messages. In the menopause as disease discourse menopause is constructed as a disease that requires HRT treatment, yet in the menopause as a natural progression discourse the experience of symptoms is considered normal and women are offered the choice of treating these symptoms through alternative or mainstream medication. The treatment of menopause as dangerous gamble discourse creates further conflicts for women who choose to confine themselves within either the menopause as disease or menopause as natural progression discourses. The popular and most commonly prescribed medical treatment for menopause is HRT. This treatment option is well researched and conforms to scientific standards of validity, safety and efficiency of treatment. Medical professionals recommend HRT as the best approach to treating menopause, yet simultaneously warn that it is risky as alternative medicines do

not meet the scientific standards set by mainstream treatments. These alternative treatments are therefore constructed as unsafe and or inefficient.

The conflict between these various discourses is smoothed over by the development of the menopause as confusion discourse. This discourse is similar to a discourse identified in the study by Lyons and Griffin (2003). In this discourse menopause is constructed as confusing and the various conflicts surrounding menopause are seen as the result of the confusing nature of women's bodies. Thus, the medical and scientific discourses are absolved from any blame in relation to the confusion. Instead the confusion is blamed on women's biology.

The menopause as confusion discourse serves to disguise the conflict between the other discourses and it is supported in this function by the menopause as responsibility discourse. This discourse constructs women as biological begins under medical control who are expected to seek medical attention based on their responsibility of ensuring fertility and family planning. Women are also required to remain healthy in order to meet their obligatory caretaker role. Although the medical experts are uncertain regarding the safety of treatment women are still encouraged to follow their doctor's advice. However, if any negative consequences result from the treatment women are viewed as responsible for the treatment decisions made. This discourse sustains the construction of medical knowledge as superior by absolving it of any blame associated with negative consequences of treatment.

The menopause as disease discourse also functions to develop the menopause as old-age discourse. Both discourses construct menopause as a sign of old age. However, due to the menopause as disease discourse's link to the bio-medical discourse aging (which is associated with menopause) is also constructed as pathological. Aging is constructed as a loss of physical and psychological health and vitality, and is thus connected to the menopause as loss discourse. In these discourses menopause is constructed as a time during which women lose their youth, beauty, health, roles within their family and community and the power positions associated with these roles. The menopause as old-age discourse is therefore strengthened and supported by the menopause as loss discourse. In both discourses older women are seen as holding less power and status in society than younger, fertile and healthy women. The loss of gender

roles was discussed in chapter two. The discussion showed that gender roles are an integral part of an individual's identity and that the loss of these roles can be experienced as losing a part of one's self worth and value in society. Within the menopause as loss discourse, women are positioned as mourning the loss of the caretaker role, which provided them with a sense of worthiness and value within society. This sense of loss is also related to the menopause as responsibility discourse which supports the construction of women as responsible for family planning and care. Although the menopause as rejuvenation discourse directly resists these discourses it remains confined to the definition of menopause being associated with the loss of caretaking roles. The menopause as rejuvenation discourse is still governed by wider socio-cultural gender discourses and continues to see menopause as characterised by the loss of certain roles. However, within the menopause as rejuvenation discourses these losses are constructed as welcomed, liberating and empowering. Thus, menopausal women are seen as gaining freedom and the ability to realise their dreams and aspirations. Within this discourse menopause is constructed as a time for new energy, revitalization and opportunity. This positive discourse concerning menopause occurred significantly less frequently in the texts than the negative discourses. This suggests that negative discourses around menopause are more readily available than positive discourses.

Lastly, there are similarities between the menopause as loss and midlife as loss discourses. Both these discourses construct menopause as a time of loss of physical health and vitality, a time were women mourn their youth and all its opportunities. However, the two discourses do follow different ontological assumptions. The menopause as loss discourse follows the assumptions of the wider bio-medical scientific discourse and sees symptoms as linked to specific underlying, biological causes. Menopause is constructed as a biological dysfunction caused by erratic hormones that can only be cured through HRT treatment. However, the midlife as loss discourse allows for the inclusion of cultural factors in women's experience of menopause and midlife. It thus resists the reductionism and determinism assumptions of scientific models. Within this discourse stressful factors such as marital conflict, children leaving home, occupational changes and ill parents are seen as influencing women's reactions during midlife and menopause.

Step Two

This step is related to step one as it makes use of the interconnections between the discourses that were identified in the first step. In this step the patterns between the discourses were reviewed. It contains a simplistic overview of the various possibilities given that the discussion is based on a limited sample (37 texts) and a limited time period (2006 to 2010).

The menopause as a disease discourse was dominant in the articles published during 2006. This suggests that the wider socio-cultural bio-medical scientific discourse was prevalent at the time. This can be seen in the language used to construct menopause as a disease and the use of empirically validated studies to justify the statements in the articles. The treatment of menopause as dangerous gamble discourse is connected to the dominant discourse as it follows the perspective of menopause requiring treatment. In addition, it constructs medical treatment approaches as superior to alternative, natural remedies. The menopause as natural progression discourse forms an alternative discourse that resists some of the assumptions of medical models. Women's bodies are objectified within the texts as they make use of the female object as biological being discourse.

The same discourses are prominent in the articles published in 2007, although the menopause as natural progression discourse starts to become more prominent and resistant to the menopause as disease discourse. In these articles the scientific framework is questioned as HRT is portrayed as potentially dangerous and alternative medicine is portrayed as effective. The menopause as confusion discourse begins to emerge in these articles.

In the articles published in 2008 the menopause as confusion discourse becomes more prominent, and the different constructions of menopause as a disease and as a natural life stage, as well as the existence of different and conflicting treatment approaches, construct confusion. The menopause as confusion discourse covers the conflicts between the dominant and alternative discourses and simultaneously creates an additional discourse, the menopause as responsibility discourse. In this way the conflict created within and between the dominant and alternative discourses is hidden as menopause is constructed as being under the control of health professionals but too

complicated to be explained by health professionals. Thus, women are still expected to follow health professionals' advice but are also positioned as responsible for their own treatment choices and any risks involved with these choices.

In the articles published in 2009 the various benefits and risks of HRT and alternative, natural remedies are discussed and the responsibility for decisions is placed with women. The development of the menopause as old-age discourse seems to occur during this year. The discourse stems from arguments regarding HRT (a replacement of the female hormone oestrogen) in previous years being constructed as the youth hormone. Menopause is thus associated with decreasing levels of oestrogen and the gradual loss of youth and beauty. HRT is constructed as a treatment to control the loss of youth and prevent aging. However, the risks associated with HRT remain prominent in the articles and this contributes to the menopause as confusion and treatments of menopause as a dangerous gamble discourses.

The articles published in 2010 appear to be concerned with fertility. The wider socio-cultural gender discourse is used to construct women as subjects who are obligated to undergo testing in order to predict the timing of menopause and allow medical experts to assume a controlling, authoritative role in family planning. There is a shift from considering women's bodies as diseased, dysfunctional and inefficient towards acknowledging women's bodies as vital for the survival of the human species. The focus thus shifts from the individual and moves towards society as a whole. Women's childbearing role is seen as essential for the continuation of economic stability.

Throughout the 2006-2010 period the female object as biological being discourse is evident. This discourse is linked with the menopause as responsibility discourse. Women are constructed as obligated to undergo medical assessment in relation to both disease and fertility. The menopause as loss discourse is also evident across the six year time frame; it appears to be strengthened by wider socio-cultural gender discourses that construct the loss of the feminine roles as negative. This may explain the very limited possibilities available for the menopause as rejuvenation discourse. This discourse decreased in prominence during the time period under investigation, and had almost disappeared by 2010. The power of the gender discourse is such that resistance from discourses such as the menopause as rejuvenation discourse is smothered.

Step Three

In this step the various possible institutional and ideological influences on the construction of the identified discourses are explored. The interconnections between myth, institutions and power are discussed with reference to Parker's auxiliary criteria for identifying discourses (Parker, 2002). The effect of these power relations in constructing discourses into dominant and resistant positions within a historical and cultural context is also explored.

The two broad socio-cultural discourses identified in the analysis chapter, namely the bio-medical scientific discourse and the gender discourse, appear to receive a great deal of ideological and institutional support. According to Parker (2002) discourses such as the bio-medical scientific discourse are located within a variety of texts such as newspaper articles, journals and research reports as well as in daily conversations between doctors and patients (Parker, 2002). Bio-medical scientific discourses reproduce and perpetuate the material foundations of medical institutions (Parker, 2002). In this way a doctor's physical examination of a patient, research material, medical seminars and medical articles are all practices and evidence of discourse, which operate to reproduce institutions (Parker, 2002).

Institutions are formed around and operate to perpetuate relations of power (Parker, 2002). Medical institutions allow individuals with medical knowledge to speak and thus offer them a position of power relative to un-knowing patients (Parker, 2002). The media is another example of an institution that operates to perpetuate power relations through and by discourses. In the current research study newspaper articles, which form part of the media, were analysed in order to ascertain the ways in which they propagate different discourses, construct various subject positions holding different relations of power and operate to give some discourses more rights to speak over others. Discourse operates to perpetuate these power/knowledge relations. Interconnected sub-discourses acting in conjunction with the wider socio-cultural bio-medical scientific discourse hold positions of power and are more dominant than sub-discourses holding conflicting ontological perspectives. For example, the menopause as disease, treatment of menopause as dangerous gamble and female object as biological being discourses are

dominant and have power effects. These discourses operate to construct subject positions for women that are subjugated and dependent on medical professionals. In contrast, the menopause as rejuvenation discourse resists the dominant medical discourses and offers women an empowered subject position.

Parker (2002) explains ideology as content which describes relationships and effects. Ideology forms a way of viewing the world within society. Specific versions of the world may have oppressive effects for some and empowering effects for others (Parker, 2005). Bio-medical scientific discourse defines disease in the same manner as gender discourses define appropriate gendered behaviour based on anatomical sex characteristics (Parker, 2005). Relationships of power between groups are defined and segregated by and within discourses based on specific ideologies.

Ideology is born within a historical context. The scientific discourse is based on the ideology of modernism. Social factors such as language are critical to understanding the construction of disease and medical technology constructed as curing the disease constructed through medical terminology. Medical discourses serve to construct and maintain mental illness, in this way certain ideologies support definitions of normality and abnormality (Parker et al., 1995).

Gender discourse is circulated and perpetuated by cultural images including advertisements, newspapers, movies, books and speech. Gender discourse varies depending on context and time. Thus, what is accepted as culturally appropriate feminine or masculine behaviour is dependent on the gender discourse available to men and women within that specific time period. Gender discourse was discussed at length in chapter two. Gender discourse is also linked to institutions and power. For example, feminine characteristics are typically devalued within medical and psychological institutions and valued within educational institutions (Parker, 2005). This means that ideological forms of myth, such as those practiced through and by gender discourse, provide subject positions for both men and women. Individuals can choose to either conform to or disregard these subject positions and be marginalised (Parker, 2005).

The wider socio-cultural gender discourse offers ideological forms of cultural myths regarding acceptable and un-acceptable gender behaviour. This dominant discourse offers a higher position of power to sub-discourses that follow and accept its

ideology. These sub-discourses include the menopause as responsibility and menopause as loss discourses. These sub-discourses both strengthen the assumptions of the wider socio-cultural gender discourse by offering women subject positions defined by traditional female roles such as caretaker, mother, housewife and patient. Women who assume these positions and act within the parameters defined by the gender discourse hold a subjugated position in relation to both men and medical professionals. The menopause as rejuvenation discourse forms an active resistance to the wider gender discourse by constructing the loss of gender roles, such as caretaker and mother, as welcome and liberating. Although the menopause as rejuvenation discourses offers women a more favourable subject position, the power of the gender discourse makes it difficult for women to access this subject position. In addition, this subject position has limited acceptance within the current cultural and historical context.

Step three clearly shows that ideology and institutions hold power that is perpetuated and held through discourse. The ways in which discourses operate can only be understood when the power positions constructed by those discourses are explored.

Step Four

Reflexivity is a very important component of discourse analytic research. Researchers are encouraged to reflect on their own subjectivity and consider the influence that their cultural context and ideological stance has on their reading of a given text. It is not possible to separate the researcher from her cultural and historical influences. In the paragraphs below these influences are outlined and acknowledged.

The researcher is a 25 year old white woman who is currently (2011) in her second year of the Clinical Psychology masters course at the University of Pretoria. The researcher chose to conduct her research by means of discourse analysis, and thus a postmodern paradigm, for various reasons. These reasons include her perspective regarding reality, ideology and knowledge.

The researcher completed her BSc undergraduate degree in human physiology and psychology. The combination of undergraduate subjects required flexibility in thinking. The scientific subjects she studied included zoology, anatomy and chemistry. Within these scientific subjects a cause-and-effect paradigm was used and the researcher

was required to continually produce scientific reports based on her practical work that made use of reductionism, determinism and linear models. As a result of this process the researcher realised that truth could be found by controlling certain variables, but also realised that when this control was removed the same 'truths' no longer applied. She therefore learned that life was not reducible to simple measurement and control principles.

During her study of anatomy the researcher became interested in the reciprocal relationships between various factors in the human body. For example, the heart works in union with other systems such within the body such as the lungs, blood vessels and organs. However, if the heart is removed from the body it continues to pump and 'beat' on its own as a separate organism. The researcher thus began to view life in terms of networks of relationships.

In addition to her scientific background the researcher also comes from a spiritual background. While attending a catholic convent all-girls school the researcher observed the immense value religious beliefs hold for people in her community. However, as she grew to know and value the people around her she realised that many held different religious positions and that even people from the same domination differed in their ideas. The researcher came to realise that people believe in different truths and that each is no more right, or wrong, than the other.

The researcher is currently completing her master's degree in clinical psychology. During the course of this programme she has come to believe that truth is relative. She was exposed to many different theories in psychology and each theory has its own beliefs about mental illness.

During the course of her studies the researcher also become aware that psychological knowledge/power forms ideology and can have an effect on both psychologist and patient. The researcher considers it important to remember the power/knowledge effect that psychology, as an institution within the mental health domain and as an ideology for its followers, holds within a given context. The researcher chose a discourse analysis research method as she believes this method of research allows for an understanding of how truths are constructed over time. She believes that language

forms a vehicle for revealing 'truths.' Although these truths are often located within an individual they are actually reflective of the effect that society has on the individual.

Prior to the research process the researcher did not have any specific views regarding menopause. She chose the topic as a family member was entering the stage of menopause. This family member's experiences of fear, confusion and anxiety relating to the experience of menopause prompted the researcher's interest in the topic. The researcher was also interested in understanding how gender discourses impacted the experience of menopause.

During the research process the researcher found that she could relate to both the disease and natural life progression discourses surrounding menopause. Her scientific background allowed her to understand the impact of the physical and physiological processes involved in menopause. However, her background in psychology allowed her to understand that the experience of menopause could also be influenced by other, not physiological, factors such as emotions and life stressors. Her background also helped her to understand that menopause could be experienced differently at different historical times and in different contexts.

As a young woman herself, the researcher thought about what it means to be a 'woman' within the reality defined by current gender discourse in South Africa. She questioned whether taking up or negating the mothering role would affect her value in society. She questioned whether her hormones control her at certain times each month. While asking these questions, she was aware of the limiting and demeaning effects that they produced. She also thought about her own possible future experience of menopause and wondered whether her understanding of the discourses discussed in this study would influence her experience of menopause.

Chapter Seven: Conclusion

Discourses simultaneously construct and perpetuate the objects of which they speak (Wodak & Meyer, 2001). Discourse brings phenomena into being and constructs a reality through and by which people experience their social world (Wodak & Meyer, 2001). In this study the researcher explored some of the menopause discourses that are available to South African women at midlife. The research focused particularly on the various subject positions that these discourses construct for menopausal women.

Through a discourse analysis process the researcher identified ten discourses that were circulated and perpetuated by and through the media over the six year time period under investigation. Several dominant discourses were identified. These discourses were: menopause as a disease; treatment of menopause as dangerous gamble; menopause as old-age; menopause as natural progression; menopause as loss; menopause as responsibility; menopause as confusion and female object as biological being. Two supplementary discourses, menopause as rejuvenation and midlife as loss, were also identified. The menopause as disease discourse was dominant throughout the six year time period, although the menopause as natural progression discourse became increasingly prominent as the time period progressed.

The discourses identified were analysed to reveal how language constructs menopause into a phenomenon within the realities defined through and by the discourses. The discourses were shown to hold power and thus created certain subject positions for readers. Through assuming these subject positions readers were either empowered or subjugated. In general, the discourses constructed women (who were seen as lacking in knowledge) as subjugated patients and constructed men and medical professionals (who possess knowledge) as powerful.

The ten discourses identified were also linked to wider socio-cultural discourses concerning science and gender. These wider socio-cultural discourses were linked to institutions and ideology. The sub-discourses supporting the assumptions of the wider bio-medical scientific discourse had more power than the sub-discourses that did not support these assumptions. These sub-discourses also functioned to reproduce and perpetuate the material foundations of the medical institutions (Parker, 2002). In a similar

way, the gender discourse supported cultural ideological forms of myth about appropriate and or inappropriate behaviour and roles for men and women. The discourses included the identification of women as caretakers who are destined to fulfil the mothering role, reproduce and care for the family. The discourses also construct men as successful breadwinners who do not stay at home and care for children. Thus, the ideology constructs subjugated, dependent subject positions for women and empowered, assertive subject positions for men.

The findings of this study suggest that South Africa is strongly influenced by western scientific ideology. Once a truth has been constructed as scientifically valid and objective it becomes very difficult for individuals functioning within this discourse to dispute this truth (Powers, 2001). Medical institutions are thus placed in a position of power based on their superior knowledge and ability to assist naïve patients.

The newspaper media appears to be governed and restricted by scientific discourse and the articles are thus expected to conform to the standards of objective, valid and well established research. Only articles presenting scientific based research are printed. Articles focusing on alternative medicines are written in such a way as to cast doubt on the safety and efficacy of these treatments. Newspaper articles are thus governed by the scientific discourse while remaining as a practice for its reproduction and circulation through society. The articles are seen to present the 'truth' and it is nearly impossible for menopausal women to reject these scientific 'truths' claims.

In addition, the research clearly indicates that certain gender discourses are prevalent and dominant within South Africa. Unlike western discourse, which emphasis beauty and youthfulness as power, within the South African gender discourse women's roles as mothers, caretakers and housewives hold power. A woman's fertility status is thus indicative of her level of power in her community. It appears that even within a culturally diverse society, where many different views of women may be held, most women are situated in traditional roles. However, it is important to remember that not all South African women have access to newspapers or are literate. It would therefore be interesting to explore, the subject positions offered to menopausal women who are not reached by the discourses circulated by the media.

This research intended to re-locate menopause. While current discourses locate menopause as a scientific and medical disorder, social constructionist thought holds that menopause is integrally linked to the social context.

As a result of the study the researcher concluded that the social world is a complex discursive network. Thus, a process of discourse analysis does not lead to the identification of a single, independent discourse. This would parallel the reductionism ideology of modernism. Rather, discourses are interconnected and each discourse is strengthened or resisted by multiple complementary and conflicting discourses forming a network through which society understands and experiences their reality.

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Appendix A

Appendix B

Table B.
A Summary of the Discourses Identified in Selected Articles from the year 2006 to 2010.

Discourse Identified	Year				
	2006	2007	2008	2009	2010
Menopause as disease	1;3;4	1;2;3;4;7;8;9	3;6	1	5;6
Menopause treatment as dangerous gamble	3;4;6	1;3;8	7	1;4	5
Menopause as old age	5	1;4;8;12	1	2;3	1;4;5
Menopause as natural progression	2;3	8;12	1;3	1	2;5;6
Menopause as confusion	1;2;3;4	1;7	1;3;7;8	1	2
Menopause as responsibility	2;3;4	1;3;4;6;8	3;4	1;2	2;4
Female object as biological being	3	1;2;3;5;7;8	3;4;5;8	Not highlighted.	1;2;3;4
Menopause as loss and midlife as loss	3;5;6	1;5;8	Not highlighted.	1;2;4	2
Menopause as rejuvenation	5	1;8	Not highlighted.	Not highlighted.	Not highlighted.
	Articles Number				