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Discourses on menopause – Part II: How do women talk about menopause?

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ABSTRACT The aim of this article is to describe which of the different available discourses women relate to as revealed in the way they talk about menopause. We use a discourse analytic approach, which implies that meaning is ascribed to things according to how we talk about them. Twenty-four menopausal women from Denmark were interviewed. They were selected to cover a broad spectrum of Danish women with different menopausal experiences and social background factors. Seven previously identified discourses could be found in the interviews, though to varying degrees from woman to woman. Nearly all women used terms from the biomedical sphere like 'a period of decline and decay', even if they did not necessarily agree with this view. Also the existential discourse permeated most of the interviews, especially when the conversation turned to the ageing process, femininity and self-development. The way the menopause was talked about almost became kaleidoscopic when images speedily changed from the decrepit osteoporotic woman or a woman with lack of vitality and sex-appeal to a healthy and strong woman with control over her body and self. Since many women contact doctors in relation to menopause, and since the way doctors talk about menopause is influential, doctors should carefully consider which words and images they use in the counselling. The medical way of perceiving menopause is just one of many, and doctors must be aware that there are other different and partially contradicting discourses at play in society and in the women's universes.

KEYWORDS *discourse analysis; menopause; midlife; social construction, women*

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Introduction

A full understanding of how women interpret menopausal experiences and construct meaning requires an examination that moves beyond the level of

the individual. The symptoms and experiences are of course unique, but the significance they acquire is shaped by the social context of which the woman forms part and by the broader cultural norms and patterns in the society in which she is living.

The cultural understanding is reflected in the way people speak or write about menopause and menopausal women. It could be captured through a discourse analytic approach, which refers to the view that things acquire meaning according to how we talk about them (Phillips and Jorgensen, 2002). Women are thus influenced by the way other people talk and think about menopause, whether in daily conversation between friends, colleges and family, or in a doctor's consultation room, or in texts whether written or pictorial.

Different discourses construct their objects and subjects differently, provide the persons involved with different positions and afford them different scopes of action. Discourse analysis aims to uncover these constructions and to investigate with what consequences they may be deployed (Willig, 2003).

Culturally available discourses form what Wetherell and Potter (1988) call 'interpretative repertoires'. Different repertoires are used to construct different versions of events (Willig, 2003): a gynaecologist may, for example, talk about menopause as a 'deficiency syndrome', while a feminist speaker may talk about menopause as a 'natural developmental period' in a woman's life. The former construction emphasizes that the menopausal woman needs to be treated with hormones and she gets the position of a suffering patient, while the latter conveys the image of an independent woman, capable of making solutions by herself. In this way, interpretative repertoires are used to construct alternative, often contradictory, versions of events (Willig, 2003).

When a menopausal woman herself takes up one discourse in preference to another, she accordingly positions herself as a subject in this very construction. By doing so, she also accepts the specific rights and duties linked to that discourse. For example, if she agrees with the gynaecologist that menopause is a 'deficiency syndrome', she assumes the role of a patient with the right to be examined and treated, but also the patient's duties, i.e. to listen to and comply with the doctor's advice, because the doctor has the position of the expert.

We have previously described seven different discourses on menopause based on written texts available to Danish women (Hvas and Gannik, 2008), each discourse giving rise to different actions and positions. See Table 1.

The aim of this article is to describe which of the different available discourses women relate to as revealed in the way they talk about menopause. Special focus is given to the biomedical discourse, which is the prevailing discourse when women contact the health care system.

Table 1 **Explanation of the seven different discourses available as interpretative repertoire (see Hvas and Gannik, 2008)**

Discourse	*Explanation*
Biomedical discourse	Menopause is seen as a deficiency syndrome caused by declining hormones: menstruation stops, various symptoms occur and the risk of future diseases (especially osteoporosis) rises. Such discourse constructs menopausal women as patients who need medication if they want to maintain body control
'Forever young' discourse	Youth and youthfulness are admired and longevity is promoted, while ageing and old people are belittled and made invisible. Menopause is seen as a negative symbol of the ongoing ageing process; a threat to be counteracted by cosmetic surgery, moisturizers, hair colouring remedies and hormones. Hormones are seen as an age-retarding commodity, or a 'life elixir'
Health-promoting discourse	Good health and physical fitness are increasingly valued and promoted, and menopausal symptoms and risk of osteoporosis are seen to be modifiable by lifestyle changes. Menopausal women are obliged to be fit, to stop smoking and follow dietary recommendations
Consumer discourse	The women should be provided with information in order to make an 'informed choice'. Menopausal women are seen as active, informed and educated, having consumer rights, but they are encouraged to make their choice together with a physician, and can choose often only among choices set up by doctors
Alternative discourse	Menopause is seen as a natural and often positive process, but also as a passing imbalance, eventually straining the body. Symptoms caused by the imbalance could be treated with natural substances such as plants and tofu
Feminist/critical discourse	Menopause is seen as a natural period in women's lives that has become medicalized by the medical profession and international drug companies. Menopause is a neutral or positive transition, but severe symptoms could arise due to stressful events in women's lives. Treatment is seldom necessary, but it is important that women are well informed about bodily changes
Existential discourse	Menopause is uplifted to a process of self-discovery, a catalyst for change and personal growth. It is a question of being able to accept life 'of good and evil', with symptoms not necessarily being something negative, but a part of life itself. Menopause and ageing include a lot of possibilities like becoming more experienced and competent and having the confidence to hold on to one's own opinions. It is also a period of more freedom, with time to spend on one's own interests, and the possibility of becoming a grandmother

A relational model of disease

In this article, menopause is conceptualized within a relational model of disease, a model that is useful when trying to understand the complex influence of internal and external contexts in women's understanding of menopause, even if it should be underlined that we do not see menopause as a disease. This model allows for seeing symptoms and disease as something that develops over time inherent in the relation between the individual and the individual's environment including other individuals. An example is the *situational* model of disease, which describes how lay people, while drawing upon personal experience and resources, construct personal understandings of disease in an attempt to maintain control and thereby improve the course of symptoms and disease. The model includes the perception of the disease or the symptoms, thoughts about causes, prognosis and treatment as well as attention to symptoms and actions taken regarding the disease (Alonzo, 1984; Gannik, 1995, 2002). Rather than existing in a static 'end-form', the personal understanding of disease develops and changes over time. It changes continually through the accumulation of personal experience while the individual utilizes personal resources, as well as through outside information in the form of professional counselling, conversation with family members and work colleagues, and through the media.

Relational disease models, including the situational model, can be seen as one way of specifying the biopsychosocial model of disease often referred to as the foundation for work in general practice and primary health care (Engel, 1980). Thus, in his textbook on family medicine, McWhinney writes about the biopsychosocial approach and the doctor who can repair and exclude serious disease:

> Both of these skills are necessary and important, but neither is sufficient. To heal the patient, something else is needed: the capacity to understand the patient's inner world – the values she lives by, her thoughts, feelings and fears; her perception of the injury and its effect on her life. (1997: 64)

In a qualitative study on personal experiences of menopause, Ekström (2005) found that the uncertainties involved were of importance to the women, and that a process that could be called 'Keeping my ways of being' emerged as the pattern of behaviour through which the women endeavoured to resolve their uncertainty. A 'personal calculation process' is described in which the women's attitudes towards menopause, ageing and hormone therapy are crucial for whether a change, a symptom or a suggestion from others is assessed as producing uncertainty at a personal level. Everything that happens is assessed in the light of the individual's own opinions, experiences and life situation, and the model thus lies in the continuation of relational models of disease.

Discourses as part of a relational model of menopause

The point of departure for the relational disease models is the personal experience, which is embedded in a social situational context. On top of

this we need to include the overall cultural perceptions in society, which are influencing all individuals. Utilizing a discoursive approach, which emphasizes that there can be no single 'true' perception of reality, but that there are actually many, it is possible to distinguish the many different ways in which women interpret menopause.

Discourse is a kind of social practice that is both constitutive of the social world and is itself constituted by other social practices. Several discourse analysts take the viewpoint that since all social structures are created through discourse practices, there is no need to distinguish between the two. However, critical discourse analysis (Fairclough, 1992) seeks to separate structures that, while discursively created, are relatively inert and resistant to change from those that are the object of negotiation and amenable to change. This can be conceptualized as a dialectical relationship between discourses and other social dimensions in which discourses not only contribute to the formation of social structures and processes, but also, in turn, reflect them (Phillips and Jorgensen, 2002). With regard to menopause, this critical conceptualization of discourse is relevant. Marriage, family relations and the labour market are social structures, which are inert and slow to change. The talk about menopause, however, is discoursive – and rapid change is therefore possible. By changing the way menopause is talked about, conditions are changed for menopausal women, which, in turn, affect how marriage, work and family life are experienced and handled.

Methodology

A questionnaire about menopause was sent to 1261 Danish women selected at random and it was answered by 77 per cent (Hvas et al., 2003). Among responders, a group of 24 52 to 53-year-old menopausal women from all over Denmark were selected to cover a broad spectrum of Danish women with different experiences of menopausal symptoms, treatment and contact with the health care system, as well as a broad variation according to social background factors (education, work and family). The women were then contacted by telephone and they all agreed to participate in a personal in-depth interview, which was subsequently carried out by the first author during 1999 to 2000. The interviews were semi-structured, they lasted about 90 minutes and they took place mostly in the women's own homes. Interviews addressed various aspects of menopause (course, symptoms and treatment) but started out with two open questions to the women in order to allow the women to set their own agenda in terms of menopausal discourse. The interview then proceeded by exploring in depth the topics the women themselves had brought up. Questions were also asked to obtain a short social status (education, family relations and work) and to uncover the women's experience and attitude to ageing and femininity. The interview included questions concerning preceding conversations on the topic with husband, doctors, colleagues and friends, and questions about read or seen

materials on menopause, which was especially relevant in order to study different discourses.

The study was granted approval by the Scientific Ethical Committee and the Danish Data Control.

Analysis

All interviews were transcribed in their entirety and read and re-read several times. They were coded and categorized into themes such as symptoms, contact with doctors, knowledge about menopause, treatment, thoughts about ageing, social relations. For every woman a short résumé summed up the themes and the biological, social and psychological 'background factors'.

For the purpose of this article, data were thoroughly read in order to discover the ways women talked about menopause. Theories on discourses focused our reading (Phillips and Jorgensen, 2002; Willig, 2003), and the seven discourses already identified and described served as a template in the analysis (template analysis style, Crabtree and Miller, 1999), that is, all the interviews were read thoroughly in order to determine which of the seven discourses were used, at which times and in which situations.

A plurality of discourses

Rather than leaning on a single discourse, the women drew on a plurality of discourses, which surfaced at different times and in different contexts during the interview, as described in detail below. Though all women drew upon elements from many different discourses, there was considerable variation in the relative weight they ascribed to these discourses. Sometimes they touched upon some of the discourses that seemed familiar to them, only to reject them explicitly immediately after. This was most striking in relation to the biomedical and 'forever young' discourse (see below), the two discourses bearing most negative myths about menopause. Thus, nearly all women used terms connected to the understanding of menopause as a period of decline and decay, for example, expecting more severe symptoms and relating menopause to biological changes in the ageing process; but later in the interview they used quite different expressions. For some women it seemed as if they picked up a ball, looked at it and threw it away. Like Kate,[1] an unskilled worker, who said:

> Well, my periods became very irregular, and I thought I owed it to my family to go to the doctor and have it checked, maybe it was something else … you know. But it was ok and now I know it is nothing to worry about. The hot flushes are ok, as long as I know what it is. I do not need any medication for it.

The biomedical discourse

As already noted, all women related menopause to the biological fact that menstruation ceases if you live long enough. When they first started telling about menopause during the interview, they used biological statements

about bodily functions like, 'I noticed I was menopausal because I went on sweating after summer had ended' or, 'I just had no more bleeding, and that was it.'

But speaking of menopause in biological terms did not necessarily mean that they spoke of menopause as a biomedical *problem*. According to the biomedical discourse, menopause is seen as a 'deficiency syndrome', that is, a problem that has to be discussed with a doctor, or treated with hormones, a fact not accepted by a number of women.

By providing two examples, we will show how one woman chooses to follow the biomedical way of thinking while another rejects it.

Elisabeth is an academic working in a county health administration. She has lived with her husband for 28 years in an apartment in a quiet area outside Copenhagen. She has two grown-up children who have both left home, and she is expecting her first grandchild in three months. Elisabeth thinks she is predisposed to osteoporosis and has experienced heavy bleeding for many years. Her blood count has been low and she feels very bothered by her irregular periods, negative experiences with blood stains on clothes and chairs, and great expense for sanitary towels. After careful consideration she accepted getting her uterus removed, and she has never regretted this decision, which she feels has improved her quality of life. She mostly regrets not having it done earlier. During the operation, her ovaries were also removed 'just to be safe and to avoid cysts and cancer'. However, she feels unsure about the relevance of this part of the operation, and says that she ought to have considered it longer before accepting. But she says she did not get any advice and that the decision had to be taken quickly. Since the operation, she has been taking hormones predominantly because the gynaecologist told her that *he* wanted her to keep taking them (because of the risk of osteoporosis). Elisabeth is unhappy about the hormones and is afraid of side-effects, particularly breast cancer. She deals with the dilemma by saying: 'I have made up my mind that I won't fear breast cancer. I will get regular check-ups and I will appreciate the years that I stay well.' However, she feels alone with the decision, and her experiences colour menopause negatively.

Elisabeth has many symptoms and seeks medical help. She tries to resist both operation and medication, but accepts both because of the severity of her symptoms. Results have been good. The quality of her life has improved because she no longer has the heavy bleeding and she thinks that she has reduced her risk of osteoporosis. But she pays with a sense of powerlessness. In spite of her academic background, she lacks knowledge and never had a real chance of deciding the issue for herself. Her role in relation to the doctors has been passive. Gynaecologists have determined the treatment. Even though she has found a pragmatic way of solving the dilemma in her attitude to hormones, she does not feel that there is much to look forward to, because she thinks that either she will get breast cancer or she will be hunchbacked.

Maria, who works in a bank, had a quite different way of coping with the changes. She started menopause with many hot flushes, which surprised her, since her mother had not suffered any symptoms at all. She had always thought of menopause as something natural that she just had to pass through. Then came the hot flushes and Maria says: 'You cannot imagine how unpleasant it is to sit in the teller and get red in the face and the water starts running down the neck!' She discusses it with her GP and gets a prescription for hormones. But she never starts taking them, because meanwhile she hears about a herbal supplement. She buys this and the hot flushes recede. She says that she does not know if it is the herbal medicine that has helped, or if the hot flushes just disappeared by themselves. She laughs about it and is a bit sceptical, but she is also happy about not having taken 'a lot of stuff, which probably also have side-effects, for something that really is natural'.

For some of the interviewees, it felt unnatural to take drugs, including hormones, and they only accepted taking the hormones when it was considered a necessary means of solving their problem. The alternative discourse (see below) helps Maria because this approach makes her feel that her wish to avoid drugs, unless absolutely necessary, is respected. She feels that she is doing something that perhaps makes the symptoms disappear, even if she may not be convinced of the evidence of the effect of the herbal supplements.

The 'forever young' discourse

The myth about loss of femininity in relation to menopause as well as society's admiration of youth was often mentioned spontaneously by the women, but at the same time it was rejected as irrelevant to them. When they mentioned it, it was often to describe *other* women's experiences of menopause, talking about girl-friends being very afraid of getting old, or colleagues using a lot of make-up to hide wrinkles. But during the analysis of the interviews, many contradictory quotations showed up, expressing ambivalence on the issue. For example, Greta, a shop assistant living in the countryside, said that menopause had not changed her femininity and did not want to take medicine for something natural, ending the interview, nevertheless, with a laugh, saying: 'Well, if someone invented hormones that could take away the grey hair, I'd probably be interested!'

There seemed to be some difference between single and married women. Two out of the three singles who were interviewed thought their possibility of finding a new partner was markedly reduced because of age, and saw this as a threat, while the third thought the opposite, saying that age did not matter when she went dating. Married women often rejected society's demands of staying forever-young with reference to their husbands ('well, *he* doesn't grow younger either') or by telling how well their relationship had grown by age, also sexually.

Often when they spoke about ageing and coping strategies, they related to their mothers, making comparisons, like Agnes who had a lot of thoughts

about women making a problem out of growing older: 'My mother is not like that either. She didn't find it a problem to grow old. Except for being dependent on help, but that is something else. Not because of age.'

It was not youth or a youthful appearance itself that seemed to be relevant, but looking decent and being treated with respect as a middle-aged woman. In relation to work, this was of special importance, and society's demands for young employees was mentioned as a threat, since being more than 50 years old was thought to be a disadvantage in relation to younger colleagues, or when looking for a new job.

The health-promotion discourse

Though much is written about the necessity of lifestyle changes in written material on menopause, the degree to which the women had integrated the idea of health promotion in relation to menopause varied extensively. Some did not mention lifestyle at all; some mentioned as a side remark that they ought to do some more workouts to get in better shape, or to drink milk to avoid osteoporosis. However, some of the women were very convinced about the necessity to do something by themselves in order to stay healthy. Below, in the example with Karen, we will explore how the discourse could constitute an alternative to the biomedical and 'forever-young' discourses by offering other options for actions.

The consumer discourse

This discourse was highly relevant for the women, especially for those who had been in contact with the health care system in relation to menopause. The women stated their demands of having sober and complete information and emphasized the importance of being able to ask questions continuously. Expressions like, 'He cannot treat me just like a number in a row; he has to see me as a human being', or 'I expect her to tell me all about different options and side-effects, so I can make up my own choice' were typical of this discourse, demonstrating that the woman's own choice was in focus.

However, some of the women were also opposed to this way of handling a medical question; knowing that they ought to seek as much information on menopause as possible, some of the women felt that they could not possibly relate to all this information.

Even women who had not discussed menopause with a doctor occasionally referred to the consumer discourse when they explained why they did not pursue the issue vis-à-vis their GP. Eve, for instance, who had treated her symptoms with herbal medicine, did not want to discuss the symptoms with her GP, because she knew he would rather laugh at than respect her choice.

The alternative discourse

Some of the women had tried alternative treatments that often eased their symptoms. These women all thought of hormone therapy as something

unnatural and they were satisfied to have the possibility of handling menopause without medication; see also the example with Maria above. Two women expressed deeper reflections on subjects like 'new-ageism' and spirituality and found them to be subjects of great importance. The use of alternative treatment was part of their taking care of their bodies. Eve, who also had a lot of hot flushes, said:

> It drains your body with all those hot flushes, it is hard work, so I think the body needs extra vitamins … I take fish oil and vitamin C, like my grandma said – when there is an 'R' in the month, you should have fish oil. And it helps; I have gone through all winter without catching a cold.

The feminist/critical discourse

Only a few women referred directly to this discourse. One was an active feminist, starting the interview by stating how important it is that women do this kind of study, 'because men have no idea of what menopause is all about'. She had been married to a surgeon, and the way he referred to his job and talked about gynaecological problems was very 'unworthy'. Others made remarks on their male GP's interest in treating them with hormones, and wondered what might lie behind his agenda.

One woman stated that she was not a feminist herself, but,

> that is easy for me to say, since I have had all the advantages former feminists have struggled for. First they fought for better possibilities for women to get jobs and education, then for the rights to have their children looked after, and now they are all getting menopausal, and they are still fighting, now for better rights for the elderly.

Others rejected the feministic discourse: for example one woman who reflected on a book on menopause written by a feministic writer: 'I have read her book, yes, some of it was OK, but I do not feel medicalized myself.'

The existential discourse

Together with the feministic and the alternative discourse, the existential discourse is the one that stands in starkest contrast to the biomedical. Most women describe menopause as a natural part of life itself and, apart from a few women, they did connect existential questions directly with the cessation of menstruation, like Karen in the example below, when she said that menopausal symptoms had made her think much about her life. However, the existential discourse permeated most of the interviews when the conversation turned to the ageing process, femininity and self-development. When issues about family, works and life situation in general were raised, the women's narratives did not focus on menopause itself, but on the experience of getting middle-aged, and they were captured in terms used within the existential discourse, often focusing on the ambivalence between seeing ageing as a threat and as an opportunity for growth.

Different discourses are in play simultaneously

All seven discourses can be found in the interviews, though to varying degrees from woman to woman. Women appear to be navigating between the discourses with much dexterity, balancing different approaches apparently without being confused. An example can illustrate this:

Karen (52) is a schoolteacher in a small provincial town. She is a single parent with two daughters who have both left home. She is an active woman with many interests. Menopause has been easy, as she has only experienced some hot flushes, which have not been too bad and she emphasizes that she has not been plagued.

Her thoughts about her appearance do not take up very much space. Yet they surface in connection with thoughts about the future and hopes of finding a new partner. In this connection, it is important how you look and she is afraid that without hormones she will lose strength and vitality. At the end of the interview she smilingly mentions that 'if one could get a reasonably priced skin lotion which would keep the skin smooth – that would be something!'

She is concerned about osteoporosis and says that several in her family suffer from this condition, especially her mother. When she consulted her GP about this, he recommended an examination and was very positively inclined towards hormonal treatment, which surprised her. 'Is my GP bought by the industry?', she asked herself. After thorough consideration she ends up rejecting the offered treatment and finds out for herself what else could be done. Instead of taking hormones, she changes her diet and starts doing workouts at a gym. She is very conscious of doing what she can in order to reduce the risk of becoming like her mother.

Her thoughts about growing older are generally very positive and she thinks of it in terms of 'mastering her life', 'taking her place' and 'getting control over herself'. She carefully considers what she wants for herself in the future and feels the need to 'practise' getting a good life.

In conclusion, she says that she feels well and does not feel wrinkled or in any way decrepit. In fact, her health has improved and the thing about mastering her life means a lot to her, though she is afraid of losing sex-appeal in the coming years. She says that even if there have not been many symptoms, menopause has caused her to think a lot.

This is a woman who has carefully considered her situation. She expresses a sense of insecurity and doubt with regard to treatment for reducing the risk of osteoporosis, and this has taken up much time. On the other hand, she also considers the positive side of menopause to be an opportunity for development and change. She not only says she is well but specifically emphasizes that she has not been bothered by menopause. She had an expectation that menopause would be hard, but it has not been as bad as expected.

The expectation that many symptoms may occur and the thoughts about risk of osteoporosis are all part of the biomedical discourse, which sees menopause as a hormone deficiency syndrome producing symptoms and risks that could be eliminated by treatment. This woman also utters the cultural wish of staying young: older women with wrinkles do not have sex-appeal, and a woman who lacks hormones loses strength and vitality. On the other hand, she speaks convincingly about existential challenges of life, which mean a lot to her.

As a modern responsible woman she accepts the need to make a choice between different options. If she finds the GP's advice insufficient, she seeks out other information (the consumer discourse). She actively follows the recommendations on health produced by the health-promotion discourse. This partly gives her control of her situation. The feminist discourse is not explicitly drawn on, but this discourse questions male doctors and medical industries and their role in pathologizing women's normal biology, and thus the discourse surfaces in the critical remark about doctors being bought by the industry. The way the menopause and menopausal woman is talked about almost becomes kaleidoscopic when images speedily change from the decrepit osteoporotic woman or a woman with lack of vitality and sex-appeal to a healthy and strong woman with control over her body and self.

Talk about menopause and the shaping of women's knowledge

It was not possible to determine precisely where or when the women had heard about menopause. It certainly seemed to be 'culturally embedded knowledge'; something that one 'just knows'.

Most women explained that in connection with their own menopause they had thought about how their mothers experienced menopause, but often this line of thinking was curtailed by the intervening years. Most women thought that their mother's menopause had not appeared problematic. However, two women conveyed exactly the opposite thing: their mothers had had a very difficult menopause. One of them was visited monthly by a nurse who administered injections. Another woman mentioned her mother-in-law who 'suffered from menopause until she was eighty'.

Some women discussed their menopause freely with their family, friends or colleagues at work, while others felt that the subject was taboo. One woman had not even mentioned to her husband that she was menopausal.

Differences were also apparent with regard to what they had read on the subject: some had sought out all available material, attended lectures, watched relevant TV programmes and used the library, while others had not actively sought information but seemed inclined to 'take it in its stride'. A few mentioned book titles or TV programmes, like 'the TV doctor', but apart from this, it was not possible to determine the exact nature of what they had read. No one mentioned specific advertisements or booklets.

Doctors contributed to women's knowledge to a varying degree. Women who had consulted a physician in relation to menopause described in detail how doctors handled the counselling on hormones or the risk calculation. Relating statements of the doctors often took up a great deal of time in the interviews, especially if the women did not necessarily agree.

What does the discourse approach offer?

Discourse analysis makes it possible to structure and categorize prevalent cultural influences in society and their impact on attitudes and knowledge. The present classification into seven different discourses is only one way of categorizing cultural currents of our time and it should not be interpreted as if discourses are fixed entities.

Discourse analysis may provide answers that cannot be obtained in other ways. By accepting that there is more than one 'truth', and therefore several valid ways of interpretation, it becomes possible to understand conflicting and contradicting attitudes on menopause and hormonal treatment as well as other subjects. The understanding of how the image of menopausal women is shaped, and how women are assigned different positions according to different discourses, paves the way for understanding the dilemmas women often end up in. It explains why women do not always choose evidence-based treatment for preventive purposes as suggested by the doctor.

The discourse analytic approach relies on examination of the spoken and written words, but it does not have the ability to 'reveal' underlying motives or causes. Nor is it able to determine the relative values or merits of discourses. It cannot, for example, by way of discourse analysis be determined whether the wish to avoid disease is better or worse than the wish to 'take life in its stride'.

Using a discourse analytic approach implies that the interviewer's role in shaping the discourse of the interview should also be examined. The interviewer's background as a GP, researcher and middle-aged woman may have influenced informants. This is especially the case for the doctor role because of the dominant position of the biomedical discourse. The women may have supposed that medical topics were of paramount importance. Thus, if results are distorted for this reason, it is likely that the importance of the biomedical discourse has been exaggerated rather that vice versa.

The positioning of the woman and the question of medicalization

The discourses contribute to the construction of the woman's situation, including her position, and constitute her scope of action. Elisabeth in the first example draws heavily upon the biomedical discourse, which partly helps her, partly positions her in a passive role as a patient, the doctor being the

active part. Her scope of action is very small and she is dependent on her doctor's offers. In contrast, Karen and Maria draw on other discourses and thereby become able to retain their self-images as active persons, capable of making their own choices with regards to hormones, lifestyle changes and herbal medicine.

It is often stated that menopause has become medicalized. Medicalization is a process where initially normal reactions and parts of life are defined as medical problems and subsequently dealt with by the health care system. However, Kaufert and Lock (1997) emphasize two prerequisites for medicalization. First, there must be an explanatory medical model suggesting a medical solution to the phenomenon at hand, which is possible for menopause. Second, the medical solution must, on the whole, be accepted by the target group. In discourse analytic terms this implies that the women should take up the position of patients needing medicine. This is only partly the case with respect to menopause. Hormone sales grew steadily in all western countries until the publication of data from the Women's Health Initiative in 2002, which found hormone therapy to have a number of side-effects. But even before that, there was a great gulf between many doctors' massive recommendation of hormones and the women's only partial acceptance of this recommendation. This is in contrast to, for example, child birth, which can be said to be medicalized because today there is general consensus in the health care system and among pregnant women that birth should take place in a hospital with doctors present.

Implications for medical counselling of menopausal women

In a previous article (Hvas et al., 2004), we described how the biomedical discourse is applied when women talk about their contact with the health care system. Women who consulted a physician in relation to menopause either wanted to: (1) discuss treatment for menopausal symptoms; (2) get an examination for diseases; or (3) get a risk assessment.

However, two other discourses are also in play when women get into contact with the health care system. One is the consumer discourse, which seems to have gained quite a footing in the relation between doctors and patients. The former paternalistic way of doctors deciding what was best for their patients is now often replaced by a wish to involve women in the decision making, by offering information and a 'free' choice. However, 'free' is in quotation marks, since the choice is between different options suggested by the doctor.

The other discourse is the health-promotion discourse. It is increasingly being accentuated by health care professionals that women can reduce symptoms and risk by improving their lifestyle. However, the health-promotion discourse is based on professional information and values in the same way as the biomedical discourse.

Since many women contact doctors in relation to menopause, and since the way doctors talk about menopause may have much influence, it is necessary that doctors carefully consider which words and images they use in the counselling. It may be provocative for doctors to realize that patients do not always consider absence of disease and avoidance of early death or functional decline as goals of overriding importance. Similarly, it can seem surprising to doctors that evidence-based medicine may not be a sufficient answer to lay people's health issues. To be able to give advice that is rooted in the woman's situational context and respectful of her priorities, doctors must realize that the medical way of perceiving menopause is just one of many, and they must be aware that there are other different and partially contradicting discourses at play in society and in the women's universes.

Note

1. In order to maintain the anonymity of the interviewed women, the names used in the article are pseudonyms.

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