HEALTHY LIVING AND KEEPING BUSY
A Discourse Analysis of Mid-Aged Women’s Attributions for Menopausal Experience

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Menopause is a complex time in the lives of mid-aged women, and this contributes to the diversity of attributions of menopausal experience. In this study, participants’ comments on a survey of attitudes about menopause were analyzed discursively to consider how mid-aged women account for their own and other women’s experience of menopause. Two discourses drawn upon to make attributions about menopausal experience were identified. Women account for menopausal experience either by reporting a range of healthy habits such as good diet and exercise or by suggesting women can overcome menopause with a “get-on-with-it” approach to life. These discourses construct women as social actors within a moral order in which the absence of menopausal symptoms is an indicator of virtuous behavior, and health is a moral imperative. The way these attributions of menopausal experience position mid-aged women has important implications for women’s self-image and health-seeking behaviors.

Keywords: menopause; women’s health; attributions; discourse analysis

Menopause generally refers to the time around the cessation of menstruation and has become a complex and confusing time in the lives of women in Western countries. A medical view of menopause as a deficiency disease requiring medical treatment has been strongly contested both in the sociological literature and in the media and popular publications. This means that women, who often use a variety of information sources about menopause, are exposed to conflicting and confusing views regarding the nature of menopause (Stephens, Budge, & Carryer, 2002). Accounts of menopausal experience have been increasingly discussed in the popular media, in health promotion material, and among women (Gullette, 1997) and reflect considerable disagreement among professionals and lay people regarding the symptoms of menopause, their causes, and the appropriate response to menopausal experience. This public discussion of menopause provides a rich
variety of socially available discursive resources for women to draw upon in making attributions about their own and others’ menopausal experience.

**MENOPAUSAL EXPERIENCE**

A wide range of physical symptoms has been associated with menopause in the lay and medical literature, from hot flushes to depression and mood swings (Defey, Storch, Cardozo, Diaz, & Fernandez, 1996). However, the association between these symptoms and hormonal status at menopause has been strongly contested by feminist writers (Goldstein, 2000), resulting in public debate about which symptoms are attributable to menopause. Research conducted to clarify issues of menopausal symptoms and experience has reported conflicting outcomes. For example, Shore’s (1999) research on women’s experience of menopause indicated that women discussed menopause as something that they must get through and preferably not discuss. They spoke of menopause as a mission over which they had no control. In contrast, Dickson (1990) found that women often considered menopause as marking the beginning of a new life. The women in her study described feelings of well-being and enjoyment of their lives.

There has also been an acknowledgment in recent literature of the importance of the social and cultural environment in defining women’s experience of menopause (Punyahotra & Street, 1998). Women living in non-Western societies have been found to report fewer menopausal symptoms than women in Western societies (Hunter & O’Dea, 1997). The recognition that menopausal symptoms are not universal has influenced understandings of menopause by implying that modern, Western social structures and gender roles have manufactured menopausal difficulty. This diversity of individual and sociocultural experience provides fertile ground for competing attributions of menopausal experience.

**MENOPAUSE ATTRIBUTION**

Attributions are explanations of why certain things happen (Shi-Xu, 1999), which include statements about causality and responsibility and are composed whenever understanding a situation or making judgments is required (Harvey, Turnquist, & Agostinelli, 1988). Attributions might also be understood as socially constructed to perform certain functions, such as blaming, justifying, or promoting particular presentations of the self (Edwards & Potter, 1994). An important social function of attributions of health and illness is the presentation of a moral identity. In studies of mid-aged women’s understandings of health and illness, Blaxter (1993) and Williams (1993) found that the women were concerned to present themselves as virtuous social actors.
The women’s accounts of symptoms and illness experience were framed in terms of the local moral order and the individual’s perceptions of their places in it. Thus, the women in Blaxter’s study described their illness experiences, or their own and others’ health, in terms of a demonstration of virtue in a social situation (Scottish working class) in which moral opprobrium was attached to giving in to illness and a claim to health was a claim to virtue. Williams further described the material effects of these attributions: how sufferers of illness and disabilities in England must develop certain strategies that depend far more on society and the individual’s place in it than on coping with the symptoms of the illness itself.

Potter, Edwards, and Wetherell (1993) suggest that language constructs and is constructed by such social practices. Within this approach, reality is seen as the object of constructive practice, which is rhetorically organized to serve particular purposes rather than as a yardstick for the measurement of the truth of attributional claims. In addition, attributional statements are seen as functioning to construct responsibility for both the speaker and the subject of the discourse (Potter & Wetherell, 1987). This understanding is particularly important in the area of health, as it involves an appreciation of the way in which attributions do not simply reflect objectively real causes of symptoms but actively construct individual responsibility for health.

Mid-aged women’s attributions of menopausal symptoms and experience have received little research attention. Liao, Hunter, and White (1994) used a questionnaire to explore women’s attributions of causality for menopausal problems. Responses to the following question were content analyzed: What do you see as the main factor that determines whether a woman will have no problems or have a bad time during menopause? Mid-aged women reported a range of causes for menopausal experience, most frequently citing emotional factors, partner support, knowledge about, and expectations of menopause, as important causal factors. Although this research allowed women to respond to an open-ended question, the analysis was not able to capture the complexity of natural, attributional statements. Natural attributions might present a variety of understandings for any given outcome, and speakers manage them with careful attention to the implications of the attribution for the speaker and the subject of the text (Shi-Xu, 1999). Content analysis ignores these facets of natural attributions and reduces them to a code, which supersedes complex and multiple attributions. In addition, the use of “a woman” as the subject of this study might have limited the extent to which the respondents drew on their own experience and knowledge of others in their attributional statements.

Research has demonstrated an interaction between mid-aged women’s experience of menopause and their attributions for menopause. In a focus-group study, Fox-Young, Sheehan, O’Connor, Cragg,
and Del Mar (1995) found that women whose experience of menopause was neutral or positive more often questioned the link between menopause and the problems commonly attributed to menopause. These women were more likely to attribute menopausal symptoms to stress. Similarly, Mitchell and Woods (2001) found that women reported a range of attributions for memory changes at midlife, with different attributions made by working women and nonworking women. These studies highlight the importance of personal experience in constructing the experience of oneself and others during menopause. Women attribute menopausal experience to a range of causes, and those causes deemed important by women will depend upon their own experience of menopause and the social context of their lives.

There is need for further research that uses women’s own language to investigate the way women construct their understandings of menopausal experience. Naturalistic or unstructured attributions might be investigated using a social constructionist approach in which attributions are seen to be located in particular instances of discursive practice. Discourses, or clusters of images and words that construct an object such as menopause (Potter & Wetherell, 1987), are shared as people describe, discuss, and debate their experience. These discourses provide the linguistic resources for use by women to discursively construct and resist constructions of menopause and attributions of physical and psychological symptoms at menopause. Thus, the socially available discourses of menopause provide the framework for attributions for their own and other’s menopausal experience. In Western society, several discourses used to construct menopause have been identified.

DISCOURSES OF MENOPAUSE

A medical discourse dominates academic and media accounts of menopause (Hunter & O’Dea, 1997). Use of a medical discourse constructs menopause as an estrogen-deficiency disease caused by ovaries failing to provide sufficient oestrogen to ensure normal functioning (Lyons & Griffin, 2000; Loppie & Keddy, 2002). This construction of menopause suggests that the appropriate response to this disease is pharmaceutical treatment with hormone replacement therapy (HRT) (Coupland & Williams, 2002). The use of a medical discourse has promoted an understanding of menopause as a threatening change in the lives of mid-aged women, indicating their inability to control their bodies without HRT (Stephens et al., 2002). This discourse also constructs menopause as a risk that pervades many areas of mid-aged women’s lives, such as their long-term health and relationships with family members (Palmlund, 1997). It has been argued that use of a medical discourse to construct menopause focuses on the role of hormones in explaining menopausal experience and neglects the role of social,
cultural, and political aspects of menopausal experience (Lyons & Griffin, 2000).

In response to this medical construction of menopause and the concomitant use of HRT, there has been increasing representation of menopause as a natural and normal part of the lives of mid-aged women (Lyons & Griffin, 2000). This construction suggests that rather than seeing menopause as a disease, it should be seen as a natural stage of a woman’s life, which can be improved through judicious use of natural (usually herbal and dietary) remedies (Coupland & Williams, 2002). The natural discourse is used to resist the medicalization of menopause (Lyons & Griffin, 2000) and to position women as having control over the distressing symptoms of menopause through natural rather than pharmaceutical methods. This discourse suggests that natural approaches and remedies for menopause empower women to take control of their own lives rather than being subject to the control of medical professionals and the marketing practices of pharmaceutical companies (Lupton, 1996).

Employing particular discourses of menopause constrains the ways in which women might account for menopausal symptoms and experience. Hunter and O’Dea (1997) argue that a woman’s subjectivity is positioned between her own physical experience and the discursive constructions of the menopause. In this way, there is an interaction between each woman’s experience of menopause and the linguistic constructions that she has available to her to make sense of these experiences. Individual experiences will influence which discourse is taken up, but the use of particular constructions is also negotiated within different social settings which might require justification of menopausal experience and responses (Stephens et al., 2002).

The discourses of menopause available to mid-aged women provide the basis of mid-aged women’s construction of and resistance to attributions of menopause. The attributions that women make regarding their menopausal experience have important implications for their understandings of their health and their healthcare choices. Naturalistic or unstructured attributions might be investigated using a social-constructionist approach in which attributions are seen to be located in particular instances of discursive practice. In this study, we examine the discursive resources used and the ways in which a sample of mid-aged women discursively construct attributions for menopausal experience.

**METHOD**

The source of the material for this analysis was a questionnaire used in a study by Breheny and Stephens (2000, 2001) on mid-aged women’s HRT use and their knowledge of and attitudes toward HRT and
menopause. The questionnaire was sent to 1,005 women aged between 45 and 60 years who were randomly selected from the New Zealand electoral roll. That study found that attitudes to HRT and attitudes to menopause were the most important predictors of HRT use, more important than experience of physical or psychological symptoms (Breheny & Stephens, 2001). It was also found that mid-aged women had important differences in their knowledge of HRT and menopause. Many women reported that they were taking HRT for reasons that are not consistent with the medical guidelines for HRT use (Breheny & Stephens, 2000). The responses from the final page of the questionnaire were used for the present study.

The final page of this questionnaire was headed with the invitation, “If you have any comments please write them here.” The response to this invitation varied enormously, with some women sharing personal and medical histories and others offering vitriolic condemnation both of HRT and of related questionnaires. Of the 495 women who returned the survey, 288 wrote additional comments on the questionnaire.

Before presenting the analysis of these responses, it is important to consider the questions included in this questionnaire. These questions provide the situational context for the attributions of menopause made by these women. The questionnaire began with biographical questions on age, marital status, occupation, and education, followed by questions on self-rated health and healthcare utilization. These health questions culminated in a list of 26 physical and psychological symptoms commonly associated with menopause, such as hot flushes, skin changes, depression, and forgetfulness. Each woman was asked to tick a box if she had ever experienced any of these symptoms and another if she attributed them to menopause. This question covered a full page and provided a strong focus on menopausal symptoms and attributions. The next section of the questionnaire examined HRT use. This section immediately set up a dichotomy between those who had used HRT and those who had not by sending each to answer different questions (e.g., “If no, please go to question 20”). This established HRT users and nonusers as separate groups to whom separate circumstances applied. Further questions included the reasons for, disadvantages of, and alternatives to HRT use.

Following this, a list of 18 statements was used to assess attitudes to menopause and HRT. The women indicated their level of agreement with each statement on a 5-point Likert scale. These statements reflected common understandings surrounding menopause such as “Women who have trouble with menopause are those who expect it” and “Menopause is part of normal life, which most women can deal with themselves.” These statements set up implicit dichotomies between women who have trouble versus those who do not and women who are able to cope with menopause versus those who cannot. Each of these dichotomies has clearly favored positions, and each provides a
position of advantage for some and disadvantage for others (Banister, Burman, Parker, Taylor, & Tindall, 1994). The discourses that women drew upon in their comments might have been influenced by these statements, which drew on the discourses generally available to mid-aged women. Finally, the last two pages of the questionnaire were concerned with mid-aged women's psychological health and their recent experience of a range of emotions.

These questions offer a context for the comments made by these women. They can also be seen as the first turn in a conversation between the researchers and the participants. The participants respond to the discursive resources employed in the questionnaire in the same way as they would respond to the opening introduction in a verbal conversation or interview. The discursive resources drawn upon in the questionnaire provide some of the material for these women to construct and resist the construction of menopause provided. The interchange between the participants in the response to the questionnaire needs to be considered in terms of the long conversation (Wetherell, 1998). Although the setting of questionnaire responding is artificial in that questionnaire responding is not the same as more naturally occurring, interactive social encounters, it still requires discursive resources and provides an opportunity for the participants to respond to the discursive resources present in the questionnaire.

Many women used their comments to present alternatives to the medical construction of menopause that dominated much of the questionnaire. Although the set of statements used to measure attitudes to menopause and HRT also reflected the natural discourse of menopause (“Menopause can mark the beginning of a new and fulfilling stage of a woman’s life”), much of the questionnaire was devoted to symptom checklists and HRT, both part of the medical discourse of menopause. Comments made by respondents on this survey can be seen to construct competing approaches to menopause that they felt had not been dealt with sufficiently in the questionnaire. One woman made this criticism explicit by commenting, “I feel very strongly that diet and exercise play a very important part in the lives of mid-life women. I was sorry to find that neither was featured at all in this survey.” The comments analyzed in the present study can be understood as countering the predominantly medical discourse of menopause presented in the questionnaire and more generally in media discussion of menopause (Gullette, 1997).

Although the comments analyzed in this present research were not intentionally collected for interpretation, this does not limit their effectiveness to display the attributions that mid-aged women make about menopause. Banister et al. (1994) stated that unexpected comments from participants might be as interesting as the original intention of the research, and they recommend using these comments to flavor the research. Rather than using these comments to flavor a more
conventional analysis, it was thought that the extent and richness of the women’s comments were sufficient to provide the basis for a separate analysis of the women’s own attributions of menopause.

ANALYTIC METHOD

Discourse analysis was used to investigate the way in which attributions of menopausal experience are constructed and the implications of this construction for menopausal women. Discourse analysis focuses on the construction of accounts and how particular constructions perform certain functions (Potter & Wetherell, 1987). Discourse analysis is used to identify discourses (Lupton, 1992), which might be identified as socially available clusters of themes, ideas, and images that are used together to construct objects. Discourses also make possible different subject positions (Korobov, 2001); these include related rights and obligations for the subject and a location for a person within this set of rights. The subject positions provided by discourses are highly occasioned and situated and need to be considered in the context of the surrounding text (Wetherell, 1998).

Discourse analysis is usually used to analyze spoken discourse and often used for interactional data such as that gathered in individual and focus-group interviews. In this instance, discourse analysis has been used to analyze data written by the participants. The data have been analyzed in their original, written form. Discourse analysis has been used to analyze written materials in the form of textbooks and popular books about menopause (Coupland & Williams, 2002; Palmlund, 1997) and media accounts of menopause (Lupton, 1996; Lyons, 2000). Pharmaceutical brochures (Coupland & Williams, 2002) and advertisements for HRT have also been analyzed (Whittaker, 1998). Although responses to open-ended questionnaire items are not traditional data for discourse analysis, this method has been used before to investigate discourses of race at a predominantly White university (Fraser & Kick, 2000). Responses to survey items might be particularly appropriate for investigating attributions and understandings surrounding highly contested notions such as racial inequality and menopausal explanation. Open-response data loses interpersonal interaction but gains a frankness that might be missing from interactional data. As a result of the anonymity of the situation, these women might provide their personal views with more ease.

Attributional statements contained within the comments written on the questionnaire were not made in isolation but were intertwined with other discursive and social activities. However, due to the range of material included in the comments, preliminary coding was undertaken to focus on those statements with strong, menopause attribution claims. The comments were read and reread to establish the repetitive patterns of attribution made by the participants. This determined
how women accounted for and positioned themselves in regard to the experience of menopause, and it lead to the identification of two main discourses. Once the two discourses drawn upon by these women had been identified, extracts were chosen to exemplify the attributional work that was accomplished within each discourse. Further analysis showed how multiple discourses were negotiated within these extracts.

RESULTS

We identified two discourses that these mid-aged women commonly used to account for their own and other women’s experience of menopausal symptoms. Other discourses were drawn upon in these comments; however, these two were prevalent in attributions of menopausal experience. These discourses were labeled the healthy habits discourse and the get on with it discourse. These discourses were often used together to make complex attributions about the experience of menopausal symptoms. Here, they have been examined separately to uncover how each discourse was used to construct personal responsibility and control in women’s experience of menopausal symptoms. Mid-aged women also drew upon their own experience of menopause to construct appropriate behavior for others during menopause.

HEALTHY HABITS

A prevalent discourse used by these women was based on images of personal control of menopausal experiences through diet, exercise, and positive attitudes. The healthy habits discourse includes words such as active, positive, lifestyle, and healthy. The use of the healthy habits discourse included specific actions required to produce a healthy, happy, symptom-free life. It was particularly common for good diet, adequate exercise, and a positive approach to life to be listed together as a prescription for good health. One respondent stated her ideas of the causes of good menopausal health by explaining,

Healthy lifestyle, and diet Positive attitude and not believing that all the symptoms listed on pg. 4 [of the questionnaire] need eventuate—or can even be attributed to menopause—especially the mental/emotional ones.

This extract shows not only that women constructed the importance of healthy habits in influencing experience at menopause but also that they questioned whether menopause was a factor in poor health. This construction places healthy habits and lifestyle as the most important determinant of women’s experience at midlife. This extract indicates that a woman who is engaging in these healthy habits will avoid most
menopausal symptoms, and that a lack of menopausal symptoms is an indicator of appropriate lifestyle and healthy behavior.

Women also used this discourse to construct the body as an object that can be controlled, cared for, disciplined, and nourished. Mid-aged women were thus seen as not at the mercy of their biology but as able to take an active part in determining their bodies’ response to menopause, as shown in this extract:

"It's very interesting to know how we can progress in life provided that we are positive in our attitudes and take each day as it comes. I am very open minded in all aspects in life and if we take good care of our bodies and treat it with respect and feed with nourishing food we won’t have all the problems that most people had. I am a very healthy 58 years old and I haven’t been to the doctor for 6 years. I don’t get sick and I don’t suffer with any ailment of any sort. Maybe I am lucky! Everything I do in life I do it in a positive loving and understanding way which makes me a better person all round and keeps me out of mischief!"

This extract constructs the body as an object that mid-aged women can care for as if caring for another person. They are able to take good care of their bodies and feed them with nourishing food to encourage healthy behavior. The evidence of this good care is then provided by the outcome of health. The clear link between care and nourishment and the outcome of good health is also provided in this extract. The care provided means that they will not have all the problems that most people have. This constructs the problems that people have as a result of the lack of care of their bodies. In this way, the use of the healthy habits discourse is linked to traditional notions of caring and nourishing others. The healthy habits discourse relates to women’s role as providers of a healthy family environment and is particularly strongly related to healthy diet. Those who employ this discourse are able to present themselves as sufficiently knowledgeable about the relationships between diet and exercise habits and good health. This nourishing of others is then transformed into nourishing the body as an object.

The repertoire of healthy behavior required by the healthy habits discourse was used to construct personal control over and individual responsibility for health and well-being. “It’s up to each individual to take responsibility for our own well-being,” stated one of the respondents. This construction functions to attribute control over health to the individual and serves to attribute blame to others for their ill health, as also shown in this extract:

"I can’t speak for what others know but would be judgmental of the poor fitness levels and prevalence of menopausal ailments/symptoms, lethargy of the general middle-age population."

Here, the link between physical fitness and menopausal health is used to construct menopausal ailments and symptoms as caused by poor fit-
ness. This extract supports the attribution for personal control over menopausal experience.

Following the strength of the evidence presented for the link between healthy habits and good health, it appears inconsistent to acknowledge the role of luck in health. However, the role of luck was commonly mentioned in conjunction with the healthy habits discourse, and acknowledges that an alternative discourse is available, that good health is a matter of chance (e.g., “I am probably one of the lucky ones!!”). The healthy habits discourse in the extract above also acknowledges the role of luck:

I don’t suffer with any ailment of any sort maybe I am lucky! everything I do in life I do it in a positive loving and understanding way which makes me a better person all round and keeps me out of mischief!

This mention of luck seems to undermine the claim that good lifestyle leads to good health. However, the acknowledgment that luck might play a part in health might be understood as an example of rhetorical work that is used to minimize the likelihood that the writer’s argument will be seen as biased (Wooffitt, 1993). The use of maybe presents a weak connection between luck and health that allows the writer to acknowledge the competing attribution for menopausal health without presenting any strong evidence for it. The exclamation mark serves to highlight this phrase. This seems to enhance the writer’s disbelief regarding the alternative discourse she has presented. The exclamation mark also highlights the implausibility of the claim that such exceptionally good health as she experiences could be the result of luck. This is confirmed through the return to her original argument on the importance of an active approach to living. By embedding the recognition of an alternative explanation within her strong argument, the alternative is acknowledged and sidelined. Similarly, another woman describes her good health by stating,

I suppose I’ve been lucky in that respect but if one tries to keep physically well, mentally well and vital to me—spiritually well in yourself.

Here luck is mentioned as an explanation for good health, but then the luck is indirectly attributed to healthy habits. Rather than luck being independent of behavior, it is incorporated into the attributions of healthy experience to healthy behaviors that include exercise, diet, and positive mental and spiritual attitudes to life.

GET ON WITH IT

This discourse was based on images of acceptance and busyness, and it included phrases such as “get on,” “boxing on,” “busy,” and “cope” to
describe women who got on with life during menopause. Phrases such as “sit about” and “dwelling” were used to describe others who were constructed as not getting on with life during menopause. The get on with it discourse is used to suggest that women should overcome their menopausal symptoms by personal willpower. As one respondent suggested, “So cope with the changes and adjust your life style and you’ll be fine.” This construction is not used to deny the existence of symptoms or to prescribe actions to eliminate them, but to assert that those who are unoccupied have the opportunity to dwell on menopause that busy women do not.

This discourse is used to construct the body as separate from the self; the body can be detached from the self through willpower, as is shown in the following:

If ladies can try and forget about their menopause. Get out there and work, find a full-on job or a very full-on hobby. Become involved, or become a caregiver, or clean houses, drive vehicles. In other words, get your mind from your situation. It helps. And before you know it these years have passed.

This constructs the possibility that menopausal experience can be separated from daily activities. Rather than focusing on the limitations that the symptoms provide in different areas of their lives, this constructs the ability to step away from menopause and into other activities.

Women also drew on this discourse to construct menopause and uncomfortable symptoms as inevitable (as constructed by the medical model of menopause) or as what has to happen. However, the response to menopause is within personal control, as in “get on with life and accept it.” In this way, the women who use this discourse both reflect and resist the medical model of menopause. They reflect the notion that negative changes in women’s bodies at menopause are inevitable but resist the medical solution of HRT in favor of activity. The get on with it discourse provides a subject position for a person as someone who focuses on external activities rather than internal states, as shown in the next excerpt. Again, women are constructed as having control, this time over their response to symptoms rather than over whether they experience symptoms.

No use worrying about what has to happen get on with life and accept it, is my thinking. Too busy with work and different organizations to be sitting around dwelling on what’s happening.

This extract shows how the writer has removed herself from the account to demonstrate that she does not focus on herself but is concerned with other matters such as work and organizations that she is
involved with. The writer accomplishes this by not including personal pronouns in the extract. The advice in the extract is framed as general advice to others, rather than a personal account, while simultaneously demonstrating the writer's own active approach to life.

This writer employs the get on with it discourse to draw a picture of that which she is not. She describes someone who is not too busy to focus on menopause but is sitting around dwelling on what's happening. Sitting around presents a strong picture of inactivity when contrasted with the writer's own activity. In this context, dwelling functions as a negative image of inactivity and morbid pondering. Thus the writer is defining herself as one type of person by illustrating another, highly unattractive alternative. The get on with it discourse is used to construct a subject position for women in a moral order in which to be busy and thus avoid experiences of ill health are good, and to be idle will result in an unnecessary focus on symptoms of ill health.

This extract highlights the complexity of discursive attributional work. Edwards and Potter (1994) have argued that a focus on the dichotomy between trait and causal attributions ignores the causal attributional work that might be discursively accomplished through trait descriptions. Here, the writer uses her own menopausal experience to accomplish a trait attribution for others.

The get on with it approach constructs a good woman as active and continually busy. Some women related this to Christianity and helping others at this time of life. For example, one woman stated,

I think menopausal time is stressing for all of us but for the busy person it is easier to forget about the symptoms. I feel being a Christian also helps. If one can lose oneself in one's love for God and care for others more than for oneself and be concerned over other people's hardships, one's own does not feel so bad.

This focus on activity and caring for others might be an attempt to continue a woman's busy life once children have become independent and to encourage women to avoid the personal reflection that might become possible at this stage of life. As one woman explained,

I think my main thing is I have gone from living a very busy life and now have a very quiet life, which does not help when your family is all grown up.

This reflection, made possible by spare time, is constructed as inappropriate and destructive by women who employ the get on with it discourse.

Evidence for the widespread use and recognition of the get on with it discourse was provided by women who refuted it. Accounts of menopause were presented to actively deny the suggestion that it is possible
to ignore menopause and that women should just get on with life. The following excerpt functions to preserve the writer’s sense of personal virtue in response to the get on with it discourse of menopause. Examining this woman’s resistance to the get on with it discourse illustrates her understanding of how the discourse is used to position her as lacking the capacity for a morally acceptable response to menopause.

Personally, I had a miserable menopause which in retrospect I feel I did not seek enough advice and help for it. I did come from the era when you did not complain and got on with things rather, and I wrestled with the fact perhaps it was all mind over matter. But it’s not, it’s horrid. And it is not helpful if you have difficulties finding a job etc (plus one’s aging parents etc) because then the lack of self worth becomes mixed up with the aging of yourself through menopause. It is not all depression and I’m fine now but it has been a fight! I think women need all the understanding and help they can get in menopause.

This excerpt uses this woman’s own position as a subject of the get on with it discourse to warrant her criticism of this construction. The writer presents her own position within this discourse by saying that she got on with things “rather.” This position allows her to present herself as an unbiased evaluator of the attribution for sufferers of menopausal symptoms as those who dwell upon ill health, and it allows her to counter the possible claim that she is merely someone who is continually and historically unable to get on with life.

The same extract uses the metaphor of a battle to construct the active nature of the writer’s approach to menopause. This provides a contrast with the picture presented by the previous excerpt, in which the alternative to getting on with it was sitting and dwelling. In this account, the alternative to getting on with it is presented as a fight. This woman resists the inactive subject position offered by the get on with it discourse. Her account serves to reposition the menopausal subject (herself) as a woman actively engaging with her problems. This alternative to getting on with it constructs menopausal symptoms as a challenge to be faced, not as a sign of a lack of moral behavior, and additionally resists the dichotomy of the body suffering ill health and the virtuous self.

NEGOTIATING MENOPAUSAL ATTRAIBUTIONS

Unstructured attributions show how it is possible to make complex attributions rather than merely attributing events to single causes. These attributions of menopausal experience did not rest entirely on the production of one discourse. It was common for complex positions in multiple discourses to be negotiated within the comments. These potentially incompatible discourses are negotiated with considerable
skill, which functioned to counteract any inconsistencies. The following extract illustrates the use of multiple discourses to support a particular subject position.

I would be delighted with any factual “info” that you might feel would enlighten me in my “ignorance” on this matter. Please do not consider any judgements as skeptical—I have sympathy for ill-health and the misery people must under-go in dealing with what is a “natural process.” So far, luck has been on my side and nothing serious has “dropped off” yet! The “use it or lose it” [if you can] therapy is something of a “commandment” in my work and lifestyle. Is it possible that participants might get some feedback from this survey? I am oblivious of generalizations on how menopause affects other women—my range of contacts is not a fair representation or else I don’t sit about discussing the topic extensively.

The principle discourses employed here are those of menopausal health as luck, healthy habits, and the get on with it approach. This extract begins by positioning the writer as a sympathetic person who understands the misfortune of others and who attributes her own good health to the luck that has been on her side. This acknowledgement of alternative constructions positions the writer as an understanding, nonjudgmental woman. The healthy habits discourse is also indicated by the use of lifestyle and ill health to describe menopause attributions and experience. The writer then undermines the role of luck in good health by suggesting that the use it or lose it approach is related to her own good health. The phrase contained within the brackets (“if you can”) serves to mitigate the strong judgement of others’ experience of menopausal symptoms and acknowledges that some exceptions to this prescription for good health might exist. The use of the word commandment underscores the moral nature of the use it or lose it approach. Finally, this woman uses the get on with it discourse by announcing that those of her acquaintance do not sit about discussing the topic extensively, which reframes her lack of knowledge of others as positive, a sign of her active life, as she does not sit about. This also constructs a negative view of those who discuss menopause with others as discussing the topic extensively, implying ad nauseam. The multiple positions that are negotiated by this woman construct her as a sympathetic, moral, active person whose experience of menopause provides an example for others.

The position that mid-aged women negotiate between these alternative constructions of menopausal experience reflects the extent to which they consider that the healthy habits or get on with it approaches will be appropriate in all situations and will allow them to construct themselves as virtuous social actors in either case. This is also shown in the following extract:
It seems to be a bit of an unknown—I mean it affects people in different ways. I have felt no changes, but then I am a healthy, fit and active person for my age.

This suggests that the experience of no menopausal changes is attributed to this woman's own healthy, active lifestyle. However, the possibility that this attribution might have to be revised is implied. The use of particular attributions involves a complex negotiation among the claim to the virtues of a healthy lifestyle, the demonstration of virtue through a symptom-free body, and avoidance of appearing self-righteous in the prescription of behavior for others in the recognition that menopause affects people in different ways. In addition, there is recognition of an unknown future ("It seems to be a bit of an unknown") in which changes in the experience of menopausal symptoms might reposition a woman within this discourse.

**DISCUSSION**

An analysis of the descriptions of menopausal experience used in questionnaire comments shows how these mid-aged women used socially available, discursive resources to make attributions regarding menopausal experience. The use of the healthy habits discourse suggested that appropriate eating, exercise, and attitude will result in a symptom-free menopause transition, whereas the get on with it discourse was used to suggest that externally focused activity is the key to avoiding menopausal problems.

These two discourses refer to other discourses available to mid-aged women in understanding menopause. As suggested by Parker (1992), discourses presuppose other discourses and draw metaphors and support from each other. The construction of objects within a discourse also creates a position for other discourses. In this way, the healthy habits discourse draws upon aspects of the natural discourse of menopause (Lyons & Griffin, 2000) through the implication that difficulties at midlife can be overcome with nonmedical solutions. As with the natural discourse, there is no place for HRT in controlling distressing symptoms at menopause. The use of the healthy habits discourse goes beyond physical solutions to menopausal problems to include mental and spiritual prescriptions for good health. In contrast to this natural-health approach, the get on with it discourse reflects understandings of the inevitability of menopause as a life stage that are also included in the medical discourse (Hunter & O'Dea, 1997). The use of the get on with it discourse additionally suggests that medication is not the appropriate solution to discomfort. Rather than trying to alleviate the symptoms, the get on with it discourse is used to exhort women to distract themselves from their experience. The interrelationship between
the medical and get on with it discourses provides mid-aged women with the discursive resources with which to construct themselves as virtuous social actors within a moral order which values self-care and work (Williams, 1993).

The women in this sample responded to the predominantly medical construction of menopause presented in the questionnaire. The discourses identified in the present study emphasize personal control over menopausal experience, and they can be seen in this context as resistant to the medical discourse, which focuses on external control of menopause with HRT. These women construct their own and other women’s ability to take control of their bodies rather than succumb to the diminution of the self that is offered by the medical construction of menopause.

Using these two discourses enabled the women writers to attribute control of the experiencing body to the woman experiencing menopause. The subject of these attributions was the woman providing the account, or women in general, or both together, as women provided prescriptions for all women’s health in using their own experience as the example. In attributing control of the body to the subject, women drew on these discourses to describe particular behaviors and experiences as morally appropriate and to position themselves and others without adverse menopausal experiences as virtuous social actors. The moral weight of attributions of symptoms to personal control was further demonstrated in two ways: first, by those women who resisted such attributions for their own experience of adverse symptoms and drew upon alternative metaphors such as the battle to maintain a virtuous position, and second, by women without symptoms who positioned themselves as virtuous actors who got on with it or maintained healthy habits and yet acknowledged the possibility of the experience of ill health for themselves in the future that might then be attributed to luck.

A consideration of multiple attributions from a constructionist perspective must include a recognition of the importance of the social context in which attributions are employed by social actors. Attributions are constructed within particular contexts to serve specific purposes. This study examined attributions for menopausal experience found in noninteractional data. Attributions constructed in different natural settings will attend to the particular purposes of the social interaction. For example, in an interpersonal situation, women are more likely to employ discourses that do not explicitly position other mid-aged women who are present in a negative light. In other words, there is likely to be less overt use of attributions of menopausal health to the unhealthy lifestyle and self-interest of other women. However, the future analysis of interactional data might show evidence of the careful rhetorical work that is managed to accomplish this same positioning.
The social construction of attributions of menopausal symptoms has consequences for the role of the individual in health care. Ogden (1995) has identified three positions for the individual within health discourse: the individual controlling health through self-regulating and self-managing; the individual interacting with the environment; and the individual passively responding to external events. These three positions were also provided in the discourses that mid-aged women drew upon to construct attributions for menopausal experience. The healthy habits discourse was used to construct the menopausal woman as controlling her own health through specific activities and attitudes. This discourse was used to position the menopausal woman as responsible for her health and women with menopausal symptoms as poor self-managers. The get on with it discourse was used to position the individual as interacting with her environment in a way that determines health. Mid-aged women are constructed as agents who have the ability to control the effects of bodily changes at menopause by engaging in diverting activities and refraining from focussing on the self. The menopausal changes might not be alleviated, but the response is within individual control. The alternative discourse, that health is a matter of chance or luck, was used to construct menopausal women as passively responding to the body.

The socially constructed attributions of menopausal symptoms and personal control over physical health might influence health-seeking behavior. Stoller and Kart (1995) found that the symptoms reported to their physicians by older adults partly reflected the respondents' attributions of the cause of these symptoms. Attributing menopausal symptoms to poor self-management (healthy habits) or to morbid self-interest (get on with it) is likely to discourage women from seeking help. Constructing menopausal symptoms as requiring active engagement to overcome is more likely to involve seeking medical assistance.

Health seeking is a social relationship, and it is also important to consider the attributions of menopause within the context of interactions with health professionals. Liao et al. (1994) found that general practitioners were more likely to attribute menopausal experience to family history and severity of symptoms than were mid-aged women, and Gill (1998) found that patients were cautious about providing attributions in medical consultations. The patients were considered experts about their health problems but not about their explanations for these problems. This negotiation of symptoms and attributions and the variety of attributions for menopausal experience among health professionals is likely to influence the nature of women's medical consultations and their satisfaction with such consultation. Understanding the construction of responsibility for menopausal health will allow health professionals to consider the negotiation of a moral identity that is required for mid-aged women to acknowledge difficulty at
menopause. Medical consultation can then be provided in the context of an understanding of the complexity of women’s lives that is broader than that constructed within a medical discourse of menopause.

NOTE

1. The medical discourse of menopause also changes. Recent evidence from a study into the risks and benefits of hormone replacement therapy (HRT) for healthy, postmenopausal women concluded that the risks of HRT might exceed the benefits of this treatment (Writing Group for the Women’s Health Initiative, 2002). This shifting of medical discourses increases the complexity of decision making for women.

REFERENCES


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