CONCEPTUALIZATIONS AND EMBODIMENT OF MENOPAUSE IN NORTHERN ARIZONA: NAVIGATING MEDICALIZATION

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ABSTRACT

CONCEPTUALIZATIONS AND EMBODIMENT OF MENOPAUSE IN NORTHERN ARIZONA: NAVIGATING MEDICALIZATION

CAROLINE SHIRLEY MENDE

By viewing the body within a biocultural context, anthropologists demonstrate how menopause is both biologically and culturally mediated. From a biomedical perspective, menopause refers to the cessation of menstruation in people with biologically female bodies and is associated with a variety of physical, emotional, and psychosomatic symptoms. This thesis examines conceptualizations of menopause in northern Arizona and addresses how people embody menopausal symptoms beyond a biomedical interpretation. Informed by medical anthropological theory, I used a mixed methods approach to address the following research questions: (1) What are the key cultural domains of menopause for people experiencing menopausal symptoms in northern Arizona? and (2) How do people in northern Arizona conceptualize, experience, and embody menopause? Ten people participated in semi-structured interviews and nineteen people responded to free listing exercises about menopause and aging. Participants were between the ages of 41 and 59 and were predominantly white, financially well off, and married. All participants reported female/woman gender identities. All participants were asked questions about their demographic background, general health, and reproductive health via a Demographic and Health Survey. Findings suggest that menopause is a medicalized experience that participants associate with aging. Participants navigate medicalization by reframing their experiences through acceptance of change. This research provides an updated look at the biocultural relationship between meanings of menopause and embodied experiences and is pertinent to the medicalization of the female body and medical violence experienced by women and female-bodied people in medical settings. Findings are relevant to both public health interventions and medical training regarding menopausal bodies.

ACKNOWLEDGMENTS

To my committee members – Dr. Liebert, Dr. Hardy, and Dr. Parsons – thank you for your support and encouragement throughout the thesis process and the MA program.

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DEDICATION

This thesis is dedicated to my grandparents – Donald Carlisle Reusch (1923-2022), Virginia Bradshaw Reusch (1929-2019), Shirley Vaughn Mende (1932-2022), and Robert Haas Mende (1932).

CHAPTER 1: INTRODUCTION

The Need for Research on Menopausal Experiences and Understandings

Assuming people live long enough, menopause – whether natural or medically induced – is a universal biological experience for people with menstruating bodies. The general lack of current research and discourse about the multifaceted experience leads to a dearth in understanding of menopause. As previous anthropological work has shown, menopause is culturally varied. This thesis project provides insights into individual lived experiences of menopause, the cultural factors that influence the menopausal experience, and how these cultural factors are embodied by menopausal people.

Much of the foundational anthropological literature on menopause is from the 1970's-1990's, with fewer recent studies. Cross-cultural studies focusing on populations in different cultures around the world have illustrated variation in the menopausal experience. However, limited attention has been given to variations in menopausal experience specifically within the US – a culturally and socioeconomically diverse country. As such, this thesis fills a gap in the literature by providing insight into a localized case study of menopausal experiences in northern Arizona. Findings reflect what menopause currently looks like for a particular subset of people living in this region of the US. Northern Arizona is a geographically and socially diverse region and this thesis provides insight into one subsection of the community.

The anthropological lens provided in this thesis addresses the cultural and social aspects of menopausal experiences. Cultural and social research provides insight into the embodiment of menopausal symptoms that is often overlooked in medical and public health research. Further, as a medical concept, menopause – and the female body/women's health – is often neglected, misunderstood, and overly medicalized, obscuring the nuanced embodiment that many people

experience during menopause and contributing to "medical violence." While the medical field is typically framed as a system that seeks to help people, medical violence occurs because of unequal – and often unacknowledged – power structures between medical professionals and those who they treat. Because of how medical care is framed through a focus on biomedical information, social aspects of health and illness are often overlooked. Medical violence results in erasure of autonomy and dignity (Shapiro, 2018). This process can contribute to stigma and a lack of empowerment in people who seek medical care. In the context of female bodies, medical violence is illustrated by the high C-section and maternal mortality rates in the United States, particularly for Black women who face medical racism (Campbell, 2021). By filling a gap in the understanding of menopause, this thesis addresses the need for more research on the variation of experiences of the female body and how culture and social structures – and structures of power – influence this experience.

This research is critical because it provides insight into the medicalized experience of menopause as a part of women's/female-bodied reproductive health. Because the findings show that peoples' needs – physical, emotional, and social – are not being met regarding menopause, this research supports the need for anthropological research on menopause. Further, this study establishes a base for continued research, including cultural modeling using cultural consensus and consonance methods.

Guiding Questions and Study Design

Menopause continues to be a taboo subject for many people. Like menstruation, many people shy away from discussing menopause and consider it a private topic, one that is not acceptable to talk about in public discourse. As such, this thesis seeks to understand how people

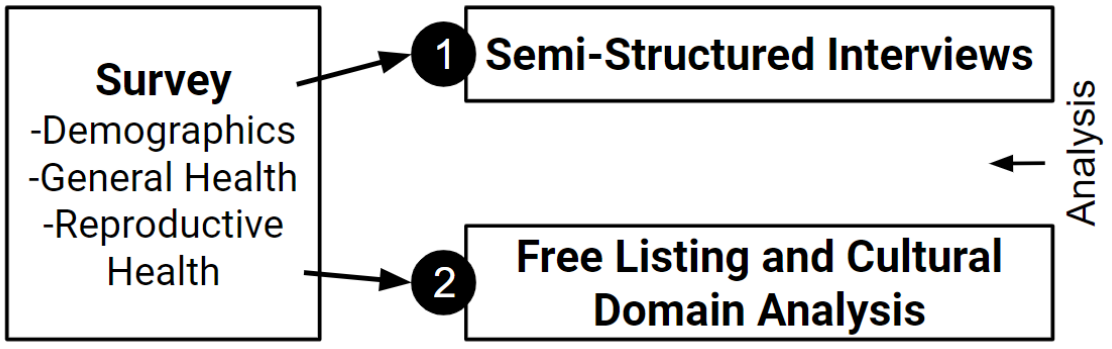
think about menopause: what's the cultural model for menopause? How is the menopausal experience in northern Arizona – a community that spans a wide geographic area and is home to people who are culturally, socioeconomically, and politically diverse – culturally informed?

To fill in gaps in the literature on current menopausal experience and to guide my research, I developed the following research questions: (1) What are the key cultural domains of menopause for people experiencing menopausal symptoms in northern Arizona? and (2) How do people in northern Arizona conceptualize, experience, and embody menopause?

Phases of Study: Mixed Methods

To address the guiding questions, I used a mixed methods approach carried out in several phases where the different data sets complement each other. Semi-structured interviews in Phase I informed free listing and cultural domain analysis carried out in Phase II. A Demographic Survey – informed by a biocultural synthesis framework and prior findings on menopausal experiences – provides contextual data for both phases (Figure 1).

Figure 1
Phases of study



Theoretical Frameworks

All phases of this research are informed by theories from medical anthropology, insights regarding the process of medicalization, biocultural synthesis, and concepts from cognitive anthropology – specifically cultural domain analysis and theory. I stress the importance of culture as a key component of understanding health and the body. Further, placing health in a cultural context is critical for improving menopausal experiences and implementing successful public health interventions.

Medical Anthropology and Critical Medical Anthropology

In 1982, medical anthropologist Allan Young argued that ideas about the body and health/illness are culturally mediated, stating that, "*all* knowledge of society and sickness is socially determined (Young, 1982, 277)" and that the role of medical anthropology is to understand how medical knowledge is culturally and socially seated. As with other focus areas in anthropology, the goal is to understand how knowledge is produced (Young, 1982). This perspective provides a general background for understanding the field of medical anthropology and some of the discipline's areas of disagreement. Further, *critical* medical anthropology places health and the body in the context of power dynamics. Baer et al. (2003) describe the critical perspective as one that functions from "the belief that social inequality and power are primary determinants of health and health care (Baer et al., 2003, p.3)."

As the editors of *Knowledge, Power & Practice: The Anthropology of Medicine and Everyday Life,* Lindenbaum and Lock frame medical anthropology as the intersection of human biology, the cultural construction of knowledge, and relations of power. They acknowledge the divide between medical anthropologists who accept biological and biomedical data as natural

facts from those who place all medicalized knowledge in a socially mediated context (Lindenbaum & Lock, 1993). In defining medical anthropology, the Society for Medical Anthropology states that the discipline "draws upon many different theoretical approaches. It is as attentive to popular health culture as bioscientific epidemiology, and the social construction of knowledge and politics of science as scientific discovery and hypothesis testing. Medical anthropologists examine how the health of individuals, larger social formations, and the environment are affected by interrelationships between humans and other species; cultural norms and social institutions; micro and macro politics; and forces of globalization as each of these affects local worlds (SMA, 2013)." This more recent approach incorporates multispecies understandings and globalization, concepts that are becoming more pertinent to the field of anthropology. Reflecting on the history and development of medical anthropology, Panter-Brick & Eggerman (2018) frame medical anthropology in four areas that characterize the contributions of discipline:

1. Critical enquiry: offering depth of interpretation
2. Global practices: championing cross-cultural breath
3. A people-centered approach to health
4. Transdisciplinary innovation

The authors conclude that "medical anthropology sits at the intersection of the humanities, social sciences, and biological sciences (Panter-Brick & Eggerman, 2018, p.237)."

While medical anthropologists use different approaches and adhere to various perspectives regarding how the body, biology, and medical knowledge are framed, the broad focus is on how culture interacts with the body, health, illness, and medical systems. This case study is guided by a medical anthropological standpoint in that it addresses a biologically

informed process that is culturally mediated. A biocultural synthesis, addressed below, situates these two areas in conversation with one another to understand the interplay between medical/biological understandings of menopause, culturally mediated experiences of menopause, and how the medicalization of menopause influences the menopausal experience. The critical medical anthropology lens is useful in that it addresses the socially informed power dynamics that influence the medicalized experience of menopause.

Medicalization

Medicalization is a powerful framework for understanding how bodies are framed in medical settings. Through this process, bodies, behaviors, and conditions are treated as pathologies and diseases. Medically speaking, they can then be studied with the intent to treat or cure (Guthman, 2011). As a culturalized process, medicalization can occur in response to changing social norms, bureaucratic organizations, and cultural conceptualizations of gendered practices (Utz, 2011b). While medicalization can be useful – many people find relief through diagnosis and treatments – it can also transform conditions into medical issues (Guthman, 2011). Through socialized forces the body is pathologized by the process of medicalization. Both anthropologists and sociologists have addressed the medicalization of childbirth (Brubaker & Dillaway, 2009). Writing on the changing distinction between "nature" and "medical," Brubaker & Dillaway (2009) note that because clinical researchers have historically had difficulty defining childbirth (in addition to pregnancy, conception, menstruation, menopause, and breastfeeding), childbirth becomes framed as a biological event that is considered "natural." By defining this process as a "natural" biological process, the medical field has culturally equated it with illness as something that differentiates from the norm. This process of medicalization of the female

body has been linked to the historical male control of scientific inquiry (Brubaker & Dillaway, 2009).

Biocultural Synthesis

In this study, I use a biocultural synthesis to understand how participants embody their social understandings of menopause. This framework is useful for medical anthropology and health-related research because it traverses the theoretical and methodological gaps between biological/scientific and cultural/humanist perspectives (Leatherman & Goodman, 2019). Through a biocultural synthesis, researchers engage with the feedback and connections between biology and social factors and can draw from biological, medical, behavioral, and social methodologies (McDade & Harris, 2018). A biocultural synthesis therefore offers insights into the effects of political economies and power structures on health (Leatherman & Goodman, 2019). Dressler (2005) articulates the usefulness of the integration between biology and culture and notes that the biocultural perspective, as a study of embodiment, connects culture to the individual:

> …a biocultural perspective is a study of embodiment in a very specific sense. It is the study of how experience gets written on the body in terms of measurable physiological, psychological and even morphological outcomes (Dressler, 2005, p. 24).

Building on this approach, the concept of "local biologies" illustrates the cyclical relationship between culture and biology in succinct locations, times, and populations (Lock, 1998). Lock (1998) uses the concept of local biologies to understand menopause – or more accurately *konenki* – in Japan. Additionally, a biocultural approach is useful for longitudinal

studies when assessing how early life histories influence later health outcomes (McDade & Harris, 2018).

Ethnography is a key method in the biocultural approach (Leatherman & Goodman, 2019). As a theory and methodology, bio-ethnography (i.e., the integration of ethnography and biomedical research) provides a nuanced understanding of health – particularly for groups that are socially disadvantaged and under-represented in scientific research – than either approach alone. By tying ethnography into biomedical methodology, researchers can assess multiple environmental factors that contribute to biological changes and differences (Lock et al., 2021). In the context of menopause, these approaches illustrate how social (e.g. gender roles, ideas about the body, etc.) and other environmentally informed factors (e.g., socioeconomic status, diet and exercise habits, healthcare options, etc.) may contribute to understandings of menopause, the experience of different symptoms, and cultural models of menopause.

Cognitive Approaches to Anthropology

Drawing from cognitive psychology, early cognitive anthropology was known as ethnoscience. Researchers in this area focused on understanding cultural systems of classification such as kinship patterns and folk taxonomies that outline how people categorize plants and animals. This approach developed into what is now referred to as cultural domain analysis, or CDA (Negrón, n.d.). Cultural domain analysis is used to identify how groups of people conceptualize various aspects – referred to as domains – of their world. Free listing is a common technique used in domain analysis where participants are asked to list as many words, terms, or phrases that they associate with a particular domain (Bernard, 2006; Gravlee et al., 2013). As a theoretical framework, CDA will help to establish how participants think about and

conceptualize menopause. This is useful because it provides information about shared ideas and understandings regarding menopause. This shared meaning can then be linked to individual embodiment of menopausal symptoms.

Culture: A Crucial Concept in Health Research

Lastly, this thesis approaches menopause from the perspective that culture is a critical concept for health research. Panter-Brick & Eggerman (2018) illustrate the effectiveness of medical anthropology in the context of cross-disciplinary partnerships, particularly in the areas of food and water insecurity, global mental health, and stress research. Frequently used within the field of public health, the social determinants of health framework articulates the relationship between health and social factors. Social determinants of health are nonmedical factors such as health-related knowledge, attitudes, beliefs, behaviors, and "upstream" causal factors like economics (Braveman et al., 2011). While this framework is useful in many contexts, Yates-Doerr (2020) argues that the social determinants of health model can incur unintended and harmful outcomes, partially because the framework treats sociality as fixed and stresses the more holistic approach to understanding how "social," "determinants," and "health" interact that anthropological inquiry provides. While this research is oriented towards public health audiences in addition to social scientists, I apply an anthropological lens rather than engaging with the social determinants of health framework for this reason.

Kagawa Singer et al. (2016) further the discussion of culture as an essential piece of health research by outlining how to better incorporate culture as a concept into study designs. The authors define culture as "Culture is an internalized and shared schema or framework that is used by group (or subgroup) members as a refracted lens to "see" reality, and in which both the

individual and the collective experience the world (Kagawa Singer et al., 2016, p.242).” This shared schema is related to the process of medicalization in that the shared understanding of medical care (socially reproduced through medicalization) influences the types of care that people seek. In a way, medicalization as a culturalized process generates embodied experiences of menopause. To begin to operationalize culture more effectively in health research contexts, researchers should acknowledge group heterogeneity and account for factors at the social and group level – areas that are often disregarded in biomedical research that is oriented at the individual level (Kagawa Singer et al., 2016). This analysis of menopause as a health concept operationalizes culture by assessing structural influences and recognizing variation in lived experience.

Ethnographic Background: Flagstaff and Northern Arizona

Designed as a case study, this thesis provides insight into menopausal experiences in a specific population in a region that is demographically distinct and diverse. As such, I recruited participants from Flagstaff and the general region of northern Arizona. Because Flagstaff is located in Coconino County – geographically the second largest county in the contiguous United States (Coconino County Health and Human Services, 2021) – demographic information about this community provides context for the study participants. 39.1% of Coconino County is Tribal land including all or portions of the Navajo Nation, Hopi, Havasupai, and Hualapai Reservations. 27.2% of the county is Forest Service land (Coconino County Health and Human Services, 2022).

In 2021, the county’s estimated population was 145,052 (Coconino County Health and Human Services, 2022). The following demographic numbers are from 2017 unless otherwise

stated. 63.6% of the Coconino County population was White, 26.6% Native American, 2% Asian/Native Hawaiian/other Pacific Islander, and 1.4% Black or African American. An additional 6.4% of people reported being two or more races. The ratio of Hispanic/Latino people to non-Hispanic people was 13.9%. Proportions of people from various races and ethnicities vary widely throughout the county. For example, Flagstaff is a predominantly White community whereas Tuba City is predominantly Native American. People between the ages of 40-59 – the age range that includes people who participated in this study – made up roughly one fifth of the population of Coconino County. Females slightly outnumbered males in the 40-44, 45-49, 50-54, and 55-59 age ranges (Coconino County Health and Human Services, 2021).

In 2017-2018, 21% of people in Coconino County were living below the poverty line. In Flagstaff, high poverty rates are related to high rent and low paying jobs (Coconino County Health and Human Services, 2021). The median household income in 2018 for Coconino County residents was just under $60,000, slightly below the national median and roughly the same as the Arizona median. 89.7% of Coconino County residents had at least a high school degree and 35.4% had at least a bachelor's degree; both rankings are higher than the state averages of 86.5% (high school or higher) and 28.4% (bachelor's or higher). The county has higher levels of poverty for all education levels than Arizona overall even though there is a higher level of educational attainment. Also in 2017, 86.3% of Coconino County residents had health insurance coverage, lower than the state and national averages of 87.8% and 89.5%, respectively (Coconino County Health and Human Services, 2021).

Format of This Thesis

Following this introductory chapter are five additional chapters. Chapter Two introduces literature regarding previous social science research on menopause and biomedical understandings of menopause. In Chapter Three I present the methods used for data collection and analysis and in Chapter Four I discuss the key themes and findings from each phase of study. Chapter Five is a discussion of the findings where I compare, contrast, and synthesis the results from the different phases. Chapter Six concludes the thesis with final thoughts and applications of the research. Figures and tables are presented throughout the document. Data collection tools are included in the Appendices at the end of the document.

Statement on Ethics

Prior to carrying out research I considered the ethical implications of my research. To make the experience reciprocal I provided monetary compensation to all participants. To minimize distress to participants – health, and women's health in particular, is a personal and private matter for many people – I considered questions that might be uncomfortable to participants and presented these in a thoughtful manner. If a participant seemed particularly uncomfortable talking about a topic during an interview, I changed the direction of the discussion. Keeping in mind the continuing health risks associated with COVID-19 and peoples' varying abilities to change their schedules and meet in person, I offered video and phone interviews as an alternative to meeting in person. Lastly, this thesis was fully approved by Northern Arizona University's Institutional Review Board and all participants signed a consent form before engaging in research activities.

Additionally, I note that my position as a white, educated, heterosexual woman placed me in a relatable context to the interview participants of this study. The recruitment strategy also reflects the willingness of participants to talk about their menopausal bodies. Most participants were forthcoming with information and wanted to share their experiences, often hoping that by participating in the study they may help other women more easily navigate menopause in the future. Overall, only one interview participant showed minor discomfort during the interview, and I chose to pursue a different question that the participant responded to positively. The slightly more diverse makeup of the free listing exercise participants – which included some of the interview participants and was administered online – suggests that a self-guided approach to data collection may be more useful for attracting a more varied group of participants.

CHAPTER 2: PERSPECTIVES ON MENOPAUSE – SOCIAL SCIENCE AND BIOMEDICAL FRAMEWORKS

In this section I outline previous research on menopause. By viewing the body within a biocultural context, medical anthropologists demonstrate how menopause is both biologically and culturally mediated. The holistic lens of anthropology fully integrates the body, biology/medical knowledge, and cultural/social factors and treats these components as a unified amalgamation. Evolutionary and human biologists approach the body from a cultural perspective and assess relationships between culture, behavior, and the environment to address impacts on health (UNC Chapel Hill, 2023). These anthropological perspectives are in contrast with the biomedical perspective which approaches the body and health through a more reductive perspective (Baer et al., 2003).

From a biomedical standpoint, menopause refers to the cessation of menstruation and is associated with a variety of physical, emotional, and psychosomatic symptoms (National Institute of Health, 2021). While menopause is sometimes considered in studies focusing on the climacteric, aging, and gerontology, it is a distinct process (Flint, 1982). Recognizing the constant connection between the social and the biological, this chapter outlines background information in two main areas: (1) biomedical perspectives, and (2) anthropological perspectives. Biological understandings span both areas, but interpretation is different in biomedical and anthropological fields.

Biomedical Perspectives

Western medicine commonly refers to menopause as the transitional period when a biological female stops menstruating and er ovarian function declines – a process that takes two

or more years (Flint, 1975). True menopause, according to this definition, occurs when a person's period has ceased for a full twelve months. Perimenopause is the stage leading up to menopause when levels of estrogen and progesterone begin to change. Postmenopause begins once the twelve month point is reached. People typically begin the menopausal transition between the ages of 45-55 and reach postmenopausal status after about seven years, although some people take up to fourteen years to reach full menopause (National Institute of Health, 2021). Menopause occurs during the climacteric, which refers to the transition between childbearing and senescence (Flint, 1975). Longitudinal studies of menopause place this experience in the context of middle age and aging (Flint, 1982).

From a biomedical perspective – one that is inherently medicalized – physical symptoms typically associated with menopause – and experienced during perimenopause – include cold, moist, and numb extremities, chills, palpitations, headaches (including migraine), vertigo, fatigue, arthralgia, dizziness, and various gastro-intestinal complaints. Emotional symptoms include nervousness, irritability, jealousies, depression, and self-depreciation. Some people also experience insomnia during menopause (Flint, 1975). Cognitive decline, changes in memory, and memory problems also occur during the menopausal transition and correspond with decreased estrogen (Sliwinski et al., 2014). These biomedical framings do not account for how they are culturally developed and are often based on historical and male-focused understandings of the body (Merone et al., 2022). This perspective and biomedically informed terminology – particularly jealousies and cognitive decline – can be stigmatizing and do not illustrate the full menopausal experience.

Anthropological Perspectives

This section outlines various approaches that biological, biocultural, and sociocultural anthropologists as well as paleoarchaeologists have used to study menopause. Because of disciplinary differences, some of these framings do not fully align with each other. Three biologically/bioculturally-oriented frameworks relating to human biology – evolutionary, developmental, and comparative – have frequently been used to address menopause through an anthropological lens. I begin this section by providing general background information on these three frameworks to provide context for how anthropologists from various subdisciplines have approached menopause. I then go into more detail and describe research that has used the biocultural approach as an anthropological lens for inquiry into menopausal experiences. Sociocultural and medical anthropological methods, including participant observation, holistic approaches, cross-cultural perspectives, and synchronic and diachronic analysis have also been applied in menopausal research. These perspectives complement the medical study of menopause (Flint, 1982). In the last section I address literature drawing from these perspectives and outline how locally-situated cultural interpretations of menopause, menstruation, and the female body inform attitudes towards menopause and those who experience this transition, as well as the full menopausal experience.

Human Biology

Evolutionary Perspectives

The evolutionary perspective explores menopause as a biological process (Sievert, 2014b). Evolutionary frameworks from archaeology and biological anthropology have been used to examine menopause. Paleoarchaeological findings based on fossil evidence suggest that

menopause and post-reproductive life evolved in the *Homo sapien* lifespan approximately 2.8 million years ago (Shaw, 2004). While earlier hypotheses suggest that menopause resulted from natural selection to increase life span via the conclusion of reproduction, recent studies indicate that menopause may have evolved because both selective pressures and reproductive value decline at older ages, thereby reducing reproductive potential with increasing age. Throughout life, female bodied people lose primary oocytes (i.e., ovarian follicles that mature into fertilizable eggs) due to the process of atresia. By 40-50 years of age – near the age of menopause – the ovaries no longer have enough primary oocytes or the necessary hormones (e.g., follicle-stimulating hormone and estrogen) to stimulate a mature ovum. Throughout human and hominin history, lifespans did not typically last long enough to reach this level of atresia. As the human lifespan has increased, researchers have hypothesized that this process has become more visible. As a biological process, menopause therefore results from atresia throughout the extended female lifespan (Crews & Ice, 2012). Like biomedical framings, these perspectives typically treat the cultural and biological as distinct factors.

Developmental Perspectives

Focusing on health and disease, the developmental perspective examines how early life environments affect later life outcomes (Sievert, 2014b). As of the 1970's, most studies exploring reproductive function in biological females focus exclusively on menarche, while little research had been completed on menopause. Flint's (1974) dissertation research assessed several factors that influence age of menopause – focusing primarily on altitude – and comparing generations of women (mothers/daughters). Additional factors included genetics, secular trends, seasonality, behavior associated with menstruation, socioeconomics, problems during

menstruation/pregnancy/menopause, and lactation habits. Flint found that early age at menarche did not lead to a late age at menopause (Flint, 1974).

This work highlights the utility of life history theory for approaching developmental perspectives on menopause experiences because it posits that investment in reproductive function at different points over the course of life affects disease and longevity outcomes. For example, Jasienska et al.'s (2017) study on menstruation illustrates how food access (high versus low availability) and other factors influence the timing of menarche and menarche cycles. Menarche then influences reproductive physiology and patterns throughout life that lead to different health risks for groups with high or low availability of food (Jasienska et al., 2017).

Comparative Perspectives

Because menopause is based on biomedical ideas of science that are culturally mediated (Lock, 1998), cross-cultural and comparative studies of menopause illustrate differences in menopausal symptoms and experiences in different populations (Sievert, 2014b). Despite the medicalization of menopause (Lock, 1998; Voicu, 2018), many studies have illustrated that menopausal symptoms vary in different cultures and populations (Flint, 1974; Lock, 1994a, 1994b, 1998; Sallam et al., 2006; Stewart, 2003). Specific examples of findings from comparative studies are outlined in the *Biocultural Perspectives and Culturally Informed Attitudes Towards Menopause* sections, below. While menopause is experienced as bodily and emotional changes that are denoted as symptoms, *interpretations* of these experiences are cultural and vary by culture. A biocultural approach is useful for analyzing menopause across cultures and populations because it exposes how biological phenomena and social factors interact (Leatherman & Goodman, 2019; Lock, 1998; McDade & Harris, 2018). The conceptualization of

"local biologies" explains this interaction as a feedback loop and acknowledges variations within both biological and cultural processes (Lock, 1994a). Because of these variations, it is critical for study instruments and research methods to account for cultural differences (Sievert, 2014a).

Biocultural Perspectives

Research presented in this section acknowledges the social components that influence variation in menopausal symptoms and experiences. Research by Marcha Flint, Margaret Lock, and Lynnette Leidy Sievert is particularly pertinent as these researchers have approached the cross-cultural and biocultural dimensions of menopause through anthropological inquiry. Several studies have shown how culture influences both physical and emotional symptoms of menopause (Lock, 1994a; Sallam et al., 2006; Sievert, 2014a; Stewart, 2003). Clinical assessments that typically use biomedical metrics and infrequently account for culture suggest that smoking habits, alcohol consumption, diet, reproductive history, body mass index (BMI), physical activity, socioeconomic status, and physical and psychosocial stress-related factors can influence menopausal symptoms (Sievert, 2014a). Additionally, Jasienska et al. (2017) illustrate how food access influences reproductive health throughout life. In their study of Japanese konenki – a concept similar to but not synonymous with menopause – Lock (1994a) describes the biocultural setting for the following symptoms: shoulder stiffness, lumbago, sore throat, heavy feeling in the head, ringing in the ears, edema, lack of sexual desire, loss of appetite, and exhaustion.

Menopause occurs at different ages for different people, and age at menopause is culturally and biologically influenced (Flint, 1974; Sallam et al., 2006; Sievert, 2014b). A variety of environmental, lifestyle, and health-related factors influence age at menopause including altitude, genetics, secular trends, seasonality, participant behavior associated with menstruation,

socioeconomics, problems during menstruation/pregnancy/menopause, lactation habits (Flint, 1974), age at last delivery, residence (urban or rural), pattern of menstrual cessation, and duration of oral contraceptive use (Sallam et al., 2006). Further, childhood stress, disease, and socioeconomic status are factors that affect age at menopause (Sievert, 2014a).

Hot flashes are a common symptom of menopause, although they are also experienced by postmenopausal women (Gerber et al., 2007). This symptom varies across populations (Lock, 1994b, 1998; Sievert, 2014a); as of the early 1990's, there was no known word for "hot flash" in Japanese (Lock, 1994a). In the US where self-reported hot flashes are ostensibly common, they have been shown to have an adverse effect on cardiovascular health (Sievert, 2014a). Hot flashes are associated with elevated waking and sleeping systolic blood pressure (BP), independent of whether women are menopausal. Sievert (2014a) notes that people in different cultural groups are inclined to pay differing amounts of attention to hot flashes as a medicalized symptom.

Culturally Informed Attitudes Towards Menopause

Lastly, this section presents findings on cultural attitudes regarding menopause. In addressing menopause in American culture, the findings in Utz (2011) is relevant to this study's examination of menopause in northern Arizona. By examining generational differences between two cohorts – baby boomers and their daughters – Utz (2011) found that the definition of menopause has changed from a naturalized perspective and is increasingly more medicalized. Older participants were more likely to consider menopause an inappropriate topic of discussion while the younger cohort discussed fears of aging and losing control. Utz (2011) links the desire to control the aging process to social and economic changes that have resulted in a wide range of products and resources to assuage the transition to old age. Cultural acceptance of medicalization

led participants to change how they define and navigate (by attempting to prevent or accepting changes) menopause Utz (2011).

Drawing from comparative studies, cultural perspectives on menopause vary broadly and, in some cases, influence symptomatic outcomes. The value placed on fertility and religious beliefs inform attitudes towards menopause. For example, those who see menopause as a natural process are more likely to use "natural" therapies. Menopause may alter opinions on what is considered sexually appropriate. For example, in religious contexts where there is social agreement that the aim of sex is procreation, menopausal people may stop engaging in sexual activity. Additionally, women with negative perspectives on menopause often report more symptoms (Sievert, 2014a). Sallam et al. (2006) note that Egyptian women reportedly suffer from higher rates of menopausal symptoms than Western women. This may be influenced by cultural conceptions of health that discourage people from claiming that they are ever completely healthy (Sallam et al., 2006).

Historically, menopause has been viewed negatively by Western societies (Voicu, 2018) including the US (Flint, 1975). Medicalization of this biological phenomenon has influenced discourse on the experience. Due to the development of artificial estrogen, menopause was addressed as a disease in the mid-20th century (Voicu, 2018), and it is frequently framed as a "deficiency" or as ovarian "failure" (Lock, 1998). While anthropologist have argued against this framing and leveraged critiques regarding the use of the words like "failed" and "deficient" to refer to this regular bodily process (Lock, 1998; Martin, 1988), negative tropes of menopause continue to shape stereotypes of middle-aged women (Voicu, 2018). In the 1970's and 1980's, menopause was reclassified as a natural phenomenon associated with uncomfortable physical

and psychological symptoms (Voicu, 2018). As of the 1990s, researchers commonly referred to menopause as a "hormonal imbalance" (Lock, 1994a).

While menopause is viewed negatively in the US, many cultures honor postmenopausal women and accompany this physiological change with a positive change in social status (Flint, 1975). For instance, rural Mayan women in Guatemala and Mexico reported viewing menopause as a liberating experience. Women from both groups expressed happiness at the prospect of no longer having their periods (Stewart, 2003). Conversely, many of the Japanese women interviewed in *Encounters with Aging: Mythologies of Menopause in Japan and North America* (Lock, 1994a) viewed menopause – roughly translated by the concept of kōnenki – with ambivalence. In my thesis I draw from this foundational literature to frame my examination of menopause and build on the biocultural, sociocultural, and medical anthropological approaches to provide updated and nuanced insight into menopausal experiences.

CHAPTER 3: METHODS AND ANALYSIS

I carried out my research in two phases using three types of data collection: Demographic and Health Survey (administered to all participants), semi-structured interviews (Phase I), and free listing exercises (Phase II).

Recruitment

To recruit, I used several approaches. I began recruiting by posting IRB approved flyers on public bulletin boards around Flagstaff, Arizona. I also reached out to community organizations, organizations focused on women's health, and doctors' offices to ask if they would assist in sharing the flyer. This type of recruitment was largely unsuccessful, so I moved to online recruitment. I posted the flyer in various community Facebook groups and on the Nextdoor app. In addition to sharing the flyer online I shared the document with people in my own network who are around the typical age of menopause and asked them to share the flyer and research opportunity with people they knew.

Compensation and Project Funding

Funding for participant compensation was provided by the Ray A. Madden Research/Internship Award. Interview participants received a $50 Visa Gift card that was either given to them in person or mailed to an address supplied by the participant. Survey participants received a $10 digital Fry's Food Store gift card that was emailed to them. During in-person interviews I offered participants water and snacks. I also used funding to pay for participant parking when I conducted interviews on the NAU campus.

Demographic and Health Survey

Developing and Administering the Survey

Each participant completed a Demographic and Health Survey – generated in Qualtrics – prior to their interview or taking an online survey. During interviews I administered the survey directly to participants and recorded their answer for them or shared a link to the survey and had the participant record their own responses and ask questions as needed. Participants in the online survey were prompted to respond to the demographic questions after completing the consent form and prior to taking the free listing survey. During the interviews – where participants were able to ask questions during the survey – I found that some of the questions lacked answer options (for example, an adoption option in questions regarding pregnancy) or needed clarifying. I implemented minor updates to the survey to make it more user friendly for survey participants who would not have the option to ask clarifying questions during the survey.

I developed the Demographic and Health Survey after reviewing survey tools from PhenX Toolkit, an online database of standardized data collection protocols used in biomedical research (RTI International, 2023). The survey includes questions about general demographics (age, gender, income, education level), general health (exercise and diet habits), and reproductive health (contraception use, pregnancies, menopausal symptoms). The last section of the Demographic Survey includes the Menopause Rating Scale (MRS). This tool, developed in the 1990s and available in multiple languages, is a standardized scale used by patients (rather than physicians) to measure the effect of aging related symptoms on their quality of life (Heinemann et al., 2004; ZEG Berlin, 2022). Heinemann et al. (2004) conducted a methodological review of the MRS and found good test-retest reliability. Researchers can confidently make comparisons between Europe and North America/the United States but should use caution when conducting

cross-cultural comparisons between Europe/North America and Latin America and Asia/Indonesia (Heinemann et al., 2004; ZEG Berlin, 2022). This is a useful tool for this study as participants are all located in North America and have spent most of their lives here, as demonstrated in the survey. See Appendices A and B for a full list of Demographic and Health Survey questions.

Analyzing the Survey

I used Excel and SPSS to calculate frequencies and other descriptive statistics. To calculate age, I entered participants' reported birth month and year into an age calculator website. To calculate the cumulative scores for the Menopause Rating Scale I added all the scores for each of the 11 symptoms. If a participant did not respond to a symptom question, I did not include them in the final cumulative score. One participant did not respond to any of the Demographic and Health Survey questions, and I removed them from the analysis.

Several questions presented challenges during this step. For example, the question "Approximately when did you start experiencing symptoms associated with menopause (even if you are not currently experiencing symptoms)?" – intended to elicit information regarding perimenopausal, menopausal, or postmenopausal status for individuals who are unfamiliar with these designations – generated a wide range of response types. This illustrates one of the difficulties of researching menopause as a varied experience that is not understood biomedically (in respect to the different phases) by everyone who experiences symptoms.

Semi-Structured Interviews

Interview Guide Development

I used a semi-structured interview approach to conduct interviews which involved creating an interview guide to inform the flow of the interviews. This type of interview allowed me to generate comparable data across participants while leaving room for individualized probing (Bernard, 2006). Prior to beginning my thesis research, I developed the interview guide and carried out three pilot interviews to test the questions and get feedback on how effective the questions were at assessing menopausal experiences. These interviews were not IRB approved and the data collected during these discussions – as part of an Ethnographic Methods class – is not included in this thesis research. I made several alterations to this pilot interview guide and used the new document to guide each interview for this study.

Conducting Interviews

I conducted semi-structured interviews with 10 participants. I met with four people in person in the NAU Anthropology Laboratory and conducted the other six interviews over Zoom or other video conferencing platforms. During each interview I asked questions in five main domains: (1) Perceptions of Menopause, (2) Perceptions of Womanhood, Women's Roles, Motherhood, (3) Perceptions of Aging, (4) Symptoms: Physical and Emotional, (5) Treatment: Medical, Alternative, etc. See Appendix C for the full Interview Guide.

I recorded all interviews using the recording application on my cell phone. I then transferred the recording files to my computer and transcribed each interview into a Word document. During transcription I made note of where the participants laughed, paused, or seemed

uncomfortable or hesitant to capture the tone of the conversation. Because I asked the same questions in most of the interviews, I paraphrased some of my own dialogue.

Because of the project design – interviews informing cultural domain analysis – I did not interview participants until I reached full saturation, but believe I began to approach saturation with the tenth interview. While some concepts became patterns across participants there were some ideas that were discussed by single participants, suggesting that there may be additional viewpoints that were not covered in the ten interviews.

Coding and Analyzing Interviews

Beginning with an immersion crystallization approach (Borkan, 2022), I generated an initial list of codes based on themes that became patterns as I conducted and transcribed the interviews. I then read through five of the interviews and added to the initial list of codes that were relevant to my research questions. Using ATLAS.ti 23, I coded each of the ten interviews based on the list of codes. As I coded, I refined several of the codes to describe patterns more succinctly and accurately and added several codes – drawing from a grounded theory approach (Bernard, 2006) – that I had not identified in the first round. Table 1 details the 62 codes identified throughout the coding process. Finally, I went back through the first few interviews and added or altered any codes that I had refined during the coding process. I tracked all code generation processes in memos and made note of where I saw patterns developing, themes that were relevant to multiple and individual participants, and questions for future analysis.

Table 1
Codes used for analysis of interviews

Codes		
Accessibility -	Fear	No more BS
Accessibility +	Freedom	Not knowing/recognizing yourself
Aging -	Frustration	Parenthood
Aging +	Giving back	QOL -
Aging +/-	HRT	QOL +
Benefits of menopause	Humor/joking	QOL +/-
Body image/body changes	Husband	Reason for participating
Change/Transition	Ignoring older women/women's health	Relationship with mother
Confusion/uncertainty	Inequality	Resources -
Control -	Lifestyle/habits	Resources +
Control +	Medication/treatment - "Western"/biomedical	Secrecy
Curiosity	Medication/treatment - CAM	Sex
Definition	Medication/treatment - Homeopath/"natural"	Shame
Denial	Meno ≈ aging	Sisterhood/camaraderie
Devaluing/Ignoring elderly people	Menopause as sickness	Sleep troubles
Dissonance	Menstruation/PMS	Supplements
Doctor	Miscarriage/Pregnancy/Fertility	Symptom - Emotional
Excitement/anticipation/ opportunity/reflection	Motherhood - Expectations/ responsibilities	Symptom - Physical
Expectations of meno	Motherhood - Personal sentiments	Teeth/bone health
Expectations of women		Treatment unreliability
Family member experiences of meno		Who you talk to about meno

Cultural Domain Analysis

Identifying Domains and Developing Free Listing Survey

Based on findings from the interviews, I identified “menopause” and “aging” as related domains to explore further through cultural domain analysis. Drawing from Borgatti (1998) I developed initial questions prompting participants to list words and phrases they associate with menopause or aging. To make the survey time effective and accessible to participants I administered the free listing questionnaire via an online Qualtrics survey. While Gravlee et. al (2013) address limitations to conducting free listing online, they also note that prior research suggests that computer-assisted questionnaires can generate less social desirability bias. In the

context of this research participants may be inclined to disclose more information in an online setting because menopause is often considered a taboo. With this in mind, I developed probing questions that could be used in an online context to facilitate listing additional words/phrases relating to the two domains. See Appendices D and E for a list of questions asked during the Free Listing exercise. Only new participants – those who had not already completed an interview – were prompted to take the Demographic Survey.

Conducting Free Listing

Typically, social scientists should aim to conduct free listing with a minimum of 30 people and continue until they reach saturation; smaller samples can be used if the researcher finds that participants are giving the same answers (Borgatti, 1998). For practical use in public health, the Center for Disease Control and Prevention suggest that a sample size of 20 people is sufficient in homogenous groups (Keddem et al., 2021). Due to time constraints, I conducted free listing with 15 people.

Analyzing Free Lists

To clean the data, I consolidated the initial question responses and probing responses into one list for each individual participant. If a participant included the same word twice, I removed the second listing. I reworked long phrases into shorter concepts or split them into multiple words/shorter phrases and I recoded words that were close synonyms. For example, in the menopause lists I recoded “Sleepless,” “Can’t sleep,” and “Insomnia” as “Sleeplessness.” I then used SPSS to run frequencies on all the words/phrases and retained all words/phrases that were

mentioned at least twice. Because of the small sample size, I did not calculate salience or other descriptive statistics that are often used in domain analysis (Borgatti, 1998).

CHAPTER 4: KEY FINDINGS

Demographic Survey

Responses to the Demographic and Health Survey are presented in six sections: (1) Demographic Characteristics, (2) General Health, (3) Reproductive Health and Menopausal Status, (4) Contraceptive and Hormone Replacement Therapy (HRT) Use, (5) Raising Children, and (6) Menopause Rating Scale. While 20 total people participated in the study overall, only 19 participants responded to the survey.

(1) Demographic Characteristics

At the time of the study, participants were between the ages of 41 and 59 with an average age of 50.5 years. Table 2 outlines participant ages in brackets of five-year increments. Sixteen participants self-reported their race/ethnicity as Caucasian/White; one participant reported that they were American Indian and Hispanic, one participant responded that they were Asian, and a third participant identified as Jewish. All participants reported female gender identities (Female, Female/Woman, She/Her, or Woman). Fifteen participants were married, two never married, one divorced, and one in the process of divorce. All participants had at least a junior college or associate's degree; most had a bachelor's degree and several completed graduate degrees. Most participants (84.2%) were currently working while others were retired or semi-retired. One participant was a full-time student working on a PhD.

Of the participants who reported both household income and household size (n=17), all were living above the poverty line according to the 2023 U.S. Department of Health and Human Services' guidelines (ASPE, n.d.). Seventeen participants were born in the US, one in England, and one participant did not respond to the question regarding birth location. All participants reported that they have spent most of their life in the US.

Table 2

Age of participants

Characteristic	*n*	*%*	*M*	*SD*
Age			50.5	4.7
40-44	2	10.5		
45-49	8	42.1		
50-54	5	26.3		
55-59	4	21.1		

(2) General Health

Most participants (18) reported that they had "Healthy" or "Very healthy" eating habits and were active at least one day in the week prior to taking the demographic survey. Fourteen participants exercised 3 or more times in the prior week. Walking is the most popular activity (11 participants reported walking). Participants also engaged in bicycling, running, hiking, paddling, dance, cardio, weights, strength training, PT exercises, Pilates, and yoga. All participants reported that they did not smoke cigarettes but 68.4% smoked marijuana; 31.6% did not. Inversely, 68.4% of participants drank alcohol while 31.6% did not. Most participants (89.5%) did not have any major health concerns. One participant noted that they had acute cutaneous lupus (ACLE). Another participant was concerned with rheumatoid arthritis (RA), asthma, sclerosis, and neuropathy.

(3) Reproductive Health and Menopausal Status

Participants experienced their first menstrual period between the ages of 10 and 18. Most participants (63.2%) did not have major health concerns related to their reproductive health.

Those who had concerns listed endometriosis, infertility, amenorrhea, heavy periods, painful sex, and chronic urinary tract issues.

Participants were recruited based on their experience with menopausal symptoms because of uncertainty around definitions and differences between perimenopause, menopause, and postmenopause. Some interview participants were unsure if they were experiencing menopausal symptoms and several participants were postmenopausal but still experiencing symptoms they associated with menopause, such as sleeplessness. Participants responded to the question "Approximately when did you start experiencing symptoms associated with menopause?" by reporting specific months and years (i.e. December 2022), general timeframes (i.e. a couple years ago), specific time ranges (i.e. 3 years ago), and specific ages (i.e. Age 42).

Throughout their menopausal experience and in the week prior to taking the demographic survey, participants experienced a wide variety of menopausal symptoms (Table 3). Two participants responded that they did not experience menopausal symptoms in the past week. Another two responded "Not applicable."

(4) Contraceptive and Hormone Replacement Therapy (HRT) Use

Participants listed the following contraceptive methods as options they had used: birth control pills (including mini pill), condoms, intrauterine device (IUD), NuvaRing, vasectomy (husband), contraceptive patch, and Depo-Provera injection. Most participants were no longer using contraception; two reported that they were. One of these two noted that she was using birth control pills as a form of hormone replacement therapy. Most participants were not using HRT at the time of taking the survey.

Table 3

Menopausal symptoms experienced by participants

Symptoms Experienced (All Time)	Symptoms Experienced (Past Week)
Aching joints and muscles	Hot flashes
Anxiety	Aching joints and muscles
Brain fog	Back pain with cramps
Change in quantity (liquid) and duration of menses	Brain fog
Dry skin	Breast soreness
Easily upset	Dry skin
Electric shocks	Fatigue
Emotional changes	Irritability
Fatigue/tiredness	Mood swings
Fluctuations in hormones	Not able to cool off at night
Food tastes different, no appetite	Sleeplessness/insomnia
Heavy periods with lots of clotting	Weight gain
Hot flashes	
Inconsistent/irregular periods	
Irritability	
Mood swings	
More prominent cramps	
Night sweats	
Palpitations	
Sleeplessness/insomnia	
Spotting in between periods	
Thought changes	
Tinnitus	
UTIs	
Vaginal atrophy and dryness	
Weight gain	

(5) Raising Children

Fourteen of the nineteen (73.7%) participants who responded to the demographic survey reported that they had children, including biological children, adopted children, and stepchildren. Those who gave birth had their first child between the ages of 17 and 40. Three participants had one child, nine participants had two children, one participant had three children, and another

participant had five children. Thirteen of the fourteen participants with children reported that they breastfed their children; the fourteenth participant with a child had adopted her daughter and did not breastfeed.

(6) Menopause Rating Scale

Cumulatively across the group, heart discomfort (score of 18) was the lowest rated symptom included on the Menopause Rating Scale. Sleep problems were the highest rated item with a cumulative score of 43. Table 4 includes scores for each symptom ranked from lowest cumulative score to highest: heart discomfort, bladder problems, joint and muscular discomfort, dryness of vagina, anxiety, physical and mental exhaustion, sexual problems, depressive mood, irritability, hot flashes/sweating, sleep problems.

Table 4
Menopause Rating Scale: Cumulative scores by symptom type

Symptom	Cumulative Score Across Participants
Heart discomfort (unusual awareness of heartbeat, heart skipping, heart racing, tightness)	18
Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)	19
Joint and muscular discomfort (pain in the joints, rheumatoid complaints)	20
Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	24*
Anxiety (inner restlessness, feeling panicky)	26
Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	27
Sexual problems (change in sexual desire, in sexual activity and satisfaction)	27*
Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	30
Irritability (feeling nervous, inner tension, feeling aggressive)	33
Hot flashes, sweating (episodes of sweating)	34
Sleep problems (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	43

Note. N=19
*N=18, One participant selected "Prefer not to respond"

Phase I: Semi-Structured Interviews

Through analysis of the semi-structured interviews, I identified five primary themes with additional subthemes. Many of these themes overlap with each other but are distinct enough to be useful for deeper examination. The themes include (1) Menopause and Aging, (2) Symptoms: Physical and Emotional, (3) Treatments: Focus on "Natural," (4) Sisterhood, Secrecy, and Who You Talk to About Menopause, and (5) Control versus Acceptance.

The interviews also addressed additional demographic information regarding sexual orientation of the participants. "Husband" was frequently used to refer to participants' partners, suggesting most of them either identify as heterosexual or are in heterosexual relationships.

(1) Menopause and Aging

In various ways, all participants associated menopause with aging, although most noted that they were different processes. For some, this was a negative experience – occasionally associated with being confronted with one's own mortality. Other participants – particularly those who were further along in the menopausal process – framed menopause as an opportunity. One woman described it as "the awakening time," saying that:

> I don't know how to elaborate on that there but I thought that was a positive tone, way to look at it. It's like a new phase but it doesn't have to be correlated with 'you're old.' I'm learning a lot, it's this whole new thing, I'm not focused on that reproductive stuff. Now this is for me. This phase is for me.

Within the topic of aging, participants identified two themes in their own experiences and cultural understandings of getting older: decreasing willingness to put up with what they deemed "bullshit" and the devaluation of elderly people, which I go into in more detail below. Because

the idea that menopause and aging are related was so salient throughout the interviews, I chose to explore these domains further with free listing exercises.

"No More Bullshit"

This sentiment varied for participants but was often associated with freedom and coming to terms with a changing body – often one that is less youthful and less palatable to social expecations of women's bodies. "No more bullshit" often meant deciding not to care about what other people think and choosing to focus on areas in their lives where they had more control, that were more meaningful, and that participants felt were more worth spending their time on. One participant phrased the sentiment of being "less tolerant of crap" as follows:

> …an attitude shift of "I just don't give a fuck" [laughs]. There's a lot of things that I used to care about before that I just, it's just not important - it doesn't matter anymore…life is just too short to spend it doing something you don't like. So that attitude shift has been – and I don't know I think menopause is tied into some of that attitude shift too.

Conversely, one participant – one of the younger participants of the group – acknowledged that she was looking forward to caring less but still felt like she cared a lot:

> I'm still waiting for, um - I was always told that you get to a certain point of your life where you're literally, like, excuse my language but it's the phrase where you have 'no more fucks left to give.' And I still give a fuck. So I'm waiting to not [give a fuck]…I'd love to not care as much as I do…I look forward to it. But I'm not there yet. I thought it would happen at 40 and it didn't. I feel a little robbed actually [laughs]. Everybody was like, "when you hit 40 you don't care

anymore." And I'm like, I really still care a lot. Maybe it will happen at 50, we'll see.

For this participant, caring appeared to refer to still feeling pressure to fit the social roles expected of women. In Western cultures, female-bodied people are often deprived access to full participation in culture, society, and politics. Conversely, female bodies are frequently placed on display as objects "to be observed, judged, valued, appreciated, rejected, modified and essentially commodified, for socially-constructed purposes (Ponterotto, 2016, p.134)." The "ideal" female body is considered middle class, white, slim, and young with unwrinkled skin. Further, this culturally generated "ideal" of beauty is frequently equated good health (Ponterotto, 2016). For some participants, the processes of aging and menopause bring pressure to maintain a youthful appearance that adheres to these "ideal" body characeristics. Whereas other participants had started to care less about expectations, this participant still felt a lot of social pressure, although it was unclear which particular areas of women's social expectations she felt most pressured to adhere to. Here, aging is also gendered by social interpretations of female bodies and the changes they go through.

Devaluation of Elderly People

Participants addressed views regarding aging and elderly people and bodies both on there own and in relation to menopause. Overall, there was a dichotomy between how people as individuals felt about the physical aspects of aging – like menopause, participants were hesitant to experience the physical changes they associated with aging – and how they believed aging was viewed from a broad cultural perspective. Most felt that older people were not respected or

valued in broad American society and agreed that this was problematic. For many participants this was reflected in the decision to embrace – or at least try to embrace – their physical changes with minimal intervention beyond lifestyle habits. Participants used words like wisdom and freedom to when talking about the positive aspects of aging. Many participants also discussed how they didn't feel as old as they expected to feel at this point in their lives, although several commented on the experience of feeling invisible as they grew older. One person commented on this, as well the concept of "no more bullshit," stating that:

> I think on the positive it's [referring to aging] like comfortability with everything. But then it's also coming to terms with this new space in life you're holding. And it's like no, you're not the young people out at the bar anymore. You're not, people aren't moving away on the sidewalk because this young little thing is walking past. So it's weird to hold a different space of a middle age person. But I think I had had some, maybe, self consciousness about it at some time along the way. But then I quickly realized, like what's the alternative? And this is the process. And I think that's another thing. We just don't talk about the process. And I've been saying that to my friends a lot. Nobody talks about the forties. It's like the most amazing decade I've been in so far because you have more socioeconomic stability. You know more who you are, what your career is. Maybe you're looking for that next career or that retirement. You've been through some things, you have more confidence, you don't really care, you know, what people think. You dress how you want. All those things. And it feels - nobody talks about it.

Here, the participant reframes aging as a period of growth and opportunity, a time to focus on yourself and care less about how other people view you. By commenting "what's the alternative" she recognizes that she has a choice to either accept the changes that come with aging or continue to feel self-conscience about herself based on external expectations of how a female body "should" look – white, young, smooth skin, slim (Ponterotto, 2016). As with menopause, aging is an experience of dissonance between one's own understanding of the self and how others understand and interpret aging people and their bodies.

(2) Symptoms: Physical and Emotional

Participants reported a wide range of physical and emotional symptoms. Table 5 lists symptoms that participants identified during interviews, characterized as emotional or physical. Some emotional symptoms may be considered psychosocial. Sleep trouble and insomnia were prevalent symptoms across participants. Participants expressed uncertainty about whether some of the symptoms were related to menopause, aging, or general stress. Many also noted how frustrated they felt by the symptoms and bodily/emotional changes they experienced. The focus on symptoms illustrates how menopause is medicalized for these participants. Menopause is framed through a set of symptoms that can be diagnosed and, potentially, treated. Medicalization serves a purpose in that it helps to frame what to expect from menopause but it becomes problematic when menopausal people are unable to fully listen to and understand the bodily and emotional changes they experience because they do not look like the medicalized version of menopause or the version of menopause they see other people experience.

Table 5

Physical and emotional symptoms reported by participants

Physical Symptoms	Emotional Symptoms
Weight gain	Frustration
"I feel like a balloon"	Depression
Being hot	Sadness
Hot flashes	Self-conscious (about looks)
Less sex	Irritability
Lack of sexual desire	Anxiety
Painful sex	Forgetfulness
Sleeplessness	Forget your words
Insomnia	Brain fog
Sweating	Mood swings
Restlessness	Less frustration tolerance
Night sweats	Quicker to anger
Joint pain	Brought to tears more easily
Hair loss/thinning	Crying a lot
Brittle hair	Laugh more easily
Vaginal dryness	Not feeling like yourself
Osteopenia	Feeling withdrawn
Irregular periods	Feeling blue
Lower energy	Things get to me more easily
Skin dryness	Questioning/thinking about my place in society
Aches and pains	
Bloating	
Body changes	
Feeling full after not eating very much	
Gaining weight very easily	
Digestive/gut health issues	
Bladder issues	
Neck pain	
Fluttery heartbeat	
Breast cysts	
More discharge	

Note. In some cases the participant identified the symptoms as emotional or physical and in some cases I added the designation during analysis.

(3) Treatments: Focus on "Natural"

While most of the participants were not opposed to using western or biomedical treatments to relieve menopausal symptoms, many used a combination of biomedical and naturopathic or homeopathic treatments. Those who used some type of HRT or other treatment

described frustration with the reliability of the treatments. Participants described the hassle of having to remember to apply certain creams and medications at specific times of day and how many of the treatments only worked for a period of time and then they had to find another option.

Lifestyle habits like exercise, diet, and decreased consumption of alcohol and caffeine were key "treatments" for some people. Several participants discussed using cannabis products to help with sleep and anxiety. One participant commented that, "Yoga has been nice. That's been super helpful. I know it's not necessarily a medical treatment but that's probably been more helpful than anything." Another said, "I think a lot of women can manage their menopause with yoga. At least I've had good luck with that." Praying was an important mental health activity for one participant. Participants also listed supplements they take, often to help with general health that they felt also probably helped them manage menopausal symptoms. One participant broadly equated good general health with a better menopausal experience. In mentioning another menopausal woman this participant noted that, "she's not super healthy and I do feel like there's something that ties into that on some level of people's symptoms."

Participants also talked about their understanding of hormone replacement therapy (HRT) and if they used this to help with menopausal symptoms. Some participants stressed their interest in bioidentical hormones, referring to this as a more natural option. Several participants noted that their symptoms aren't bad enough yet but would consider using HRT in the future. Several commented that they would want more information before deciding to try HRT but wouldn't be opposed to learning more. Participants typically addressed HRT in the context of weighing benefits: improved menopausal symptoms versus side effects and cancer risk of HRT. This quote

illustrates a participant who isn't ready to consider HRT but has considered what might make her look into this treatment option:

> My symptoms haven't been so bad that I feel like I'm ready to even explore them [HRT options] but, I don't know…I'm always open to learning about them. And even trying them if my symptoms get so bad that it starts to affect my quality of life and that really HRT would be an appropriate treatment and that the risk would outweigh - or the benefit would outweigh any risks.

Access to Care

In their discussion of treatments, supplements, and other ways that they manage their symptoms participants generally agreed that they had access to their desired treatment in their local community. Here, participants often framed treatment as a choice; they felt that they had access to options. One participant acknowledged that her treatment of choice – a specific type of hormone replacement therapy that she finds more convenient to use – is expensive and not particularly accessible. While she has been able to find some reimbursement options and discounts it is still a pricey option. Another participant noted that she does not have trouble finding what she needs in Flagstaff but would probably have trouble in more rural areas.

As with the focus on – and breadth of – symptoms, participants' interest in treatment suggests that they view menopause as a medical experience that can be "fixed" or "cured." While some participants do not use biomedical treatment, they often choose not to fully dismiss it as an option. Conversely, most participants embraced non-biomedical "treatment" options through various lifestyle habits. This marks the dissonance between the medicalized understanding and the embodied experience of menopause. Comments on access to care illustrate how menopausal

experiences may be mediated by socioeconomic status and structural issues regarding equal access to care. Further, the unreliability and inconvenience of HRT described by patients hints at impartiality towards developing and providing female bodies with (biomedical) treatments that work for them. For one patient, this concept was illustrated by the low-cost point of Viagra – a treatment used for a medicalized "issue" with the male reproductive system – versus the high price tag on HRT.

(4) Sisterhood, Secrecy, and Who You Talk to About Menopause

Sisterhood and secrecy play into the menopausal experience. While some people had lots of family and friends to talk to about menopause – and were able to build comradery through their shared experience – others wished they had more people to have open discussions with. Some participants mentioned feeling alone and lonely in the experience. One participant described wanting to tell her younger friends about menopause but not wanting to scare them.

Another key pattern throughout the interviews was the focus on relationships and who participants talk to about menopause. Doctors and nurse practitioners were commonly mentioned as medical professionals who participants went to for guidance Most participants talked about menopause with their female family members and used their knowledge of mother's and older women's experience to inform what they anticipated experiencing. Participants described varying experiences with talking about menopause with their coworkers in workplace settings. One noted that she felt comfortable discussing menopause and her body with female coworkers but would never discuss these topics with male coworkers. Another found that her coworkers weren't particularly interested in talking about menopause.

Confusion, Uncertainty, Curiosity

Many participants experienced confusion about the different phases of menopause and their symptoms. This quote illustrates hesitation and questions a participant asks her female family members about menopause:

> What's a hot flash like, does it hurt? You know, um, asking them about – mostly just asking – like the hot flash thing, the hot flash thing is mysterious to me and I'm sort of terrified of them. And I have anticipatory anxiety about them. So I ask a lot about 'how do you know you're having one? How long does it last? What helps? And what helps you to alleviate?' Then I'll ask them like, 'are you taking medication to help?'

One participant commented that she did not learn until it was a year after her last period that she was postmenopausal. Another participant noted confusion around emotional symptoms as a component of menopause:

> I think the emotional symptoms have been harder to deal with because I didn't really relate them to the physical symptoms…I think maybe one of my preconceptions about menopause is it was all physical…the emotional part, that's where I was really blindsided. It was the emotional part. I think that was why they were a little harder for me to deal with. 'Cause I'm like, where is this coming from? Why do I feel like this? The physical stuff made sense because your body is changing but the emotional, didn't expect it.

Whereas most participants expressed some degree of confusion related to the symptoms they were experiencing, younger participants also discussed feeling curious about what menopause would be like. Some participants noted symptoms like hair loss that they weren't

sure qualified as menopausal symptoms. This reflects how menopause is medicalized as a set of distinct symptoms rather than treated as a "natural" biological change; when participants' experiences did not align with what they understood about menopause from a biomedical position they felt confusion.

"Normalizing" Menopause

Because of the secrecy participants described regarding menopause, participants also expressed a desire for "normalizing" menopause. Participants also felt that women's health was an under addressed area both medically and socially. This quote illustrates the connection participants made between menopause and other bodily, reproductive experiences like puberty and pregnancy – also often shrouded in secrecy.

> But if you don't have your mother or your aunts or somebody around or it's [puberty] shrouded in secrecy…I think there's a lot of things they hide from us though. Like I said, I sort of feel like I'm maybe doing it a little bit to my younger friends too because some of it's like, I don't want to tell her that [laughs]. But I think it's true. Like with childbirth and menopause - all of these things that are difficult in many ways. I guess older women don't want to freak us out. But I think there is almost this pact of like, 'they'll figure it out. They don't need to know yet.'

Cumulatively, these findings suggest that menopause is still considered a socially unpalatable subject by many of the participants and the people in their social networks. While they try to navigate this – and many expressed wanting to talk about menopause more frequently and openly – they also felt pressure to talk about menopause in ways that other people see as

socially acceptable. In some cases, it was difficult for participants to tell just how much other people were open to discussing menopause. Women and female bodied people have many shared bodily experiences – menstruation, childbirth, menopause, etc. – but they often experience these alone if they don't have relationships with family members, friend, coworkers, or others that allow them to find camaraderie. By looking to medical professionals and other people in their networks, participants are ultimately looking outside themselves for guidance on the menopausal experience. This speaks to the medicalization of menopause as something that participants should and must seek care and treatment to address.

(5) Control versus Acceptance

Reframing menopause as an opportunity for self-reflection and introspection is one way some participants gained control over change. One participant commented that,

> Menopause means you're getting older. You can either face it or become angry at it. And I don't like being angry, it's exhausting. You know? I try to embrace it. Embrace the changes…I kind of just view it as inevitable, a part of life. Just like death. We've known that we're gonna die and it's inevitable and there's not much we can do to stop it.

By reflecting on the connection between menopause and aging this participant recognizes a need to not fight the experience because the changes will occur whether or not they want them to. This framing also naturalizes and normalizes menopause and aging as unavoidable aspects of mortality. This participant gains control through acceptance by understanding menopause as part of the larger experience of living.

Introspection also involved feeling out of place. In reflecting on her menopausal experience, one participant commented that she was unsure of her place in the world:

> I don't know if it's tied to menopause but, um, finding myself - like, what am I contributing to society outside of me just going to work 9-to-5? What am I supposed to be doing? I mean, I know until my nephew is done [with school], it's being there for him. He's getting his PhD at NAU. But that's kind of like, what's my next?

Another participant felt similarly:

> Just the philosophical, your view of life. But I'm pretty sure that's a menopause symptom. But it's talked about in the book that I read but it's not talked about in general culture I don't think. The book was definitely pretty eye opening in that regard. I'm like, well OK that makes a little more sense now. Because literally your brain becomes very different. The whole way that you think becomes different. And not necessarily in a bad way, but it's just different. And it's like huh, OK. So I think maybe one of the positives is you are better able to value yourself for who you are, instead of getting where you fit in. Because you don't feel like you fit in anywhere anymore. That's one of the big things that kind of triggers that whole…soul searching kind of part of menopause. Is that you just don't feel like you fit in anywhere anymore.

These comments relate both to aging and the process of confronting social expectations that participants embody when they decide not to care or "give a fuck" anymore. By discarding social expectations, the second participant is unsure where she fits during this time of transition. The first participant finds meaning in her relationship with her nephew but finds that part of the

menopausal and aging experience involves relational changes that alter her position in her social circle. Her quote illustrates how she's wrestling with that change.

Most participants also described a push and pull between wanting to embrace the physical changes that come with menopause and the aging process while also resisting change or trying to find ways to control the process. For some, attempting to gain control of the body took the form of diet and/or exercise to preserve a "youthful" body. One participant noted that she had an ultherapy procedure for her chin but felt self-judgmental about the decision. Conversely, another participant expressed disinterest in the anti-aging products that her friends use, preferring to embrace her changing body and only use "natural" products:

> I've embraced it [aging] more [as I've gotten older]. I have friends that literally are so obsessed with anti-aging everything. To the point of, like psychosis…I have friends that spend hundreds of dollars monthly on anti-aging creams and this, that, and the other. And I use a hemp moisturizer, you know? I'm more concerned about things being organic versus being anti-aging. I worry more about putting less chemicals on my body and in my body than, you know, preventative – all that anti-aging crap.

Multiple participants discussed resource seeking as a way to gain control over the symptoms and changes they experience/d. Books, podcasts, and web spaces provide insight into the experience and clarification on what is happening to the body (biomedically) during menopause. One participant mentioned taking a short online course, "Shedding the Menopause Middle." Another participant found a nurse practitioner who focuses on menopause by using the menopause practitioner finder tool from The North American Menopause Society. Participants also sought information about menopause from family members, friends, coworkers, doctors,

nurse practitioners, and holistic practitioners. Figure Table 6 presents resources participants use to gain information about menopause.

Table 6

Resources for information about menopause

Resource Name	Resource Type/Format
The Vagenda	Website and newsletter
Itchy and Bitchy	Podcast
Shedding the Menopause Middle	Short online course
The North American Menopause Society	Organization, website, practitioner locator
The internet, reputable website, journals	Website

As with seeking insight from medical professionals, friends, family, etc., additional ways of seeking resources suggest that participants view menopause as something they need to treat rather than as a natural transition that – while potentially uncomfortable – is a normal transition that bodies go through. One participant honed in on this idea when she said,

> And if we had the language and the people and the regular conversation all along, that it wasn't sickness at all – and neither is getting your period by the way. We kind of treat it that way too. Although that's a little more normalized – I think that far more people would just feel better. Even if the night sweats suck, even if you're a moody, pain in the ass, even if your vagina hurts, even if your depression is terrible and anxiety is terrible, um, if we all just normalized and talked about it – I don't think it would manifest and be as terrible as it is."

For this participant, de-medicalizing menopause was equated with normalizing menopause as a socially acceptable topic of discussion.

These findings illustrate how participants are navigating cultural understandings of female bodies and aging bodies. The findings detailed in the "Devaluing of Elderly People" section show that aging bodies and people are not respected. In response, participants decide whether to control their changing bodies – often through fitness, diet, procedures, or treatments – or accept and possibly embrace the changes and reframe the experiences of menopause and aging on their own terms. The distinction between the self and broad understandings of aging people suggests that participants experience menopause as an individualized experience.

Phase II: Cultural Domain Analysis

Participants identified 50 salient words/phrases during the menopause free listing activity and 51 words/phrases associated with aging (Table 7). Aging, Grandma (Granny/Grandma), Grey hair, Old, Pain (Pains), Tired, and Weight gain were notable terms for both menopause and aging. "Menopause" was listed once on the aging free lists while "Aging" was listed by four participants on the menopause free lists. Both the menopause and aging free lists included symptoms, although more symptoms were included on the menopause lists. The presence of symptoms on both lists suggests that participants see both menopause and aging as medicalized processes, although based on the frequency of symptoms on the menopause list, perhaps this experience is more medicalized. This may reflect menopause as a gendered experience whereas aging is universal. Because medical violence is frequently gendered (Campbell, 2021; Shapiro, 2018) and the female body is objectified (Ponterotto, 2016), menopause may be more susceptible to the process of medicalization than the experience of aging (although aging is also gendered because female bodies go through this process). The words on the aging free lists suggest a time

of change and transition to a new phase of life to a greater degree than the menopause lists. Both lists focus largely on the more negative aspects of menopause and aging.

Participants also listed words/phrases in the aging free lists that were not consolidated during the data cleaning phase because of their disparate nature. However, these items are broadly linked by a theme of negative experiences associated with aging. These words/phrases (all listed only once) include disrespected, being a burden to others, invisible, out of date, irrelevant, ageism, unfair treatment, marginalized, and nuisance. The participant who listed "disrespected" also included "respected" on their list.

Table 7

Free list results: Menopause and aging

Menopause: Word/Phrase	Frequency	Aging: Word/Phrase	Frequency
Hot flashes	9	Retirement	8
Moody/Mood swings	7	Grey hair	7
Old	7	Old	6
Weight gain	6	Death	5
Anxiety	5	Slowing down	5
Change	5	Wisdom	5
Confusion	5	Wrinkles	5
Aging	4	Aches	3
Frustrating	4	Forgetfulness	3
Irregular period	4	Grandma	3
Low libido	4	Increased health concerns	3
Sleeplessness	4	Joint pain	3
Tired	4	Loneliness	3
Transition	4	Loss of mental capacity	3
Bitchy	3	Pains	3
Fat	3	Weak	3
Fatigue	3	Weight gain	3
Free	3		
Grey hair	3		
Hormones	3		
Hot	3		
Lack of information	3		
Loss of youth	3		
New outlook on life	3		
New phase of life	3		
Night sweats	3		
Pain	3		
Sadness	3		
Sex	3		
Unattractive	3		
Unpredictable	3		
Anger, Belly fat/Jiggly belly, Cranky, Depression, Dry, Dryness (vaginal), Energy, Freedom from menstruation, Glad to stop getting a period, Granny/Grandma, Heat, Introspection, Irritability, Kegel exercises, Natural, No period, Solidarity/Sisterhood, Uncertainty	2	Acceptance, Ageism, Aging, Calm, Care, Decline, Doctors, Elder, Elderly, Exercise, Financial concerns, Free time, Freedom, Friends, Glasses, Grey, Hearing loss, Ignored, Illness, Invisible, Isolation, Joke, Life cycle, Loss of physical abilities, Mentor, Mom, Naps, Patience, Reminiscence/Memories, Saggy, Supporting others, Tired, Travel	2

Note. N=15 participants

CHAPTER 5: DISCUSSION

Many of the findings of this study support the conclusions of previous research – both anthropological and otherwise – while providing new insight into menopausal experiences in northern Arizona. Symptomatically, many of the participants described experiences that fit within the medical background on menopause. In the following paragraphs I synthesize the findings across the different phases and data sets (surveys, interviews, and free listing activities) and note broad concepts that emerge through this mixed methods approach. I also address how the findings agree with, diverge from, and add to the literature on menopausal experiences. Lastly, I discuss practical applications of the findings, and reflect on the limitations of the study. Overall, the findings reflect the experiences of people who identify with the female body. As such, the socialized interpretations of the female body are crucial to the understanding and synthesis of these findings.

Synthesizing Across Methods and Addressing Previous Literature

Menopause is Medicalized

Overall, the findings suggest that participants think about menopause from a medicalized perspective, supporting the findings from (Utz, 2011a). They seek treatments and care, manage symptoms, talk with medical professionals, and weigh treatment options. Both physical and emotional experiences are referred to as symptoms. Here, a critical medical anthropologic lens is useful for understanding how people navigate a biological process that is seated in a cultural interpretation of the body. Participants' frustration with medicalized care and treatment options (medical professionals with limited knowledge of menopausal bodies, treatments that are inconvenient and/or expensive) reflects the general trend in medical violence towards female

bodies. Ambivalence towards menopausal bodies in medical settings has the potential to cause harm by disregarding the varied lived experiences of patients.

Most participants saw menopause as something they needed to find outside support and guidance for – rather than trusting the bodily process as a "natural" function – but also framed menopause in the context of aging as something that was inevitable. Participants sought to embrace menopause on their own terms but also felt conflicted between their own experiences and culturally normative and medicalized perceptions of menopause and aging.

While menopause is medicalized, there is still a lot of confusion about what to expect and dissonance between what participants expect and what they experience. This suggests that medicalization – a process that can in some instances helps people find relief (Guthman, 2011) – is often not helping the participants navigate the changes they're experiencing. When embodied experiences do not fit with what people expect from a medical standpoint people feel dissonance; medicalization obscures the variation in menopausal experiences by normalizing bodies that are mediated by cultural and social factors.

The findings of the interviews and free listing activities also suggest that aging is medicalized, although potentially in a different way than menopause. While the menopause lists were largely words that participants defined as symptoms during the interviews, there were fewer symptomatic words listed in the aging free lists and more words focusing on relational and social changes (i.e. retirement, slowing down, loneliness, ignored). Discussions of aging during the interviews focused less on treatment seeking than in the discussions of menopause. Further investigation in this area would be useful to understand how aging and menopause are medicalized in different ways.

How Participants Navigate Medicalization

In contrast to Utz (2011), this sample of participants appears to be more inclined to push back against the process of medicalization. They sought care options that are outside of the medical system and focused on their general health. In some regards this can be considered resistance to the medicalization of the menopausal body and in other ways it reflects participants' perceived need and desire to find some way to feel better when medical care did not meet their needs. Often because of the dissonance participants experience in a medical setting, participants found alternative ways of managing and reframing the physical and emotional symptoms they experience. The participants in this study embody aspects of both generations described in Utz (2011). Like the baby boomers, participants begin to frame menopause as an inevitable experience – i.e. "natural" process – a as a way to navigate their experience. Like the younger cohort, they also expressed a need to control (typically through treatment, lifestyle habits, and focus on general health) and understand the process.

Participants also expressed dissonance between their lived experiences and the cultural norms regarding menopausal and aging bodies. This is visible across the three sets of data where participants described both frustration with menopausal symptoms and trying to positively reframe their experiences with menopause and aging through acceptance and introspection. In this setting, self-acceptance became a form of resistance against social pressures of aging and "womanhood." Turning inward to understand menopause in a different light became a way to resist medicalization of the experience when medicalized treatment options didn't meet their needs.

In some ways, establishing the relationship between menopause and aging can be interpreted as a way for participants to come to terms with the bodily and emotional changes that

come with menopause. As outlined above, participants discussed aging in slightly less medicalized terms than menopause and often viewed this aspect of life as an area where they needed to accept changes; the alternative – fighting change – makes aging more difficult. While aging was not always viewed positively – a culturally informed view – the findings begin to suggest that the association between menopause and aging may be a less medicalized mechanism for confronting the frustration participants feel regarding the changes they experience during menopause.

A Localized Experience

As a localized study, the findings reflect menopausal experiences for a subset of people in northern Arizona. The concept of "Local biologies" (Lock, 1998) provides a useful framework for understanding the feedback between participant's demographic background and their menopausal experiences; the demographic data provides crucial context for understanding the varied lived experiences participants described during the interviews. At 21%, Coconino County has a high poverty rate (Coconino County Health and Human Services, 2021), but the participants of this study are all financially well off. In some ways this may translate to the responses regarding access to care where most felt that they had access to doctors and treatments that they desired. Diet and exercise habits also reflect access to healthy foods, safe spaces to exercise (many activities listed by participants are outdoor activities), and time to exercise, all of which are generally correlated with financial security and stability.

Social demographics may also influence participants' experiences with finding camaraderie in their relationships that allows them to openly discuss their menopausal experience. Many of the participants have full-time jobs and families, both of which take up a

large amount of time. Participants in this situation may have less time to spend developing and engaging in meaningful relationships with people who are going through the same experiences. For example, while some participants were able to build relationships at work that allowed them to build menopausal camaraderie, others were not as successful in this area.

Menopause and the "Ideal" Female Body

Menopause is not only localized in the case study; findings also illustrate a specific population of people who identify with being female (or woman). As discussed by Ponterotto (2016), female bodies are subjected to objectification, scrutiny, and commodification. In responding to and navigating the medicalization of menopause, participants also navigate social scrutiny of their bodies and what is acceptable – both physically and for social discourse. Part of reframing their experiences with menopause and aging involved actively confronting culturally acceptable versions of the female body and engaging with their own understandings of the female body.

The participants are also predominantly married individuals and interview discussions suggest that most of the ten participants were in heterosexual relationships. Because gender identity and sexuality often relate to how people experience their bodies, these findings should not be generalized to all people who experience menopause. People who have different genders and sexual orientations may conceptualize and experience menopause differently than the people who participated in this study. Additionally, most of the participants are white. Because the "ideal" female body is racialized and marked as white, menopausal people of other backgrounds may navigate their changing female bodies differently. Further research in different groups would provide additional insight into the embodied menopausal experience.

Research Challenges

Menopause as a subject of research presents challenges because the experience they sit at the crux of a biological process that has been biomedically constructed while being culturally mediated. Biological understandings of the body are useful for understanding the symptoms people experience, but alone often do not account for the interpretations of those symptoms. Menopause must also be approached with attention to the nuance of how female bodies are culturally interpreted. While biomedical tools like the Menopause Rating Scale and other methods for measuring biological metrics are useful in some contexts, they obscure the variation and full embodiment of the menopausal experience. Further, participants' understandings and interpretations of menopause also makes it difficult to standardize across experiences. This is both a challenge and an advantage, as standardization provides meaningful information about a group of people whereas understanding the variation of the experience provides deeper insight into the possibilities for reframing and improved care. In response to these challenges, this case study has applied frameworks from biocultural and medical anthropology to engage deeply with how menopause is conceptualized and embodied.

Practical Applications

These findings could be applied in public health interventions and medical training to better meet the needs of menopausal individuals. Because menopause is medicalized – as this study and Utz (2011) show – menopausal people are likely to continue to interact with medical professionals and use medical interventions as they experience menopausal symptoms. As such, implementing anthropological perspectives into these biomedical frameworks may be most useful for reaching menopausal people. Interdisciplinary and collaborative efforts between

anthropologists, other social scientists, public health professionals, community health workers who have anthropological training, and medical professionals are one way to address the need for culturally-informed care for menopausal people. Anthropologists – particularly those who are practicing and applied – are well positioned to interface with the public in this setting because of the interactive and socially immersive nature of anthropological research.

Participants expressed wanting more resources about menopause and opportunities to discuss it. Some felt that menopause needs to be part of everyday conversation. One way to implement these findings could be in reproductive education about puberty. Most education regarding menstruation does not address how menstruation changes in later life. Reproductive health educators are well positioned to address how the reproductive system changes as people reach menopause.

These findings also highlight the need for awareness about menopause – and the variation in the experience – in medical settings. Because medicalization of menopause limits how participants understand and experience their bodies, awareness about the process of medicalization and alternatives to this framing of menopause and health is crucial. Further research into *why* menopause has become increasingly medicalized would provide insight into how people can more effectively navigate medicalization and push back on this process that is frequently detrimental to menopausal people and their bodies.

Limitations and Opportunities

The small size of both the interviews and free listing exercises are limiting factors for this research. Despite the small size, the findings provide preliminary insights into menopausal experiences that open opportunities for future research. Similarly, the limited racial/ethnic, socio-

economic, and educational diversity of the study participants is a limiting factor for understanding the diversity of menopausal experiences and conceptualizations. Again, the findings of this research provide possibilities for additional inquiry.

CHAPTER 6: CONCLUSION

In this study I examined how conceptualizations of menopause influence embodied experiences of menopause in people who report female/woman identities in Flagstaff and broader northern Arizona. In response to the process of medicalization, participants in this study navigate their experiences by seeking guidance about their bodies from medical professionals, other people experiencing menopausal symptoms, and other external resources. Participants associate menopause with aging and reframe both experiences as times of opportunity and seek acceptance of physical and emotional changes as a way to confront medicalization and find comfort in often physically, socially, and emotionally uncomfortable experiences.

Future Directions

The raw data and findings from this research provide opportunities for further analysis and inquiry into menopausal experiences. Free listing and cultural domain analysis are the first steps in conducting cultural consensus and cultural consonance modeling. These theories and methods – consensus and consonance modeling – are useful tools for understanding the salience of cultural domains (Dressler, 2012; Weller, 2007). Cultural consensus and consonance modeling would provide further insight into how people in northern Arizona conceptualize and embody menopause. Additionally, there are many possibilities for applying inferential statistical analysis to the free list and Demographic and Health survey data. Inferential statistical analysis could be used to answer questions regarding the relationship between demographic factors and words included in the free lists. For example, is there a relationship between negative versus positive words on the free lists and menopause rating scale scores? How do demographic factors like

income or education level relate to menopause rating scale scores or the types of words participants included on their free lists?

Lastly, I am interested in sharing my research with a wider audience. Because this research is relevant to a variety of focuses – public health, biology, aging, sociocultural anthropology, feminist literature, etc. – I could reframe my work and submit several articles to different journals with different focus areas. Currently I am considering reworking this thesis to submit manuscripts to *Practicing Anthropology*, *The Journal of Aging Studies,* and *Menopause: The Journal of The North American Menopause Society*.

Why This Research Matters

This research is important because it provides insight into an area of female-bodied health that is medicalized (often to the detriment of menopausal people) and stigmatized. As a result, findings show that participants of this case study experience confusion and frustration during menopause, often looking for relief outside of biomedical care that does not meet their care needs. Reframing menopausal experiences, biomedical treatment, personal care, and lifestyle habits can help menopausal people navigate the menopausal experience on their own terms. The biocultural and medical anthropology frameworks are crucial to the study of menopause because they show how culture influences embodied experiences of biological symptoms. Incorporating these embodied experiences into care – both biomedical and non-biomedical – can result in better menopausal outcomes and minimize stigma related to menopause, female bodies, and aging bodies.

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APPENDICES

Appendix A: Demographic and Health Survey Questions

Demographics

1. What year were you born?
2. What month were you born?
3. What is your gender identity? (For example, woman, non-binary, transgender)
4. What is your ethnicity or race?
5. Where were you born (include city, state, and country)?
6. Have you spent most of your life in the US?
7. Where else have you lived (list locations and durations of stay)?
8. What is your approximate yearly household income before taxes?
9. How many people are in your household?
10. I would like to know about what you do - are you working now, looking for work, retired, keeping house, a student…?
11. What is the highest grade or level of school you have completed or the highest degree you have received? (For example: high school, associate degree, college degree, graduate level degree, etc.)
12. What is your marital status?

General Health

1. How would you describe your eating habits? (very unhealthy/unhealthy/healthy/very healthy)
2. How many days in the past week did you exercise?
3. What types of exercise do you do regularly (check all that apply)?
4. Do you smoke cigarettes?
5. Do you smoke marijuana?
6. Do you drink alcohol?
7. Do you have any major health concerns?
8. What are your major health concerns?

Reproductive Health

1. Are you currently experiencing any symptoms associated with menopause?
2. Approximately when did you start experiencing symptoms associated with menopause (even if you are not currently experiencing symptoms)?
3. What menopausal symptoms have you experienced?
4. What symptoms have you experienced in the past week that you associate with menopause?
5. Have you had any major health concerns associated with your reproductive system (such as endometriosis, breast cancer, cervical cancer, ovarian cysts, amenorrhea prior to perimenopause, infertility, etc.)?
6. Have you ever used hormone replacement therapy (HRT)?
7. Do you have children (biological, adopted, stepchildren, etc.)?
    a. How many children do you have?

    b. Are any of your children adopted or stepchildren? If so, how many?
    c. How old were you when you had your first child?
    d. Did you breastfeed any of your children?
8. Have you ever used contraception?
    a. What kinds of contraception have you used (e.g., condoms, birth control, IUD, etc.)?
    b. Are you still using contraception?
9. How old were you when you had your first menstrual period?
10. If you are still menstruating, when was your last menstrual period?
11. If you are currently perimenopausal, what is the longest amount of time you've gone between periods?
12. *See Appendix B for Menopause Rating Scale questions.*

Appendix B: Menopause Rating Scale (MRS) Questions

Which of the following symptoms apply to you at this time? Please, mark the appropriate box for each symptom. For symptoms that do not apply, please mark 'none'.

Symptoms:	none	mild	moderate	severe	very severe
Score =	0	1	2	3	4
1. Hot flushes, sweating (episodes of sweating)	☐	☐	☐	☐	☐
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early)	☐	☐	☐	☐	☐
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Note. ZEG Berlin. (2022). About MRS. *ZEG Berlin*. https://zeg-berlin.de/expertise/diagnostics-tools/menopause-rating-scale/about-mrs/

Appendix C: Interview Guide for Semi-Structured Interviews

How is your day/morning/afternoon going? Would you like some water or a snack [offer refreshments]?

Thank you so much for taking the time to speak with me. As you know, I am researching menopausal experiences of women in the northern Arizona community. In this interview I will be asking questions about lifestyle, demographics, motherhood, treatment, and menopausal symptoms. Please let me know if there is anything I can do to make this interview as comfortable as possible.

Before we begin, we need to discuss the consent form and any questions you have about the research. [**HERE IS THE CONSENT FORM**] Would you like to read it yourself or have me read it aloud? I can also talk through each section with you. Do you have any questions?

If you're comfortable and have no additional questions, please sign the consent form. There is a section that asks if you give permission to be recorded.

Again, please let me know if you feel uncomfortable answering any of the questions and we can talk about how this information is relevant to my research. You can decide to stop the interview at any time or skip any questions.

If you're ready to begin, I will **turn on my recorder**.

Introductory Questions

Thank you for filling out the Demographics and Health Survey. I would like to begin with a few additional introductory questions about you.

1. What are your preferred pronouns?
2. Where do you currently live (city, state)?
3. Are you currently perimenopausal?

Perceptions of Menopause

I would now like to move onto questions relating to menopause.

4. How would you define menopause?
5. What are 5-10 words you associate with menopause? *You can either list them to me verbally or write them on this piece of paper.*
    a. PROBE: You mentioned [X]. Can you explain? Why did you include [X?]
6. What are or were your expectations of menopause?
7. What did you imagine menopause to be like when you were in your 20s and 30s? Did you ever think about menopause in your younger years?
8. Who do you talk to about menopause (friends, family, doctors, etc.)? What do you talk about in these conversations?
9. Do you wish you had more people to talk to about menopause?

Perceptions of Womanhood, Women's Roles, Motherhood

Switching gears again. These questions relate to women's roles, motherhood, and perceptions of aging.

10. Do you have any children? Can you tell me about them?
    a. What made you choose to have children?
    b. Is there any reason you chose not to or were unable to have children?
11. Please list 5-10 words that you associate with motherhood. *You can either list them to me verbally or write them on this piece of paper.*
    a. PROBE: You mentioned [X]. Can you explain? Why did you include [X]?
12. Can you tell me about your work or career? What did or do you like most about your work/career?
    a. PROBE: Can you tell me more about [that].
13. What do you see as the specific roles and expectations associated with your gender?
14. Do you try to fill those social roles? How so?

Perceptions of Aging

1. Please list 5-10 words that you associate with aging. *You can either list them to me verbally or write them on this piece of paper.*
2. How do you view age and aging?
    a. PROBE: Please explain [X]. What makes you say [X]?
3. How has your perception of aging changed as you've gotten older?
4. Do you associate menopause with aging? Can you tell me more about your response?

Symptoms: Physical and Emotional

This is the second to last section of questions. I would like to ask you about menopausal symptoms that you experience, both physically and emotionally.

5. What – if any – physical symptoms do you experience that you associate with menopause?
6. What – if any – emotional symptoms do you experience that you associate with menopause?
7. Are there any other symptoms you experience that you are unsure if they would be considered menopausal symptoms?
8. In general, how do these symptoms affect your quality of life?

Treatment: Medical, Alternative, etc.

This is the final section of questions. We'll talk about treatments, therapies, and access to care.

9. Who do you go to (or would you go to) to seek treatment for menopausal symptoms?
10. Can you tell me what you know about hormone replacement therapy (HRT)?
11. What types of treatments do you use for menopausal symptoms? If any. (Examples: HRT, herbal remedies, etc.)
12. How accessible are your preferred treatment options?
13. Are there any other ways you manage menopausal symptoms? (Examples: therapy or counseling, sticking to a particular diet or exercise regimen)

And that's the end of our interview. Thank you again for taking the time to share your story and opinions with me. Do you have any last thoughts as we finish up? **I'm now turning off the recorder. [Remember to turn it off!]**

Appendix D: Free Listing Questions for Menopause

Listing Activity: Menopause

Begin by thinking about all of the words and phrases that you associate with experiences of **menopause**. These can be personal experiences, things you talk about with other people, ideas you see in the media, etc. Take a minute to think about what menopause means to you.

Now list all of the words and phrases you can think of that you associate with experiences of **menopause**.

Enter each word or phrase on a separate line (hit Return/Enter to create a new line). This will help me differentiate between each thought and phrase you write.

Are there any other positive, negative, or neutral words you associate with menopause? Please list these. If you can't think of anything write "None."

Have you listed any emotional or physical symptoms? Are there any more symptoms you can think of that you associate with menopause? Please list these. If you can't think of anything write "None."

Go through the alphabet in your head. Are there any words that start with A that you associate with menopause? Are there any words that start with B that you associate with menopause? C? D? And so on. List these here. If you can't think of anything write "None."

Are there any other words or phrases that you associate with menopause or the experience of menopause? If you can't think of anything write "None."

Appendix E: Free Listing Questions for Aging

Listing Activity: Aging

For this final set of questions I'd like you to think about all of the words and phrases that you associate with experiences of **aging**. Again, these can be personal experiences, things you talk about with other people, ideas you see in the media, etc. Take a minute to think about what aging means to you.

List all of the words and phrases you can think of that you associate with experiences of **aging**.

Enter each word or phrase on a separate line (hit Return/Enter on your keyboard to create a new line). This will help me differentiate between each thought and phrase you write.

Are there any other positive, negative, or neutral words you associate with aging? Please list these. If you can't think of anything write "None."

Go through the alphabet in your head. Are there any words that start with A that you associate with aging? Are there any words that start with B that you associate with aging? C? D? And so on. List these here. If you can't think of anything write "None."

Are there any other words or phrases that you associate with aging or the experience of aging? If you can't think of anything write "None."