THE INTERSECTIONALITY OF AGE, GENDER, AND BODY: A CASE STUDY ON EDUCATED WOMEN'S MENOPAUSE EXPERIENCES

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ABSTRACT

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In our contemporary world, the definition of biomedical aging is the dominant and widespread discourse in the construction of age identity. The biomedical model sees menopause as a starting point for the aging process of women. The aging process is based on the body, which loses its functionality and begins to decline. In that sense, the decreasing hormone levels during menopause make women more vulnerable as a biological destiny. However, recent research claims that menopause experiences are not universal and that culture is highly influential in differentiating experiences. In that context, this study tries to understand the sociocultural structure of menopause by considering the biomedical model. The study aims to reveal the menopause experiences of women without referring to biological and cultural determinism. Thus, intersectionality theory enables us to understand how aging, body, and gender intersect and dynamically construct menopausal experiences. In this study, which methodologically focuses on women's experiences, feminist methodology and life

course approach were used, and in-depth interviews were conducted with 24 educated women from different provinces of Turkey.

Keywords: menopause, gender, aging, body, intersectionality

ÖZ

YAŞ, TOPLUMSAL CİNSİYET VE BEDENİN KESİŞİMSELLİĞİ: EĞİTİMLİ KADINLARIN MENOPOZ DENEYİMLERİ ÜZERİNE BİR VAKA ÇALIŞMASI

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Biyomedikal yaşlanma tanımı, yaş kimliğinin inşasında güncel ve yaygın bir söylemdir. Menopoz, biyomedikal model tarafından kadınların yaşlanma sürecinin başlangıç noktası olarak görülmektedir. Bu süreç, işlevselliğini yitiren ve gerilemeye başlayan beden kavramı üzerine kuruludur. Bu anlamda, menopoz döneminde azalan hormon seviyeleri, biyolojik süreçlerin doğal bir gereği olarak tanımlanmakta ve bu durum kadınları daha savunmasız hale getirmektedir. Ancak, yapılan son araştırmalar, menopoz deneyimlerinin evrensel olmadığını ve deneyimlerin farklılaşmasında kültürün oldukça etkili olduğunu ortaya koymaktadır. Bu çalışma, menopozun sosyokültürel yapısını biyomedikal modeli göz önünde bulundurarak anlamayı hedefler. Bu nedenle, çalışma, biyolojik ve kültürel determinizme düşmeden kadınların menopoz deneyimlerine odaklanmaktadır. Bu doğrultuda, kesişimsellik teorisi, yaşlanma, beden ve cinsiyetin birbiriyle nasıl kesiştiğini ve bu durumun menopoz deneyimlerini dinamik bir biçimde nasıl inşa ettiğini anlamak açısından

önemli olacaktır. Metodolojik olarak kadın deneyimlerini merkeze alan bu çalışmada feminist metodoloji ve yaşam seyri yaklaşımı kullanılmış ve Türkiye'nin farklı illerinden 24 eğitimli kadın ile derinlemesine mülakatlar gerçekleştirilmiştir.

Anahtar Kelimeler: menopoz, toplumsal cinsiyet, yaşlanma, beden, kesişimsellik

To my grandmother, Fatma, who is the person I love and miss the most.

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LIST OF ABBREVIATIONS

AKP	Justice and Development Party
HRT	Hormone Replacement Therapy
HUIPS	Hacettepe University Institute of Population Studies
TDHS	Turkish Demographic and Health Survey
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

> *The menopause is probably the least glamorous topic imaginable, and this is interesting because it is one of the very few topics to which cling some shreds and remnants of taboo. A serious mention of menopause is usually met with uneasy silence; a sneering reference to it is usually met with relieved sniggers. Both the silence and the sniggering are pretty sure indications of taboo.*

The Space Crone (1976) starts the sentences which are quoted above. Ursula Le Guin questions the social meanings of changes in the female body. According to her, there are three stages women go through in their life: virginity, sexual competence and fertility, and menopause. From menstruation to menopause, women are surveilled by the social gaze. However, menopause, as the third stage in a woman's life cycle, differentiates itself from the other stages because menopause is a third and new condition, which is a transition from being young to old. Menopause is a birth that a woman experiences alone, and she generates herself all over again. No male obstetrician will measure the rhythm of her pains, give her sedatives, stand ready with forceps in her hand, and sew up torn tissues at the end.

Moreover, ignoring menopause, avoiding it, and pretending nothing have changed is ignoring her femininity, parrying it, or pretending to be like a man. In other words, Le Guin explicitly opposes the medicalization of menopause and celebrates the aging process of women. She prefers an old feminine body that does not accept discourses about being younger or attractive. Mainly, she affirms the aging body, which comes with the menopause process because this body gets rid of the obligations of womanliness. Therefore, the crone can think, behave, and act differently after

menopause. The aging process through menopause is the least glamorous topic and taboo because it is experienced only by women.

The Space Crone is not a novel or a story, and Le Guin talks about menopause and aging through her own experiences. While she criticizes those gendered norms that laboriously construct menstruation, virginity, and fertility, she gives a particular field for menopause and becoming old to be free of these norms and obligations. However, why cannot menopausal women liberate themselves from feminine burdens although their biology allows them? This fundamental question that triggers menopause has sociological importance because it is an intersection point of gender, aging, body, and medicine, subsections of sociology. Yet, before discussing menopause in different sociological contexts, there is a need to demonstrate why menopause is a social issue instead of an individual issue. The background and research issue part gives us the empirical importance of menopause.

1.1. Background and Research Issue

Studying menopause can be seen as the least glamorous topic because it is a very ordinary life event, but at the same time, it is crucial. The significance of menopause is increasing in two ways. First of all, women's life expectancy increases, and the time spent in the menopause period also expands. According to the World Health Statistics (2019), the World Health Organization (WHO) conducted, women's life expectancy regularly increases (Fig. 1.1).

The demographical change shows that the quantity of menopausal women in the population increases day by day, and menopause becomes a crucial issue for women. At the same, this trend demonstrates that the increasing life expectancy of women causes the change of understanding of aging because the definition of older people shifts. Although statistically, there is a change for women in later years, there is a considerable gap about how they experience aging. There is a lack of women’s definitions, perceptions, and emotions about their life trajectories.

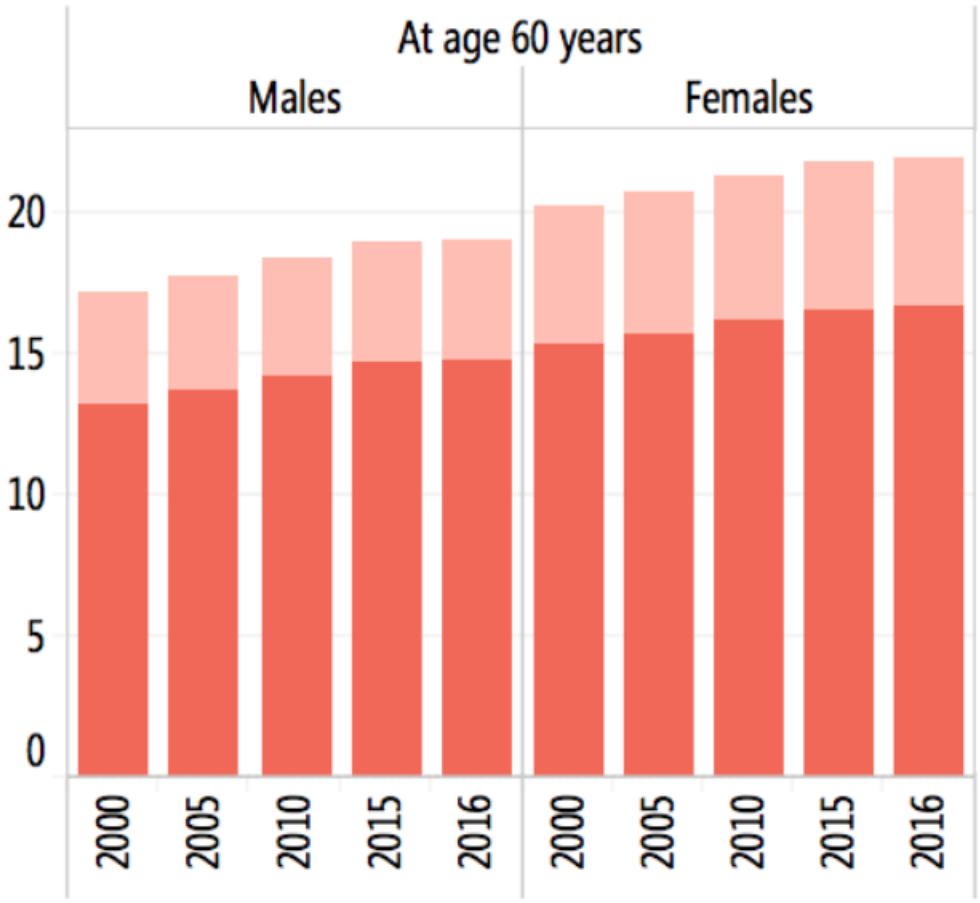

Figure 1.1. *Global life expectancy and healthy life expectancy 2000- 2016, WHO (2019).*

A similar trend can also be seen in the age at which menopause occurs (Fig 1.2). Women's menopausal age increases when looking retrospectively. This change is critical to understand reproductivity and being menopausal women are not constant and change historically. In other words, menopause experiences are produced and reproduced in the historical background. In that sense, this study does not consider the menopause ahistorical concept. On the contrary, focusing on recent experiences enables us to see the differentiation of the construction menopause.

TIME PERIOD	AGE
The Roman Empire	<30
Middle Age	33
19th Century	38
1900	41
1906 Scheaffer	47.26
1919 Moris	47.89
1976	50.2
1978	50.4

Figure 1.2. *The age at menopause, Çetin, 2000, p. 28*

Another vital thing is that statistics can change from one country to another country. The classical demographic studies are base on developed and developing countries' categorization. According to this approach, the developed countries have a longer life expectancy, and the postmenopausal period also will be longer. On the one hand, this statement can be true because the age at menopause in developed countries is between 50-51, and in Turkey as a developing country, the age at menopause is 47, and it varies from 45-49 ages (Çetin, 2000, p. 28). On the other hand, Diczfalusy (1986) highlights that menopause is not the only problem for Western societies. It will also be a problem for developing countries in the middle of the 21st century. Immensely, the developing countries will suffer from the lack of suitable medical infrastructure.

In the context of Turkey, the significance of menopause is increasing. When medical articles and thesis are analyzed, the increasing life expectancy of women and the extension of postmenopausal years are highly considered. Moreover, the government is also considered menopause. When Turkish Demographic and Health Surveys

(TDHS), which Hacettepe University Institute of Population Studies (HUIPS) conducted, there was no information about menopause in reports completed in 1978, 1983, and 1988. Until 2018, menopause was examined under *"Other Intermediate Factors Affecting Fertility"* and played an essential role in women's preferences over 30 years old to quit or not use contraceptive methods. In 2018, menopause was discussed under the main heading of *"Fertility"* instead of *"intermediate factor."* Although menopause continues to address fertility as a content, the scope appears to have expanded in recent studies.

Additionally, when the rate of women who experienced menopause from 1993 to 2018 was statistically examined, the ratio was around 8-9% until 2018. It increased to 10.3% in 2018. To be more precise, menopause becomes important both qualitatively and quantitatively.

Secondly, menopause is a significant issue because scientific and medical authorities have started to question it in the 1970s. *The personal is political* is a compact summary of radical feminism because radical feminists see that women's personal problems are political issues. They elaborately criticize the distinction between private and public spheres (Saulnier, 1996, p.32). The subjects like sexuality, reproduction, abortion, violence against women, rape, etc., are moved political arena because radical feminists argue that women's oppression is legitimized by medicine, religion, science, law, and other social institutions (Lorber, 2012,p.127). Significantly, at the end of the 70s, the emphasis on sexuality shifts from focusing on sexual double standards and the right of women's sexual freedom to sexuality and power (Richarson, 1993, p.160). In other words, women's issues have started to discuss as public issues, and women's health and sexuality have become questionable because these issues are not independent of political, economic, or medical discourses. In that sense, women's health and sexuality are conceptualized as a social construction within the frame of power relations—especially the inequalities between men and women.

1.2. Research Question

In Turkey's context, talk about women's bodies, sexuality, and reproduction didn't start at the same time as western countries. Historically, the political atmosphere is slightly different from the West because the military coup in 1980 was an obstacle for feminist organizations. Significantly, feminism in Turkey could not develop until the 1990s, and it could not consolidate simultaneously with the developing libertarian movements. On the contrary, when the women's movement in Turkey rose, anti-Western modernity and the identity and faith movements became powerful (Sancar, 2011, p. 80). Turkey's rising conservative and neoliberal politics is crucial because the AKP (Adalet ve Kalkınma Partisi – Justice and Development Party) administration has tried to regulate women's sexuality and productivity under party policies idealized as mothers and wives. A central role is assigned to the family (Unal and Cindoğdu, 2013, p.24). In other words, being a woman was defined only within family boundaries.

On March 8, 2008, Prime Minister Recep Tayyip Erdoğan advocated that women should give birth to at least three children to prevent that the young population in Turkey does not decrease in the future (Çetik, Gültekin, and Kuşdemir, 2008). The political intervention became more harshly, and Erdoğan stated that each abortion was murder in 2012. This discourse is enlarged through the put limits C-sections because women cannot give birth to more than two children (Habertürk, 2012). The AKP's political agenda causes reactions because women's reproduction goes under the conservative policies, and the women's movement opposes these restrictions and governing the women's bodies through political arrangements.

In this context, women's movements justifiably focus on women's bodies and reproduction. However, women who cannot give birth are neglected in these discussions. Significantly, global and neoliberal policies stealthily come into menopausal women's life. Nevertheless, menopause cannot find a place in academic discussions in social sciences. When menopause is searched on the official website of

the Council of Higher Education's Thesis Center, every year, at least one thesis is published by medical schools from 1988 to 2020. The psychology discipline also studies menopause, which generally focuses on depression. Unfortunately, only four academic theses are published about menopause in the sociology discipline between 1988 and 2020 years, and feminist theory and methodology are used in the two theses.

Consequently, this master thesis tries to fulfill the gap in sociology from a gender perspective in menopause. Therefore, this study argues that menopause is when women's gendered social roles are reshaped social roles in middle age, beyond the hormone deficiency disease defined by medicine. In that sense, global and neoliberal understanding of health becomes critical to understand the contemporary meaning of menopause and its medicalization process. Secondly, menopause is cannot only be considered as an only medical issue. The social and cultural implications of menopause are notable because menopause is seen as a sign of aging and the end of fertility. Within this scope, it is noteworthy to reveal the meaning of being a woman in Turkey and how gender norms constitute menopause in that culture. These two main questions' significance is how structural changes and gender norms come together and how this cooperation continues male domination over women.

1.3. Significance of the Study

Sociological studies about menopause are very limited. In Turkey, there is a domination of medicine over menopause. Medicine is an absolute authority in the scientific field. The studies about menopause are rarely in social sciences. Additionally, medicine enlarges its power from the scientific field to daily life. Almost all writers of a book or the speakers on TV talking about menopause are doctors. The experts or different sources frequently talk about menopause; however, women’s voices cannot hear in those conversations. Most studies are based on medical definitions, symptoms, or treatments instead of women’s actual experiences. Primarily, there are limited sources in which women are considered as the subjects in scientific studies. This thesis tries to question medicine's power over menopause and

develop an analytical critic from a sociological perspective. However, the sociological perspective prioritizes gender and aging instead of classical and mainstream theories and methodologies. Using qualitative research techniques is critical to understand how women construct their menopause experiences. Although quantitive studies show the changes in menopause, there are limited researches based on women's own words, biographies, or narratives. In other words, qualitative research enables us to understand how women construct self-notion and their identity in their middle ages.

Therefore, I use qualitative research and aim to give a place to women who experience the menopausal process. When doing it, menopause considers as a part of women's life cycles; therefore, the subtle and overt forms of ageism and sexism try to reveal. At the same time, women do not consider as a victim or passive role. On the contrary, this study makes an effort to contribute to the empowerment of women.

1.4. Structure of the Thesis

This thesis consists of five chapters. The first chapter is the introduction chapter, which locates menopause as a sociological fact because there are limited studies about menopause. Mainly, menopause is studied from a medical perspective. However, the increasing life expectancy of women brings a demographical change because the menopausal years last longer. The background knowledge about menopause and locates it into a sociological problem is explained in the introduction chapter.

The second chapter is the literature review. This chapter divides into two main topics: the biomedical model and menopause and the sociocultural model and menopause. In the biomedical model, menopause had defined differently in different periods. Therefore, the historical background of menopause is crucial to understand its changing structure. After that, I focus on current concepts about menopause which are medicalization and biomedicalization. Another main topic is that the sociocultural model conceptualizes menopause as a social construction intersection of gender,

aging, and body. Sociocultural definitions and meanings will be significant to discuss menopause as a midlife experience.

The third chapter is the methodology and research design. Feminist methodology and life cycle analysis are the fundamental approaches for researching menopause. On the one hand, menopause is a gendered experience constituted through social interactions, which means menopause does not only refer to a biological process. Notably, the conceptualization of menopause negatively or the silence about it shows that talking about women's bodies is problematic, and feminist methodology allows me to articulate menopause as a women's own experience and find a voice in that research. On the other hand, menopause is the last event in women's biological cycle because it is the end of menstruation and reproductivity.

Nevertheless, menopause is not an isolated experience from the meanings attributed to menstruation, sexuality, pregnancy, and birth. At the same time, women's menopause experiences can intersect with other life events. At that point, understanding menopause as a transition process helps us understand the construction of midlife. The life cycle analysis helps me bring different events and trajectories together and draw a meaningful analytical picture.

The fourth chapter is the analysis part of the research findings. Menopause is a transition process divides into two main topics. The first topic is that biomedical aging and menopause includes five subtopics: the first impressions of menopause, physiological changes, psychological changes, reproductivity and sexuality, and lastly, health and lifestyles. In that part, I analyze women's perceptions, attitudes, and behaviors about medicine and medical discourse. The second topic is that sociocultural aging and menopause also consist of five subtopics: being a woman, being a retired woman, being a grandmother, aging and maturing, and intergenerational ties. This part is crucial to understand how menopausal years intersect other life events and affect the menopause experiences of women. To sum up, this part scrutinizes how menopause becomes a symbol of the aging process, for

women and this process has individual, biological, chronological, social, and cultural dimensions.

The fifth chapter is the conclusion which tries to draw a general picture of this research. It helps to understand the connection of all chapters and highlight the significant and final issues about menopause experiences of women in Turkey.

CHAPTER 2

LITERATURE REVIEW

This chapter divides into two main parts. The first part will analyze the conceptualization of menopause in the biomedical model and critiques it. Moreover, medicalization and biomedicalization signify two different health paradigms, and menopause is elaborated with these paradigms. The second part is the sociocultural model and menopause, which conceptualize women's social roles and status changes and interactions through aging.

2.1. Menopause and Biomedical Model

In this part, I try to draw a conceptual framework about the relationship between menopause and medicine. The first subtopic covers how the definition of menopause changed throughout history. In that context, I focused on the conceptualization of menopause in the premodern era, which shows that menopause is not fixed-term and is a construction. The other subtopics engage with modern and postmodern/neoliberal definitions of menopause. This analytical distinction is crucial to locate the current understanding of menopause.

2.1.1. Historically Changing Meaning of Menopause

Modern medicine defines menopause as a permanent cessation of ovarian function, which means the women's reproductive potential ends. The experience of menopause is universal, signifying women's aging process (Sherman, 2005, p. 44). World Health Organization classifies menopause in the stages: *Perimenopause*, which is the period immediately before menopause (when the endocrinological, biological, and clinical features of approaching menopause commence) and the first year after menopause.

Premenopause is often used ambiguously to refer to the one or two years immediately before menopause or to the whole reproductive period before menopause. *Postmenopause* is defined as dating from the final menstruation period (FMP), regardless of whether the menopause was induced or spontaneous (International Menopause Society, 2020).

Contemporary medicine takes into consideration menopause in very detail and separates it into each step. In other words, menopause is not defined as a unified term; on the contrary, menopause proliferates with different statements. However, the plurality of definitions is peculiar to the modern understanding of medicine. This section tries to show how the medical definition of menopause has changed through history and how it is a reconfigured term instead of a natural event of a women's life cycle.

In 1816, Dr. C. P. L. de Gardanne firstly used the term menopause, which is taken from the Greek word pausis (pause) and mēn (month) (Baron, 2012, p.34). However, menopause has a more extended history. According to Foxcroft (2009), Greek and Roman physicians have seen women as inferior creatures- *"different, weak, whorish, irrational, prone to sickness and in contrast need of supervision."* Women, because of their reproductive systems, are defined as inherently pathological. Therefore, they have to condemn by medicine.

Preindustrial European medicine still has focused on menstruation as a sickness. However, the cessation of menses was still an ambiguity. Early modern scientists who studied menopause in the 15th and 16th centuries focused that menstruation was a cathartic process because they thought the female body was sick. Menstruation purifies the women from the destructive powers, and menopause restrains the flux of blood, and this blood accumulates in the body. Therefore, women become plethoric (Stolberg, 1999, p.408).

Until the end of the 19th century, the relationship between the end of menstruation and the loss of ovarian function could not link by the scientists, and ineffective and

dangerous treatments were applied. For example, in 1853, Edward Tilt, the London Obstetric Society founder, relied upon menopause as a kind of madness-hysteria-which takes its source from the uterus. (Baber and Wright, 2017, p.85.) Therefore, Tilt asserted that the removal of the uterus in the treatment of women's hysteria.

Kellogg (1886) states that menopause is "*a change of life*" because the end of menstruation brings several physical changes like getting smaller ovaries, the decreasing of size of the vagina or breasts (p.369). He also implies that menopause is "*a critical period"* by reason that "a woman who was a feeble person through the all life, "*a sufferer from female weaknesses of various sorts, will find this period a veritable "Pandora's box" of ills* (p. 372.). In other words, Kellogg's study tries to link menopause and the change of women's general health system. However, women's bodies must be constructed as a pathological situation both in menstruation and menopause periods.

In that context, menopause, like menstruation, is seen as a sickness. At the same time, women were attributed with weakness because of the reproductive system of women. However, the crucial thing is that the feminine body is inherently conceptualized as unhealthy and femininity becomes unpredictable; therefore, the common view was that medicine must control the feminine body. According to Helman (2007), a natural feature of the female life cycle has been increasingly medicalized. While, in the nineteenth century, the medical authority had thought that menopause was the cause of illness, in the mid-twentieth century, menopause has itself been redefined as a disease (p. 166). In other words, the medical conceptualization of the female body and femininity and its nature have constantly produced negative connotations, and medicine has tried to control and dominate women's bodies through sickness.

From another perspective, medical discourses are social and cultural constructions. Especially, gender perspective becomes more significant to see how patriarchal relations are embedded in medicine. When doing that, feminist critics are substantial of the power relations, the authority of medicine control, and the devaluation of

women's bodies. Therefore, the following topics explore how menopause is medicalized and what are the critics of feminist thought.

After brief historical background about menopause in the medical arena, in this section, I am trying to elaborate on medicalization in the modern and postmodern eras because there are significant differences in the construction of menopause. Specifically, this part enables us to see how menopause relates to health and how the paradigm changes affect menopausal issues.

2.1.2. The Modern Understanding of Health

In classical sociology, the relationship between medicine and society addresses illness and deviance in social control and its mechanisms by Talcott Parsons. According to him, in general terms, medicine is oriented to provide individuals' health in illness or sickness through treatment or therapy. In other words, medicine tries to deal with the pathological states and reconstruct them into health and normality. (Parsons, 2005, p.289). In line with this, being healthy becomes a function that ensures the continuity of the social system. Parsons emphasizes that illness is a deviant behavior because when the individual becomes sick, he/she cannot perform the social roles. In other words, the sick person needs to help other people and becomes dependent. However, this deviancy is not equal to criminality; on the other hand, the sick role is institutionalized and gains relative legitimacy in the social system because the sick person needs help from the medicine (Parsons, 2005, p.211). In brief, Parsons conceptualized medicine as one of the social control mechanisms and seeks to treat the illness, and the sick person becomes a normal individual who performs social roles.

In the modernist era, medicine was seen as a major social control institution rather than traditional institutions such as religion or law. (Zola, 1976, p. 210). The scope of medicine widens its scope through medicalization. According to Conrad (2007), medicalization is "a process by which nonmedical problems are defined and treated as medical problems, in terms of illness and disorders" (p.4). The definition of a problem

in medical terms is based on “normal life events.” It creates new categories that include common life processes like “anxiety and mood, birth control, infertility, childbirth, menopause, aging, and death” (p.6). In other words, the normal and natural processes of life turn into an illness and require specific treatments. However, medicalization is not a static and one-directional social control mechanism, and it is not gendered equal. According to Ehrenreich and English (1978), medicine “discovered that female functions were inherently seen pathological,” including puberty, childbirth, menstruation, and menopause (p. 117). In the 20th century, the medical professions extended their authority over individual and social life. The growing feminist movement started to question male doctors’ roles and a male-dominated health system in controlling women’s bodies and reproductive capacities (Frawley, 2015, p.3). Women’s health movement in the 1970s revealed that the medicalization of women’s bodies reflected the traditional sex-role stereotypes, and women were victimized as passive actors (Riska, 2003, p.67). In other words, the feminist movement displays sexism in medical treatments and male dominance.

2.1.3. Menopause in the Context of Medicalization

Modern medicine changed its practices in the 1950s, 1960s, and estrogen was prescribed as long-term therapy for postmenopausal women. This approach caused blurring boundaries between normal and pathologized menopause and aging. Although every woman experiences menopause at a certain age, they are blamed for diminishing femininity because of their bodies’ changes. (Watkins, 2007, p. 1). Especially in 1966, Robert A. Wilson published *Feminine Forever*, which summarizes the gendered medicalization of menopause. Wilson described menopause as a deficiency disease that causes to misplace women’s youth, femininity, and sexuality. He claimed that estrogen replacement therapy allows women to prevent deficiency disease. Thereby, they remain “fully sexed” (Houck, 2003, p.104). In that context, McCrea (1983) argues that the medicalization of menopause creates the prevailing

ageism and sexism, and she points out four themes of the medical definition of menopause:

1) Women's potential and function are biologically destined
2) Women's worth is determined by fecundity and attractiveness
3) Rejection of the feminine role will bring physical and emotional havoc
4) Aging women are useless and repulsive (p.111).

In other words, modern medicine does not change the point of view about women's bodies. On the contrary, it clinches patriarchal gendered norms and roles which are attributed to women. In other words, women's menopausal experience is seen as a vulnerability and weaknesses of women. Being a woman is idealized through youthfulness, being attractive and sexually desired, or the perfect woman's idea. Hormone replacement therapy (HRT) is presented as a miracle. However, HRT experienced its first fall in 1975 through clinical research on which estrogen is the cause of endometrial cancer (cancer of the uterus). It lasted for less than a decade. The second rise happened in the 1980s. (Watkins, 2007, p.4). The important thing is that the second rising of menopause coincides with the change of health paradigm, and neoliberal economics and politics transformed the understanding of health. Therefore, the medicalization of menopause after the 1980s is discussed in a different context.

2.1.4. Neoliberal Understanding of Health

Since the mid-1970s and the beginning of the 1980s, a new paradigm of health emerged in especially economically developed countries. Although the old model of health is based on public health services oriented to cure the illness, the new model depends on preventing disease and health promotion. WHO's First International Conference on Health Promotion shows that the individual's empowerment to take responsibility for their health is the primary duty. To overcome chronic illnesses is at the heart of late modern society (Moore, 2010, p. 101).

Biomedicalization is a concept which engages with complex, multi-sited, and multidirectional processes of medicalization. The switch from public health to individual health influences the medicalization process, gaining different directions. According to Clarke et al. (2003), medicalization shifts from bio-medicalization through technoscientific changes. Her main argument is that,

> The extension of medical jurisdiction and the commodification of health are fundamental to bio-medicalization. That is, health itself and the proper management of chronic illnesses are becoming individual moral responsibilities to be fulfilled through improved access to knowledge, self-surveillance, prevention, risk assessment, the treatment of risk, and the consumption of appropriate self-help/bio-medical goods and services (p.161-162).

Health practices are shaped under the neoliberal social order in the new paradigm, and health knowledge diffusion brings health consciousness. On the one hand, health consciousness changes the individuals' position from the passive under medical professionals' control. On the other hand, the proliferation of medical knowledge and health consciousness increases anxiety and the idea of improving health. It turns into a vicious cycle, which is *control* > *anxiety* > *control* > *anxiety* (Crawford, 2006, p, 415).

In other words, the technoscientific approach and the individualization of health's source is susceptibility. The susceptibility is about potential health risks in the future; in other words, the diseases or illness is tried to capture without being visible. Therefore, any individual becomes a pre-patient (Rose, 2007, p. 19-20). In that sense, healthism requires perpetual *self-control* and *self-surveillance,* and this process turns into *a lifestyle*.

Another dimension of the health paradigm is that skepticism is not only toward individual health concerns. On the other hand, the ambivalence between the lay populace and modern medicine benefits increases because people become more skeptical about the increasing dependence on medicine and technological changes. People are not only passive actors about health issues. Social reflexivity gains

importance. Moreover, mass communication media and systems play a significant role when health turns into a socially mediated experience. (Williams and Calnan, 1996, p.1614-1615). In other words, the medical authority is not absolute power as a decision-maker, and the proliferation of medical knowledge through mediation affects the individuals' perception of health and medical professions.

2.1.5. Menopause in the Context of Biomedicalization

The second rising in the medicalization of menopause is happened in the 1980s because of two scientific developments. The first development is that synthetic progesterone or progestin is added as a second hormone to reduce endometrial cancer risk. The second development is that the approval of estrogen is effective in preventing bone loss and osteoporosis. The collaboration of media, the pharmaceutical industry, and the medical professions contribute to the regaining popularity of HRT. Even HRT became more popular after the clinical reports in the 1990s because, according to these reports, HRT decreases heart disease risk. However, in 2002, the Women's Health Initiative published its report. It drew attention to the unexpected results, and estrogen-progestin combination causes to escalate the risk of heart disease, strokes, blood clots, and breast cancer (Watkins, 2007, p.5).

The conflict between the reports is significant in two ways. Firstly, HRT usage results make women more susceptible to using synthetic hormones and doctors' advice. On the other hand, the risk of osteoporosis, breast cancer, heart disease, etc. Its relationship with menopause has become the main topic of middle-aged women's health. Medicalization enlarges its framework from the physical symptoms based on decreasing hormone levels such as hot flushes, vaginal dryness, sweating, and fluctuation of emotions to menopause, which is a sign of the starting point of chronic illness or the acceleration of these symptoms illnesses. In other words, menopause is not only a time-limited and biological event. Moreover, it was a primary symbol of the multiple mid-life issues they were facing (Jones, 1994, p.51).

Another critical aspect of menopause and the increased risk to women's health requires self-control and risk awareness to prevent chronic disease in menopause. This situation indicates that the menopausal context has moved from medicalization to biomedicalization. However, this transformation does not mean that medical treatments and medical understanding have reached gender equality by clearing sexism and ageism. Instead, the new health paradigm and the neoliberal dogma's expansion that health is the individual responsibility of people's own life experiences affect women more. In this understanding of health, women are held responsible for their personal health and the family's health. As a result, protection from illness turns into a state of concern for women, while getting sick brings a sense of guilt (Moore, 2010, p.104). In other words, women's health decisions do not only belong to their own choices, and being healthy becomes both an individual achievement, but at the same time, it is familial.

Traditional gendered roles become crucial. In that sense, the usage of HRT, any doctor help, lifestyle choices, diets, or exercises are not independent of being a mother, a grandmother, or a wife. Therefore, women's motivation to receive medical help or not and their strategies to deal with menopause gains importance.

2.2. Menopause and Sociocultural Model

Menopause as an experience is more than hormone levels. There is a medical gaze that surveils and controls the aging women's bodies. Although biomedical discourse is highly dominated, it is not a universal menopause experience that all women share. According to Lock and Kaufert (2001), menopause is a complex biosocial and biocultural process. Their research shows that Japanese women and Japanese doctors do not define menopause as a sign of female middle age compared to Western culture. *Kônenki* means the period of change of one's life instead of the narrow meaning of menopause, and there is no word to define the hot flash in the Japanese language. The other significant finding of the research is that almost a quarter of the sample point out the end of menstruation is not a sign of *kônenki*, which means that their aging process

is not stigmatized by the biological features (p. 502). Amini and Cormack (2019) also criticize the dominance of Anglo-American perspectives about menopause. To universalize the Western women's experiences means the marginalization of the other women's experiences, primarily patriarchal Muslim societies. In their case, Iranian women's experiences of menopause show that the loss narratives focused on suffering and regret are common, but, at the same time, menopausal time is a finding agency. Amini and Cornmack states that,

> We have documented elsewhere that these women's sexual agency was severely restricted, with sex often being a place of hurt rather than pleasure. Participants engaged in sex with their husbands sometimes because they felt obliged to and feared not doing so. In this research, we focus on how these women asserted agency through menopausal time to challenge the harmful sexual practices they encountered, particularly through using menopausal time as an excuse for rejecting unwanted sex (p. 6).

Their research findings clearly show that while patriarchal culture and medical discourse are dominant in the menopause experience of Iranian women, the menopausal process can turn into an advantage for women to avoid unwanted sex, and women become agency about their sexualities. Another research about menopause in Thailand shows that "Thai women's traditional ties to Buddhism play a major role in their acceptance of midlife as part of the life cycle; an event that is best managed with support from other women" (Noonil, Hendricks, & Aekwarangkoon, 2012). Thus, Tai women's menopausal experience indicates a knowledge network among the women and how religious thoughts and culture play a significant role.

Another critical issue is that the knowledge about menstruation is an intergenerational transmission, enabling us to learn cultural meanings of menopause. Menstruation is an embodied experience linked to the social fabric of women's lives, and menstruation stories are passed down from generation to generation (Field-Springer, Reece,& Randall-Griffiths, 2019, p. 79). In that sense, the end of menstruation is not independent of cultural norms and beliefs. Field-Springer, Reece, & Randall-Griffiths

(2019) extends the menstruation argument till the reproductive health transitions, that is,

> Intergenerational approaches to understanding communication across the lifespan of women assume that familial scripts manifest and shape recurrent narratives passed down to the next generation (Miller-Day, 2004). These familial scripts shape positive and negative perceptions of girls and women that inform cultural understandings of women's reproductive health transitions (p. 82).

In that sense, menopause as part of women's reproductive transition is transmitted through the culture, and familial relations are at the center. In Turkey, cultural transmission and intergenerational approaches are significant. Şenyürek (2019) wrote a master thesis based on the women's menstrual periods in three generations. Her research finding shows that the interviewees generally talked about menopause with their peers. In addition, it has been seen that they can speak to their neighbors, sisters, daughters, or brides. However, the content of the speeches mainly covers the troubles of menopause and rarely includes the positive aspects of menopause. Women's attitudes towards the phenomenon of menopause, which they have not yet experienced, are primarily shaped by what they see and hear from menopausal women (p. 129-130). This research clearly highlights the knowledge about menopause from cultural beliefs, and there is a social network that primarily consists of other women rather than medical professionals.

In 1949, Simon de Beauvoir brought the concept of gender to the agenda of feminist thought. Beauvoir draws an apparent distinction between gender and sex, and she states that,

> One is not born, but rather becomes, woman. No biological, psychic, or economic destiny defines the figure that the human female takes on in society; it is civilization as a whole that elaborates this intermediary product between the male and the eunuch that is called feminine (p. 330).

In Beauvoir's argument, the significant issue is the rejection of biological determinism. According to Butler (1986), Beauvoir's formulation is crucial because

the common understanding of femininity and biology turns upside-down. In that sense, a gender is a form of identity that develops over time. When it comes to debunking the claim that anatomy is destiny, the distinction between sex and gender has been critical. Sex is understood to be the invariant, anatomically distinct, and factic aspects of the female body. In contrast, gender is understood to be the cultural meaning and form that that body acquires, the variable modes of that body's acculturation, and the distinction between sex and gender has been crucial (p. 35). The difference between sex and gender clearly shows that being a woman and her body is about constructing an identity based on culture.

The cultural construction of menopause is a significant issue because menopause as a woman's bodily experience is not only about biological change. Kaufert (1982) argues that,

> 'Passage through menopause' is also an event occurring within a socio-cultural context. It is this — the cultural dimension of the menopause - which forms the second level of its reality. It is at this level that explanation has to be sought for cross-cultural variations in the menopausal experience. The available anthropological data suggests a relationship between a society's definition of the menopause as a positive or negative event and its definition of a woman's status as increasing or decreasing in middle age (p. 144).

Menopause has a broader definition in the sociocultural context. First of all, menopause is not only about the physical or biological change, and sociocultural meanings of menopause give a broader perspective. Second, according to Runciman (2018), Western thought midlife, aging, sexuality, body image, gender roles, and reproduction because definitions and experiences of menopause are embedded in a larger sociocultural context. The last parts try to give more detailed information about midlife, aging, sexuality, body image, gender roles, and reproduction in menopause and how these different concepts intersect each other and constitute middle-aged women's bodies and identities.

2.2.1. Menopause and Intersectionality Theory

When anybody does short research about menopause on the Internet, this person first sees medical definitions, symptoms, treatments, and pictures which symbolize menopausal women who are unhappy, depressed, bored, or anxious. The texts and pictures portray that middle-aged or older women who suffer from menopause. To be more precise, menopause turns into a performance of pain for older women.

The previous chapter shows how women's bodies and life cycles become pathological, and each woman is under the threat of illness because of their biology. At the same time, the brief historical background demonstrates that the medical definition of menopause is not a uniform and unchanging term. In the neoliberal era, the medical authority tries to develop the universal and standard definition, symptoms, and treatments. The women's aging body lies at the standardization process of menopause.

At the same time, medical understanding of menopause is not free from social norms and cultural values. The significant issue is that the dominant menopause discourse reproduces the negative perspective about older women. Therefore, this part attempts to locate menopause in the broader perspective instead of taking HRT or not with considering age and gender relationship at the center.

Intersectionality as a concept is significant for gender and women's studies. For example, Kimberle Crenshaw (1989) clearly asks whether black women are women in Western law and culture. She points out that Black women's subordination is an intersectional experience, which is not the sum of racism and sexism (p. 138). On the contrary, race and gender hierarchies marginalize Black women (p. 151). In that sense, being a woman and being a Black does not equal being a Black woman. The first reason is that gender hierarchy bases on the subordination of white women, not Black women. The second reason is that White men dominate Black men. Distinctly, there is no explanation for Black women through isolation race and gender from each other. In that sense, Black feminism shows how different power relations operate each other and open a new path for feminist thought. To draw a broader perspective, I want to

continue with other definitions of intersectionality because it inspires the recent discussions for gender and women's studies.

Patricia Hill Collins (2015) defines "intersectionality as a knowledge project whose *raison d'etre* lies in its attentiveness to power relations and social inequalities" (p. 5). She continues her argument with the relationship between race, class, gender, sexuality, age, ability, nation, ethnicity, and similar categories should analyze instead of isolating them from each other. These categories are mutually constructing, which underlie and shape intersecting systems of power (p. 14). In that sense, intersectionality gives an analytical approach to analyze the power relations between different categories. In that sense, intersectionality does not mean that it attaches two or more categories together. Reversely, intersectionality allows analyzing the difference.

According to Davis (2008), intersectionality is significant for contemporary feminist thought to understand the effects of race, class, and gender on women's identities, experiences, and struggles for empowerment. (p. 70-71). In that sense, feminist thought criticizes who is the subject of feminism. The universal category of women as a subject had become questioned, and the diversity of women's struggles worldwide has become crucial. The western understanding of feminism bases on the white middle class is highly criticized. (Ramazanoğlu & Holland, 2002, p. 6). However, there are current critics about how feminist thought does not get enough attention the age relations. Calasanti et al. (2006) argue that age is part of the system of inequality. Still, some feminists mention age-based oppression but treat it as a given an "et cetera" on a list of oppressions to indicate that we already know what it is. (p. 13). In other words, there is a need for a gender lens when looking at aging.

To deepen the intersectional relation between age and gender, I would like to explain the dynamic structure of aging, midlife, sexuality, and women's changing roles and status to capture in a broad spectrum the construction of menopause. I believe that menopause has slippery ground because it symbolizes change, which is sociocultural.

Therefore, the following parts seek to conceptualize the directions and features of the change.

2.2.2. Aging

Age identity encompasses each individual's collection of "information" about age and aging in general, as well as stories about their age and aging in particular (p. 15). Age as an identity is a significant issue because it is socially constructed as well as gender. In that sense, age definitions vary in terms of different levels. According to Lorber & Moore (2002),

> At the individual level, age identification is a complex process involving much more than a simple reference to one's chronological age—the number of years since birth. Subjective age, which involves individuals' evaluations of their aging process in relation to their age peers, also plays a role in age identification. And, of course, what individuals believe about others' perceptions of themselves matters in how one defines one's age. Such perceptions could be based in part on notions of occupational age. That is, people may be considered "old" at different ages according to their employment. Finally, scholars also talk about functional age, which involves an assessment of an individual's physical and mental abilities in relation to an ideal type for his or her age group. (p.17)

It is clear that age is constructed differently by individuals and social institutions. Furthermore, the changing meanings of age indicate its dynamic and complex structure. Therefore, the relation between menopause and age cannot be considered only the chronological age of women. However, this does not mean that age is not a significant issue. On the contrary, menopausal age and the construction of aging through menopause are very important.

To talk about menopause at the biomedical level means that hormone levels determine the process, and everything can be visible in biomedical laboratories. However, fundamentally biomedicine tells us what happens when a woman's body gets old. According to biomedical understanding, menopause is a risky situation for women

because their body starts to decline, reproductivity ends, ultimately, women because their bodies become dysfunctional. They are imprisoned into their bodies and ready to suffer from the decline process. Sagging breasts, wrinkling face, lack of sexual drive, pain during the sex, sweating all the time, and suffering from hot flashes. The biomedical model tells us menopause is not only about the decline of hormones. It specially says about the aging process of the feminine body.

The medical authority narrates menopause-like that there is a young, beautiful fertile, and attractive woman once upon a time. The woman wakes up in the morning, and she screams when she looks in the mirror. Her body totally changed during the night, and she looked very old. She thought that I lost my health, sexuality, or youthfulness because I am a menopausal woman anymore. When Snowhite, Cinderella, or whoever princes automatically turns into an old, ugly witch who does not have a name. This anonymity is the most considerable magic because her superpower is invisibility. There is no necessity for the invisibility cloak. Her body and gender are enough to make her latent and silent.

The tale above becomes for the women who have not menstruated for a year. Sociologically speaking, medical discourse is an example of ageism that mirrors a rooted distaste for growing old, disease, disability, and fear of powerless, uselessness, and death (Butler, 1969, p. 243). The biomedicalization of menopause and its relation to aging is not a coincidence. According to Calasanti and Slevin (2001), the biomedical understanding of aging is an illness, which is an obstacle to seeing the inequalities in old age. In other words, a social issue becomes a medical or a personal problem which only medical intervention can solve. Thus, power relations like class, gender, race, ethnicity, or sexual orientation are left untouchable (p. 17). Therefore, too much focus on the biomedicalization of menopause does not broaden the horizon of this research. Calasanti and Slevin (2001) continue their arguments with gender. The social and cultural construction of aging bodies is at the core. The gender lens is essential to see power relations, the diversity of age constructions, and explore hidden dimensions of age social arrangements taken for granted. On the one hand, aging

through a gender lens also enables us to see multiple inequalities, disadvantages, and ageism. On the other hand, this approach reveals the strengths of older people, their empowerment, and how disadvantages can be turned into an advantage in a different context (p. 28).

The construction of aging is not a uniform and unchangeable entity. On the contrary, it is a reconstructed process through social and cultural norms. Twigg (2004) argues that,

> The aging body is thus not natural, is not prediscursive, but fashioned within and by culture. Dominant culture teaches us to feel bad about aging and to start this early, reading our bodies anxiously for signs of decay and decline. We breathe in this toxicity daily. Narratives of decline have replaced all other forms of meaning and interpretation of the body in later years so that other more humanistic or plural readings become impossible (p. 60-61).

Ageism directed at those in their middle years has emerged as a new form of discrimination in American culture and the economic system. Middle ageism attacks its victims from multiple angles (media stereotyping, jokes, cartoons, novels, internalization, "anti-aging" practices). These psychic and social assaults are exacerbated by midlife downsizing, drops in real income, substandard employment, and unemployment. (Gullette, 1998, p. 263).

The phrase "the new regimes of decline" may be an acronym for the growing evidence that ageism and middle-aged discrimination is becoming a severe problem, and Gullette (2011) explains the new regimes of decline as,

> The entire decline system—innocent absorption of cultural signals, youthful age anxiety, middle- ageism, ageism—infiltrating our society from top to bottom, is increasingly a threat to psychological well-being, to healthy brain functioning, public health, midlife job growth, full employment, and a growing economy, intergenerational harmony, the pursuit of happiness, the ability to write a progress narrative, and the fullest possible experience of life itself. (p. 15).

Gullette's argument about middle ageism is very significant when analyzing menopause women are mainly between the 40s and 50s ages, and it is different from being in the 60s or 70s. Especially, middle-aged people actively work as a paid labor, which differentiates them from the retired people. However, being a paid labor or actively working does not mean that middle-aged people are free from age discrimination. On the contrary, middle age as a starting point of aging gains specific features, differentiating itself from young people and older people. In the previous part, I will try to enlarge the argument about middle age and middle ageism in the context of midlife.

2.2.3. Midlife

Midlife is a critical developmental stage in women's lives. It traditionally has been constructed as a physically debilitating and emotionally traumatic stage of life. Women must cope with multiple transitions, including menopause and changes to family life as young adult children move out of the home (Dare, 2011, p. 111). When midlife is defined as a crisis, the empty nest syndrome becomes the first thing because empty nest transition or the period is children permanently leave the parental home when their parents are in their middle ages. According to Mitchell & Lovegreen (2009),

> Early research on transitions to the empty nest has focused primarily on midlife role loss, particularly among women and, more specifically, stay-at-home mothers. Based on traditional role norms, the prevailing. The thought was that mothers, compared with fathers, experience greater distress when children leave home because they put in a greater amount of time and effort into child-rearing and thus have a stronger bond with their children. As a result, the launching of a child was viewed as a particularly unhappy time for mothers (p. 1654).

Midlife is not only the period when children leave their houses. At the same time, menopause mainly occurs during midlife. The biomedical model does not only define menopausal women's bodies as a decline. It also claims that women become more

depressed and mood unstable, and emotionally, menopause is fragile when women feel depressed, sad, or nervous (Gifford, 1994, p. 303). However, substantial research was conducted by Winterich & Umberson in 1999, which shows the relationship between midlife and menopause. The research findings demonstrate that most participants report that stressful life events are more significant than menopause by forming their emotional conditions (p. 62). Kaufert (1994) also criticizes the stereotype of the menopausal woman as depressed because "her children are leaving home and her marriage is an empty sham." She highlights the problematic issues about the medicalization of menopause (p. 343).

To sum up, the literature about midlife shows that women's midlife is marked by menopause, primarily psychological problems like depression or stress and sudden mood changes. However, the research indicates no direct relation between psychological health and menopause based on a sociocultural perspective. On the other hand, aging, changing social roles and status can be effective. Therefore, the next part will be considered femininity and gender roles.

2.2.4. Feminity and Gender Roles

In the context of aging, menopause is seen as a loss of femininity, and menopausal women become less feminine, and the gender difference becomes indistinct. In other words, menopause is conceptualized as a genderless process through aging bodies. However, Calasanti & King's research in 2018, which is based on data from an interview collected from people aged 42-61 to ask whether masculinity and femininity are less age-related and whether people feel gender-neutral, based on theories that men and women become more similar with age,

> First, that respondents see manhood and womanhood as rooted in the appearances of their bodies. Second, they see these gender ideals as based on youthful standards. Third, respondents see masculinity and femininity shifting, for good and for ill, with age as bodies change. Fourth, the loss of status with age produces a struggle over the extent to which they can

> control their bodies. We conclude that while popular ideals of gender are based on youthful bodies, older persons still see themselves as men and women. Further, these new gender ideals challenge neither gender nor age inequalities (p. 11).

The research clearly indicates that gender identity is reconstructed in the aging process, and masculinity and femininity are reproduced in duality. The bodies are the critical factor in that analysis. Being young is idealized through the body. Social gerontologists argue that successful aging is a significant concept for the relationship between the body, age, and identity construction. Successful aging defines as (a) the avoidance of disease and disability; (b) maintaining high levels of mental and physical function; and (c) active engagement with life, which revolves around "relationships with other people, and behavior that is productive" (Rowe and Kahn, 1998, p. 40 as cited in Calasanti, 2016, p. 1094). Nowadays, older women are encouraged to fit into a "successful aging" discourse, which essentially encourages women to invest resources, both economic and personal, to achieve a "socially approved identity." (Piqueras, 2019, p. 86).

According to Katz (2013), the lifestyle discourse is based on the set of practices determined by the relationship to empirically derived predictors of successful aging. The authors assert the familiar theme that the predictors of successful aging are in many ways under personal control. Lifestyle is also typified by choices around smoking, diet, and exercise (p. 61). The changing lifestyles through menopause and control and manage this process are not independent of the cultural norms. According to Bell (1987), the medicalization of menopause reflected and reinforced cultural norms about the 'proper' role of aging women. Menopausal women were encouraged to behave in socially appropriate ways by specialists' prescriptions, such as reading good books, getting enough rest, and participating in social and helpful activities (p. 540).

The second significant issue is that the proper role of aging women is about the traditionally expected attitude and behaviors from menopausal women. Wilk & Kirk (1995) claims that clinical analysis of the meaning of the phrase "getting old" has

revealed that many women associate “getting old” with becoming like their mother or grandmother, in addition to changes in role, status, body image, and sexuality. At menopause, women who see themselves as becoming their mother appear to jump 30 years in age, as if they were already the 80-plus-year-old woman (p. 237). In that sense, the relationship between menopausal age and women’s social status start to change, and being a grandmother adds to women’s social identity.

The third important issue is that menopausal age is around the retirement age. In that sense, women experience menopause mostly during their retirement period or just before. According to Calasanti & Repetti (2016), active aging encourages older adults to remain engaged in paid work as well as social, cultural, and civic life. In policies, the emphasis has been on paid work and, when retired, engaging in activities with an economic implication (p. 37). Second, the representation of retirement as a time of leisure has very different meanings in the experiences of men and women. These differences are shaped by the unequal distribution of work throughout the life course. Women continue to work in the home after retirement, which means they have only left one paid job. In addition, they may increase their unpaid work in retirement (p. 38). In that context, women’s traditional roles and unpaid domestic work after retirement reproduce again. However, the difference is that domestic work and care as unpaid work intensify. Hochschild & Machung (1989) defines the second shift,

> Most women without children spend much more time than men on housework; with children, they devote more time to both housework and child care. Just as there is a wage gap between men and women in the workplace, there is a “leisure gap” between them at home. Most women work one shift at the office or factory and a “second shift” at home (p. 4).

The second shift is also defined that the phrase “double burden” is frequently used to describe the difficulties a mother faces when balancing employment and domestic responsibilities (Chen et al., 2018, p. 2325). However, in midlife, the definition of second shift changes. According to Miller (1981), adult children of the elderly who are “sandwiched” between their aging parents and their maturing children face a lot of stress. As the primary resource and support for the elderly, this group demands

services that the helping professions are only now beginning to meet. A sandwich generation defined by Miller clearly shows that women's burden in the middle ages more than doubles. In that sense, the relationship between traditional gender roles and second shift blended in the sandwich generation, the care responsibility varies from the parents to grandchildren. The women mostly lade the burden.

To sum up, middle-age is defined as an aging process, and it is related to being a woman, a mother, and a grandmother. Whereas women's occupational status cannot be ignored, whereas women work outside of the house, their shift is tripled after retirement.

2.2.5. Sexuality

The biomedical model explains the relationship between menopause and sexuality with the sexual function deteriorates. The most commonly reported symptoms are low sexual desire (40–55%), insufficient lubrication (25–30%), and dyspareunia (12–45%), which is one of the complications of genitourinary syndrome of menopause. Declining levels of sex steroids (estrogens and androgens) play a significant role in sexual response impairment; however, psychological and relational changes associated with aging, as well as an increase in metabolic and cardiovascular comorbidities, should also be considered (Scavello et al., 2019, p. 1).

Issues arise when menopause is viewed from a biomedical standpoint because working on the assumption that biological changes negatively affect sex enjoyment denies the experiences of women who experience positive changes or no changes at all. Furthermore, a biomedical viewpoint employs medical language, which decontextualizes health and illness from their social context and fails to account for the complexities of experience. Instead, proponents emphasize how social and personal contexts influence women's menopausal experiences. Indeed, proponents of the women's lives approach argue that menopause does not occur in a vacuum and

that other life events that cause significant upheaval may occur concurrently (Hinchliff, Gott, & Ingleton, 2010, p. 725).

The common understanding about sexuality is that sexuality change over time. The findings revealed that couples' sexual experiences evolve over time but that the intersection of gender and age shapes this evolution. Changes in their sex lives upset midlife couples (ages 50-69), most likely because they prevent couples from engaging in gendered sexuality. The cause of this dissatisfaction is age-related physical changes, but it manifests differently in husbands and wives. Couples in their later years (ages 70 to 86) were more likely to value emotional intimacy over sex as they grew older (p. 428).

According to Gary et al. (2011), the female body is the ultimate marker of sexuality. Their analysis shows an acceptance of women's material bodies as a fundamental and visible marker of their sexuality. Participants' recognizing several "womanly ideals" alluded to by participants throughout their interviews as part of perceiving the body as an external marker of one's sexuality (p. 90). Dillaway (2005) argues that,

> Feminist scholars have extensively documented the importance of external appearances in Western cultures and described the external body as a "text of culture; it is a symbolic form upon which the norms and practices of society are inscribed" argued that "of all the characteristics that distinguish one human being from the next, physical appearance has the most immediate impact . . . The power of physical appearance pushes people to assimilate in order to avoid unwanted attention or to attract the desired attention." (p. 4).

In that sense, the body in the context of sexuality is about appearance, and physical features are gazed at by the social and cultural norms and reproduced symbolically. Significantly, the relationship between aging, body, and sexuality becomes more complex because, commonly, sexuality is labeled as being young. In that sense, older people are seen as asexual because of the lack of active sexual life and desire.

The traditional stereotype of the 'asexual old age' is challenged by a sociocultural shift in attitudes toward sexuality and aging. As a matter of fact, the current view of celibacy as a "new deviancy" has persisted into later life, to the point where "lifelong sexual function has come to be seen as a primary component of achieving successful aging in general" (Gott, 2006, p. 106). According to Katz & Marshall (2003), "the new aging" optimistic cultural imagery has rallied marketing and consumerism. We focus on the recent emphasis on active sexuality (narrowly defined as heterosexual intercourse) and its promotion as a predictor of positive and successful aging (p. 4).

When looking at the consequences of the new aging and cultural imaginary of sexuality, sexuality is seen as the standard of desirability and aging is encoded as a series of shortcomings, and menopause becomes a turning point in sexual life. After menopause, women are labeled as older, their self-esteem is impaired, their chances of romance are reduced, and they lack a good sex life (Gullette, 2011, p. 125). When considered as a whole, ageist and sexist stereotypes and discourses present a more significant challenge to women as they age. These ideas are encapsulated in discourses about menopause in which gender and aging discourses merge and "devalue older women."

Menopause is widely recognized as the most likely period during which women will experience a loss of sexual desire and cease to regard sexual activity as important Hinchliff & Gott, 2008, p. 67-68). Hinchliff & Gott's research, which was conducted in 2008, tries to challenge the myths and stereotypes of women and aging. The finding is significant to points out sexual activity affects various factors, and there is no single meaning of sexuality, especially for older women. For instance, "religious beliefs, parental attitudes, own sexual and relationship history, and current situation with, or without, their partner as influencing and making changeable the importance of sexual activity" (p. 74).

2.3. Menopause in Turkey

In Turkey, menopause literature is mainly studied by medical schools, especially by nursing schools. However, there is a limited piece of information about the socio-cultural meaning and construction of menopause. Therefore, this part focuses on the sources both from social sciences and medical sciences. First, however, I selected the medical sources which are also considered the gender, cultural and social contexts of menopause.

The menopause discourse is about the western understanding of medicine. Medicalization of menopause is about the westernization process of Turkey. The specific condition of Turkey is that it geographically lies between east and west, and the social lifestyle also shows a wide variety. Some women live more traditionally while others, relatively small in number, live more in a "western" style supported by the laws of the secular republic. Regardless of how they live, most women in Turkey are currently exposed to the western concepts of health and well-being through media and the medical establishment that follows the European tradition. (Cifcili et al., 2009, p. 2). At the same time, women in Turkey adapt and resist the globalized/dominant western medical discourse on menopause to varying degrees. It is almost always framed within the discourse of *bilinç* (can be translated in English as consciousness) and modernity (Erol, 2009, p. 269).

According to Erol (2009), women defined themselves as having the *bilinç* to recognize menopause and seek medical help, while others (such as their mothers) did not. It contains subtle references to education and urbanization and traces of modernization ideals in this context. A slightly different interpretation relates to the more recent emergence of consumerism, such as having the ability to shop for doctors. Another aspect of having *bilinç* is self-education through health information gleaned from newspapers, popular books, and occasionally public health conferences (p. 383).

The visibility of menopause in the public sphere is a relatively new and primarily urban phenomenon in Turkey. There is no word that is equivalent to menopause in the

Turkish language. Women recognize the cessation of menses mainly as a sign of the end of reproductive life, but there is no specific language for changes that come with it. According to the narratives of menopausal women, menopause was a hidden subject, not talked about up until about 15 or 20 years ago (Erol, 2009, p. 375). In that sense, the social and meanings of menopause become significant to grasp the construction of menopause in Turkey.

The medicalization of menopause differentiates itself from Western culture because menopause is seen as a natural transition period instead of deficiency disease by menopausal women. "Natural" was defined as an inevitable but difficult time that one should go through (Cifcili et al., 2009, p. 6). Another critical issue is the religious effect on the menopausal experience because Muslim practices are common in Turkey. According to Cifcili et al. (2009), menopausal women described menopause as "cleanliness." They defined "cleanliness" as the absence of a period or vaginal leakage, both of which they associated with menstruation. In addition, women are required to "bathe" after their period is finished before returning to religious practice, which is known as "cleaning" (p. 7).

Health and menopause are mainly researched in the context of quality of life. However, the relationship between aging and health is solid, and there is a wide range of topics in studies that deal with both issues together. According to Yaylagül & Baş's study (2016), research areas where health and aging intersect are represented by chronic diseases, menopause, dementia, care, masculinity, physical activity, euthanasia, cryonics (extra life extension), accidents, and anxiety (p. 150). The physical complaints are listed hot as flashes, night sweats, facial flushing, palpitations, constipation, distention, osteoporosis, muscle pain, joint pain, decreased range of motion, dry eye, vaginal dryness, stress incontinence, skin wrinkle, fatigue, joint pain, decrease in sexual intercourse, irritability, sexual aversion, insomnia. These are decreasing the life quality of menopausal women (Erkin et al., 2014; Atasü, 2004; Erdem, 2006).

The quality of life term is related to the risk concept in our society. Erol (2011) draws attention because menopause is defined as a risk factor for women's health. She illustrates how osteoporosis turns into postmenopausal risk. She states that in Turkey, the medical discourse defines osteoporosis risk as a combination of embodied and lifestyle risks: women are thought to be at risk due to menopause, and lifestyle changes are required to prevent this embodied risk. The lifestyle risk discourse regards future actions as moral obligations, including retrospective blame for past actions (p. 1496). In that sense, the lifestyle and its regulation become the key factor for preventing the risk factor. To manage the menopausal complaints and their consequences is also seen as a women's duty.

Another critical issue in the relationship between health and menopause is sexuality. Many factors influence sexuality during menopause, including individual characteristics because of a dramatic decrease in estrogen and androgenous oscillation, as well as internal and interpersonal factors. While a drop in estrogen production directly affects sexual function by causing vaginal dryness, hot flashes and night sweating cause women to lose energy, which leads to a reduction in libido. The presence of vasomotor symptoms has less of an impact on life quality during menopause than sexual dysfunction. Sexuality is one of the essential components of women's health, regardless of age (Bozkurt & Sevil, 2016, p.497).

However, cultural myths or narratives can be effective in the menopausal process. One of the myths is that during menopause, women often become unconscious, lose interest in sex, and believe it to be a sign of the end of their femininity. Therefore, it is considered an event that is the end of women's social usefulness and reproductive capacity (Erdoğan & Yılmaz, 1987, p.12).

Similarly, Erol's (2014) research about menopause shows that some of the women she spoke with alluded to sexual problems after menopause, particularly as an issue that affects their relationships with their spouses. Concerns about losing femininity and decreased sexual activity after menopause were the most common concerns they raised. This concern is frequently linked to marital issues that arise due to decreased

sexual activity and their spouse's lack of sympathy. These fears about marital problems were sometimes translated into worries about husbands seeking sexual satisfaction in other women. Despite the prevalent narrative of sexually active husbands dissatisfied with their menopausal wives and fears of marital dangers, some women reported relief from sexual obligations and defined male partners as a burden during menopausal complaints (p. 48). In that sense, women's sexuality is considered the wife's duties instead of enjoying the sex, and women's sexuality is constructed culturally within the borders of family.

Erdoğan and Yılmaz (1987) argue that about menopause, the scarcity of explicit information and the abundance of legends and husband and wife tales are inversely proportional to each other about menopause. These tales create negativity in behavior (p. 12). This research clearly shows that medicine is not only an authority as a knowledge source, and women in Turkey learn menopause from different sources. Therefore, the knowledge production about menopause and its sources are crucial to understanding the sociocultural meaning of menopause.

According to Erkin et al. (2014), their study finds that 10.7% of women did not receive information about menopause, 48.0% received information from health personnel, 34.0% from the media, and 7.3% from books. Therefore, the women's level of knowledge was perceived as 6.7% very good, 39.3% good, 33.3% medium, 8.7%, and 12.0% as very bad (p. 1101). However, Zıvdır, & Sohbet (2017) argues that 74.4% of the women received information about menopause, 16.6% of these women received information from their neighbors, 14.6% from their neighbors and relatives, 13% from relatives and health personnel, 9.8% from their relatives, 9% from health personnel (p. 3).

Additionally, this research points out menopause significantly affects guilt felt by thinking about bad situations. It was determined that knowledge significantly affects perceived guilt. It was found that as women's guilt and shame levels increased, their quality of life decreased, and their guilt-shame and quality of life levels were above

the average. (Zıvdır & Sohbet, 2017, p. 7). These two kinds of research show that the receiving knowledge sources vary.

In some cases receiving information from neighbors or relatives can be higher than when we compare to receive information from the doctors or nurses. The crucial point is that there are many sources for the proliferation of knowledge about menopause, and acquired knowledge affects women's quality of life. In that sense, peer education may contribute to women's positive health behaviors in the menopausal period (Tanrıverdi et al., 2014, p. 75).

One of the most common issues is that the relationship between menopause and depression. Most studies argue that menopause can be a midlife crisis, and women suffer from psychological problems. However, Bayraktar & Uçanok (2002) say that in a recent study on this subject, the frequency of onset of depression after the age of 40 in women receiving outpatient depression treatment was not significantly different from that of women men. Contrary to false beliefs, this finding shows that women are not more likely to experience depression during menopause than men (p. 4). Furthermore, Turkish women chose "being close to their spouse" as the first or second value. In that sense, the quality of the marital relationship and the social support received from the spouse in Turkish society were highly influential during the menopausal process. Therefore, it plays a vital role in dealing with complaints (Bayraktar & Uçanok, 2002, p. 5).

Another significant issue is social class when analyzing the menopausal experience because the meanings of menopause vary in different social classes. For instance, Çıtak (2021) seeks menopause as a womanhood experience, and her analysis is based on the meanings ascribed to the female body concerning menopause. Social and cultural factors influence the menopause process. According to the results, menopause was described as a natural process by the participants. However, the meanings of menopause are on a socio-economic scale; differ in terms of cultural capital. In this context, while menopause is a new life cycle for those in the higher income group and those with high cultural capital, it is characterized as a lower-income group's destiny.

Notably, it was understood that the participants with higher cultural capital and financial income made an effort not to gain weight, not to get old, not to get sick, not to look neglected and bad after menopause, and they feel happier in this way. For this reason, the importance of doing sports, having routine check-ups, walking, and maintaining a feminine and youthful image are emphasized by the participants (p. 73).

Being a menopausal woman can turn into a stigmatization process because of the ageist and sexist discourses, and menopausal women as a stigma emerge as a form of discrimination. Onat & İnanç (2017) researched people's perception of menopause and andropause in social media, and she analyzed the twits. The results show that menopausal aunt, *menopoz teyze* in Turkish, has become popular with the famous comedian Cem Yılmaz. He used the expression "Aunt Menopause" in his play 1 Tat 1 Doku, "The most effective way to build a house out of cardboard is when a woman gives herself to cardboard because she has given up on everything." says (p. 69). Although the gender of the users on Twitter could not be determined precisely, it was observed that about 80% of those who shared negative content about menopause were women. On the other hand, about 70% of those who shared negative content about andropause were men. Thus, when we look at the menopause-related content produced on Twitter, almost symbolic violence is applied through age and gender discrimination (p. 77).

To sum up, Turkey's westernization process is significant to understand menopausal experience because there are some challenges or resistances through the adaptation process of western medicine. In that sense, sociocultural beliefs, norms, and practices should consider when analyzing menopause in Turkey.

CHAPTER 3

METHODOLOGY AND RESEARCH DESIGN

My personal story triggers me to think about menopause. This story includes several doctor visits, examinations, using the drug for months. I had problems with my menstrual cycle, so I had visited the gynecology clinic several times. While I was sitting and waiting for my appointment, the doors were opened and closed. I knew that most of the women were anxious, uncomfortable, and worried when they lay on the gynecologist's table. I was one of them. The worst thing is that these feelings do not stay behind the doctor's room and follow you if the doctor said nothing about your complaints, and you are normal, but you have to use the drugs regularly. So there is a paradox for me if I am normal, why do I have to use the pills, or if I have a problem, what are the name and particular treatment of an illness?

After my last doctor visit, I wished that my cycle was over and felt free. This idea relieved me because I imagined that a body without trouble, there is no burden of womanhood. After a while, I tried to remember my mother's experience, but it was blurred. It was like a half-joke and half reality. Again, there is an invisible curtain over the women's body. At that point, I asked myself why a woman's life cycle is so fragmented, and each part of this cycle is taboo. Menstruation, sexuality, pregnancy, birth, and menopause are both interrelated but simultaneously different and unique types of taboo. However, I thought menopause had specific features. I saw menopause as a period when all the negativities imposed on women would come to an end. At that point, I question how life is after menopause.

When I decided to study menopause, I was a senior student in the sociology department. Menopause did not seem like a hot or core topic for the sociology discipline, especially in the mainstream approaches. The most significant point is that menopause is not a sociological subject to study; it is a fact. Therefore, studying

menopause requires demonstrating its sociological significance and theoretical conceptualizations. As I am now aware of what I wanted, I aimed to question what I have taken for granted about everyday life issues, which look pretty natural and factual. The concept of sociological imagination explains my situation well. According to C. W. Mills (1959), sociological imagination enables its possessor to comprehend the larger historical scene in terms of its significance for the inner lives and careers of a diverse range of individuals. In other words, menopause through sociological imagination is not an individual process. On the contrary, it has a social and historical background. This background is women and their bodies systematically ignored for many years from the social sciences.

Daily life analysis is complicated, especially talking about personal issues, but at the same time, it is inspiring. In other words, subjectivity becomes a significant part of my first scientific research. Therefore, taking the road from subjective experiences or curiosity opens me to new approaches because it stands critically in objective scientific research. Power relations become crucial to understand how ordinary or natural things or links are highly related to social, political, cultural, and economic aspects.

Thinking about menopause and mining its meanings in different social contexts is my starting point. Although gender is used widely instead of sex in many research, being a woman is still considered biological. Primarily, medical authority defines menopause as an aging process of the feminine body because of hormone deficiency. There are two central axes in this statement. These axes are gender and age because menopause by definition signifies an aging woman's body. The menopausal body is also social and cultural construction of aging upon the sexist and ageist grounds. Therefore, the intersectionality of aging and gender requires methodological discussions and theoretical. Thus, further discussion opens in this study on how menopause can be methodologically studied while considering the significance of gender and age.

3.1. Feminist Methodology and Life Cycle Analysis

A methodology is a philosophical and analytical approach to research, including accounts of how the general structure of theoretical research applies (Harding, 1987, p.3). The feminist methodology does not offer superficial social analysis, which is gender-sensitive and adds a variable. On the contrary, the feminist methodology enables us to put the women at the center (Stacey & Thorne, 1985, p.303). When placing the woman at the center in research, their experiences become more visible in the analysis. The visibility of women's experiences means that the experiences of feelings, emotions, and perceptions should be taken seriously into consideration (Browning, 1993, p. 16). Considering women's continually experiences means that,

> (i) theory derived from experience analytically entered into by enquiring feminists;
>
> (ii) subject to revision in the light of that experience;
>
> (iii) thus reflexive and self-reflexive and accessible to everyone (Stanley & Wise, 1990, p. 23).

In that sense, the feminist methodology provides research based on the individual experience, criticizing the hierarchical relationship between the researcher and the participants. Studying menopause in Turkey is significant in two ways. The first aspect is that menopause is taboo, and talking about it is not easy. Therefore, the feminist methodology provides to make visible women's menopausal experiences.

Secondly, the feminist methodology allows one to conduct research and analyze it, struggling with common knowledge about menopause. At the beginning of the fieldwork, I aim to focus on women's menopausal experiences. My research was reshaped during the fieldwork because participants highlighted that menopause is not an isolated experience from women’s life cycle experiences. Aging has become a significant issue. Therefore, the life cycle enables us to understand women’s experiences in depth.

On the individual level, menopause is a permanent cessation of the menstrual cycle, totally biological. However, the isolation of menopausal experience from the social, cultural, and economic aspects makes the analysis one-dimensional. To link between individual experience and structural elements, the life cycle analysis helps to draw a connection between macro and micro-level analyses. Therefore, I follow Glen H. Elders' conceptualization of life course analysis and explain step by step why the life course analysis is crucial for studying menopause. One part of menopause is about women's bodily experiences. The other part is that menopause is about aging. According to Elder and Rockwell (1979), age has three developmental, social, and historical meanings; that age is about both agency and structure. In other words, studying age gives a chance to make a multidimensional analysis. Mainly, it is very significant when age intersects with gender in the menopausal experience. To be more precise, the life course analysis can interoperate with the feminist approach because menopause as an intersection point of gender and aging gains individual, social and cultural meanings. Although the biomedical model describes menopause as the last menstrual period, menopausal transition, and quality of life, according to the life course perspective, they result from lifelong factors and influences (Yisma & Ly, 2018, p. 401).

To understand the dynamic structure of menopause and to study patterns about it, I will conceptualize menopause within the principles of the life course perspective, which Glen H. Elder (1998) defines in The Life Course as Developmental Theory:

> (1) The first principle is historical time and place: individuals' life course is embedded in and shaped by the historical times and places they experience over their lifetime.
>
> (2) The second principle is timing in lives: the developmental impact of a succession of life transitions or events is contingent on when they occur in a person's life.
>
> (3) The third principle is the linked lives: lives are lived interdependently, and social and historical influences are expressed through this shared relationship network.

(4) The fourth principle is that the human agency states that individuals construct their life course through their choices and actions within the opportunities and constraints of history and social circumstances.

First of all, the participants in this research live in Turkey and experience menopause between 1994 and 2020. The time difference is noteworthy to understand how the context of menopause changes over time in Turkey. Significantly, the simultaneous rise of the feminist movement, neoconservative politics, and the neoliberal economy in Turkey have been significant. Therefore, mainly discussing the menopausal experiences is very critical between 1990 and 2021.

Secondly, the time of occurrence of menopause is significant because the social roles or status can change in the age of menopause. For example, women can be retired or be a grandmother in their middle ages. Similarly, premature or early menopause can affect women's life course because they experience unexpected situations. Therefore, the transition of social roles and expectations can intersect with menopause.

Thirdly, menopause is an interdependent point of individual and historical events that share in a network. For example, women come together and share their menopausal experiences, or menopause can narrate from one generation to another. Additionally, menopause as a shared experience can create its networks via social media. Therefore, the menopause experience carries new possibilities for creating new networks.

Fourthly, although the social structure limits individual agency, there is still room to make choices. In other words, an individual's preferences and actions are effective in constructing the life course. For instance, HRT usage can be widespread in Turkey, but there is no legal obligation about using HRT, and women are free to use or not use the HRT. Individual choices and actions can differentiate women's attitudes or beliefs.

To sum up, historical time and place, the timing of lives, linked or interdependent lives, and human agency are the key points of the life course approach. These points give a multidimensional analysis of menopause instead of an isolated experience. Social, historical, and individual constraints and opportunities are significant in

menopause because of the advantages or disadvantages of childhood, adolescence, or adulthood, cumulating in the middle ages. For example, a woman cannot know the biomedical definition of menopause because of being illiterate, not about disinterested in menopause. Besides, socioeconomic status can be distinctive the entrance age of menopause or their quality of life.

3.2. Research Method and Design of the Study

This thesis aims to understand how menopausal experiences are constructed in women's lives and how their individual lives affect their menopausal process. Therefore, two main axis points are necessary for achieving the thesis aim. On the one hand, I need to collect data about women's lives and their backgrounds. On the other hand, I need to gather information about menopausal experiences. To ensure the balance between the menopausal and women's life course, I used the qualitative research method to locate the women's experience at the center. In addition, I used an in-depth, semi-structured interview that consists of the key questions the study addresses. As a result, open-ended questions are more common, persuading people to speak more openly in the semi-structured interviews (Arksey & Knight, 1999, p. 97).

Feminist interviews concern getting at the subjugated knowledge of the diversity of women's realities that often lie hidden and unarticulated (Hesse-Biber, 2007, p. 113). In that sense, asking questions and exploring issues of particular concern to women's lives lie on the ground of this study. My questionnaire comprises main topics about menopause experience instead of closed-ended or "yes/no" structured questions. At the beginning of the interview, I only ask sociodemographic questions to identify the standard and distinct features of the participants. These questions are about the name, current age, age of menopause, marital status, number of children, level of education, profession, family income, and individual income. The socioeconomic and demographical characteristics will be critical in analyzing data. So, these features enable me to group the participants sociologically.

Secondly, to know the participants in detail, I asked them to tell their life stories. I aim to understand the turning points and trajectories in participants' lives. The second part of the interview has only one question; however, it is the wealthiest part of the interview because the menopausal experience is not isolated from women's experiences. Moreover, the women's life story enables participants to remember their feelings and memories about menopause more clearly and compare before and after menopause.

The third part of the interview tries to understand how the participants define menopause and the physiological and psychological changes—the fourth part of the interview endeavors to grasp the meanings of health and well-being. Finally, the last part focuses on more cultural implications of menopause and changing social roles in their middle ages.

After the questionnaire was ready, my advisor and I checked to double all major and minor questions in the interview. The language of the questions should be symbolically violence-free and not include leading questions or discriminative language. We tried to ask more coherent and straightforward questions without changing the interview direction and without creating any doubt. After the preparation process of the interview questions, I applied to the ethics committee at METU.

3.3. The Processes Before and During the Fieldwork

Choosing and putting criteria about participants is very significant in a methodological manner as the selected sample directly affects data. The important thing is here; there should be consistency between epistemology, methodology, and ontology to obtain and analyze data in a meaningful way. I want to explain how the sample choice transforms this study. When I took the Qualitative Research course, my professor told us to conduct field research at the graduate level, and she highly recommended studying our master thesis. Before conducting fieldwork, I had to choose my sample and report it to my professor. I wanted to research with the women who get medical

help, and I was planning to interview in hospital settings. Mainly, I planned to go to the menopause clinics in Ankara as I aim to understand the medicalization of menopause, and my sample consisted of menopausal women who get medical help, especially using hormone therapy. The problem is that I was working six days a week and only Mondays were my holiday; however, I had two courses from 09.40 to 17.30 every Monday.

Consequently, it was impossible to research the hospital settings. Therefore, I had to change my sample criteria, and I decided to interview any menopausal women without the obligation of using hormones or getting medical help. At the end of the research, I realized that women's decisions about their bodies and perceptions were highly influential about getting medical help or using the hormone. The critical point for me, women can resist the medicalization of menopause, and I ignored these women's experiences, and I locate women in a passive role with medicine. When I shared this situation with my professor, she smiled and said to me:

> *Do you always go to the doctor every month for your menstruation?*

This question was critical because I categorized menopausal experience as a disease at the beginning of the research. The field research also shows me how the perceptions about aging could differ when comparing the Western culture. In the end, I evaluate this research experience as pilot research and reconstruct my thesis statement and structure.

In this thesis, I try to be more careful about sampling. I am open to various menopausal experiences; hence, I only have one criterion that women should be experiencing menopause now or experienced before. There is no restriction about age because I consider premature, early, or late menopause. Moreover, pandemic situations do not

allow me to conduct face-to-face interviews; in that sense, instead of space limitation, I could reach more women across Turkey through online video conferences.

My fieldwork came across the COVID-19 pandemic; therefore, I have waited to approve my interview questions for approximately two months. I was aware of this situation because working conditions and working hours could increase or decrease according to the positive cases. Two months was a long period for waiting; hence, I decided to do a feasibility study about the research sample. I made a list of who I could reach and divided them into three parts. The first part includes my network, especially, mothers of my friends. The second part, my close friend, who has lived in Ankara for a long time, could help me because his mother's network is pervasive in the neighborhood and work environment. In the third part, my mother could talk to her friends, neighbors, and relatives.

After I started the research, my sample turned into the snowball technique. I met with some women in the first and second parts, and they told me they could help find participants. With growing snowball sampling, I reached 14 women, and sharply the participation decreased. I wanted to solve this problem; however, I do not want to dominate one group and create a homogenous sample. Additionally, I had never contacted the women in the third group because they live in the same neighborhood who migrated from Bulgaria to Turkey. At the same time, their closure could cause biases when they were answering the questions.

After a stagnation period, I decided to write a post on the Facebook group METU Women Solidarity. Thanks to this group, I conducted the women whose daughters or nieces replied to my post, and the new participants also recommended my study to their friends. In the end, I reached 24 postmenopausal women. I gave the participants detailed information about the interview through messaging, e-mails, and telephone calls before the interview. If they agreed to interview, we planned a day and a particular time for the meeting. I preferred to use the WhatsApp application for video conferences because it is the most widespread communication in Turkey. After all, it is free, easy to use, and does not need a password or invite link. The participants could

answer my calling with only one touch. The only need was the telephone number, and I have already had talked about the numbers for asking the participation. In that sense, 21 interviews were done through WhatsApp; only one was conducted via Zoom. The other two started with facetime but turned to a typical telephone call because one participant said that her Internet was limited. We could not see and hear each other in the other meeting because of the poor internet connection.

Privacy was fundamental for the interviews as my participants and I were not physically close ourselves; we only met and talked to each other via the Internet. It seemed so virtual, and I had to try new techniques instead of traditional ones. At the same time, I had to develop a relationship based on trust and comfort. I conduct 23 interviews on my mobile phone and one interview from my computer. All participants allow me to record their voices. I took only voice records through my tablet, and I showed my tablet to the participants to prove that I never recorded their videos.

Moreover, all names are changed with pseudo names to protect the identities of the participants. I was fortunate because I had no problems with trust. On the contrary, my participants offered me to meet their friends who experienced menopause. Lastly, I transcribe all voice records and translate them into English myself.

3.4. The Demographic and Socioeconomic Characteristics of the Sample

METU Human Subjects Ethics Committee approved the interview questions on 29th January 2021. After the approval date, I immediately started my fieldwork which ended up on 1st March 2021. Overall, I conducted 24 postmenopausal women in different provinces of Turkey. To have an analytical approach, I need to classify the data which comes from the field. At that point, two tables summarize the data. The first table indicates the demographic and socioeconomic features of the participants, which are below. The second table demonstrates a typology, which includes how menopause experiences differentiate each other and how they can be grouped

according to their similarities. In that sense, there is a classification of the data which comes from the field.

Table 3.1. The Demographic and Socioeconomic Characteristics of the Sample

Names	City	Current Age	Age of Menopause	Marital Status	Number of Children	Education Level	Profession	Family Income (TL)
Piraye	Londra	42	32	Married	0	University	Advertiser and writer	20.000
Nil	Ankara	48	40	Married	3	High School	Market worker	10.000
Türkan	Çorum	51	40	Married	2	University (O)	Public official	12.000
Aylin	Ankara	59	41	Married	2	University	Public official	11.000
Safiye	İzmir	62	42	Widowed	3	Primary	Housewife	3.000
Gülay	Aydın	54	45	Married	1	High school	Housewife	10.000
Müşerref	Ankara	59	45	Married	2	High School	Housewife	3.000
Nigar	Ankara	68	45	Widowed	2	High School	Bank employee (R)	7.000
Nurşen	İstanbul	60	45	Single	1	University	Teacher (R)	4.500
Elvan	Çorum	54	46	Married	2	Primary	Housewife (R)	5.000
Hasibe	Ankara	63	46	Married	2	High School	Public official (R)	4.500
Mercan	Çorum	53	47	Married	2	University	Public official	16.000
Şahika	Ankara	60	47	Married	2	University (O)	Public official (R)	6.000

Table 3.1. Continued

Adile	Ankara	58	48	Married	2	High School	Self-employed (R)	5.000
Nihan	Ankara	64	49	Single	2	University	Self-employed (R)	3.500
Aysu	Konya	77	50	Married	2	Associate degree	Teacher (R)	7.000
Ayçil	İstanbul	52	50	Married	2	High School (D)	Housewife (R)	7..000
Aygül	İzmir	52	50	Married	2	University	Teacher (R)	30.000
Esma	İstanbul	52	50	Married	1	Doctorate	Academician	17.000
Gülben	İstanbul	55	51	Married	1	University	Industrial Engineer (R)	15.000
Mehpare	İzmir	54	53	Married	1	University	Bank employee (R)	11.500
Nuray	Çorum	60	53	Married	2	Master	Public offical (R)	6.000
Nevra	Ankara	65	55	Married	2	University (O)	Public official (R)	10.000
Neslihan	Ankara	59	57	Single	2	University (O)	Public offical (R)	3.400
						O: Open University	R: Retired	
						D: Drop out		

According to **Table 3.1**, the spatial distribution participants are that 10 of them from Ankara, 4 of them from İstanbul, 3 of them from İzmir, 4 of them from Çorum, 1 of

them from Aydın, 1 one them from Konya, 1 of them from London who is a Turkish citizen and experiences menopause in both Turkey and England.

The current age of the participants varies from 42 to 77, and the average age is 57. Another important aspect is that age of menopause is between 32-57, which means that women experienced menopause between 1994-2020. The average menopausal age is 47. The number of children listed like that 17 of the participants has two children, 5 have one child, 2 have three children, and 1 has no children. In that sense, having two children is the most common type in the number of children. The marital status changes that 19 participants are married, and 5 participants are single, 3 of them divorced, and 2 of them lost their husbands. There is no question about sexual orientation in the interview questions, but the marital status and women's narratives also indicate that heterosexuality is the dominant form. Therefore, I do not specify the type of relationship as heterosexual, and I will explain the causes of the domination of heterosexuality in the limitations and new possibilities part.

The education level is higher because 15 participants have a university degree, one associate degree (2 years university degree), one master's, and one doctorate. The second widespread education level is high school degree, 6 participants graduated from high school, and one participant is a high school dropout. Only two of the participants have primary school degrees. Depending on high-level education, only 4 participants defined their occupation as a housewife. Others are actively working or retired from their jobs. One of them is a blue-collar worker, and the others are white-collar. The significant point is that 12 out of 20 are public officials. Only 4 participants work in the private sector, and 2 participants are self-employed.

Monthly family income can divide into three parts. The first part of monthly family income varies between 3000-4500 TL; 6 participants are in this part. In the second part, income goes between 5000-7000 TL; 7 participants are there. Finally, the last part is between 10000-30000 TL; 11 participants are in this part. In that sense, the upper-middle level is higher than middle and low-level income.

Up to here, I draw a general picture to familiarize my data. Then, after collecting socioeconomic and demographic information and in depth-interviewing, I started to analyze my data more carefully for a deeper understanding. Here, I want to explain how and why I need to group the participants in the second table below. First of all, I read the transcripts of the interviews carefully and tried to find the patterns through coding. Then, I highlighted similar explanations and statements and colored them. After that, the main themes became more visible to the conceptualization of the experiences of menopause.

The main concepts were being a woman, bodily changes, emotional changes, doctor help and using the hormone, aging, maturation, reproduction, sexuality, health and wellness, and knowledge about menopause. However, I realized that these concepts follow the same patterns in different age scales. For example, the meaning of reproduction is different who experience menopause age at 30 than 50 years old. Therefore, I decided to create typologies to make the classification. According to Gibbs (2007), typologies are useful analytic and explanatory devices because data can classify in a multidimensional way (p.83). In that sense, I create five typologies to understand the menopausal experience following premature, early, almost on time, on time, and late. To demonstrate more clearly, I made a table that includes the codes about data and how these codes are grouped and colored in a certain way.

Table 3.2. Typologies of the participants

Names	**Current Age**	**Age of Menopause**	**HRT Usage Time (M)**	**Type of menopause**	**Marital Status**	**Number of Children**
Piraye	42	32	12-24	Premature	Married	0

Table 3.2. Continued

Nil	48	40	24-36	Premature	Married	3
Türkan	51	40	54	Premature	Married	2
Aylin	59	41	6-12	Early	Married	2
Safiye	62	42	24	Early	Widowed	3
Gülay	54	45	0	Early	Married	1
Müşerref	59	45	12-24	Artificial	Married	2
Nigar	68	45	0	Early	Widowed	2
Nurşen	60	45	0	Early	Single	1
Elvan	54	46	1-2	Artificial	Married	2
Hasibe	63	46	0	Normal	Married	2

Table 3.2. Continued

Mercan	53	47	0	Normal	Married	2
Şahika	60	47	1	Normal	Married	2
Adile	58	48	1-2	Normal	Married	2
Nihan	64	49	0	Normal	Married	2
Aysu	77	50	0	Normal	Married	2
Ayçil	52	50	0	Normal	Married	2
Aygül	52	50	0	Normal	Married	2
Esma	52	50	0	Normal	Married	1
Gülben	55	51	0	Normal	Married	1
Mehpare	54	53	0	Late	Married	1

Table 3.2. Continued

Nuray	60	53	0	Late	Married	2
Nevra	65	55	0	Late	Married	2
Neslihan	59	57	0	Late	Single	2

According to **Table 3.2**, the first typology is premature menopause, whose color is red. In this group, women experience menopause under 40 age. Premature menopausal women use hormone replacement therapy (HRT) from 12 to 54 months, which is the most prolonged HRT usage among the other groups. This group also applies for medical help is frequent and regularly more than the other groups. Moreover, medical authority sees that premature menopause is a pathological issue. It has to be cured by hormones because the body experiences a sudden hormone level difference. At the same time, the time in menopause lasts longer, which means the body suffers from hormone deficiency longer. According to Mishra et al. (2019), the appropriate medical term for premature menopause is primary ovarian insufficiency. It is associated with an increased risk of all-cause mortality, cardiovascular disease, type 2 diabetes, depression, osteoporosis, and dementia risk (p.83). In medical understanding, premature menopause turns into a high-risk factor that the body becomes more open to the diseases. Another significant issue is the menopausal age because women experience menopause when they do not expect it at that time. Therefore, menopause can turn into an unexpected and unprepared situation.

The second type of menopause is early menopause, in which women experience between 40 and 45 (Edwards et al., 2019, p.46). This group is colored orange. The only difference between early menopause and premature menopause is the age when

menopause occurs. Although the medical definitions of early and premature menopause are almost the same, HRT usage varies between 0-24 months. The crucial point is that the participants in 41 and 42 age use the HRT longer than others. One participant experienced artificial menopause, which occurs through surgery and removal of ovaries. The important thing is there other participants whose age at menopause is 45 do not use HRT, and they naturally experience menopause. It is evident that although medical authority defines early menopause as a risk and pathological issue, increasing age can differentiate the medical intervention and perception.

The third type of menopause is almost on time, which has a yellow color. This group is the transition type between the pathological and natural kinds of menopause. The participants' experiences show that menopause between 46-49 is normal, but there can be little medical help. In that sense, half of this group never uses HRT, and the other half only uses 1 or 2 months. I call this group almost on time because there is no joint agreement about HRT usage. Some doctors think that menopause at 46-49 is normal. However, other parts of doctors continue to prescribe the HRT. The difference can cause the difference between the average age of menopause. International medical research shows that the average age at menopause is 51, and menopausal age decrease between 47 and 48 in Turkey (Seyisoğlu, 2006, p. 7). At the same time, the participants' perceptions, attitudes, and behaviors are similar to medical authorities in Turkey. In the first months or years of menopause, they need medical help, but they do not need it or make limp during their doctor visits.

The fourth type of menopause is on time, and women’s ages are between 50 and 52. This group is colored green. Not only scientific authority, but the participants also agree that they experience menopause is natural because of their entrance age of menopause. This group rarely uses the HRT and needs a doctor's help. They drive a giant wedge between the doctor visits, and the most go to the doctor for regular checkups, with no complaints about menopause. Their common opinion is that menopause is a natural process, and its difficulties are temporary. Hence, they think

that they do not have to use drugs, and they can get over menopausal problems through the change of lifestyle.

The last type is late menopause, which is colored blue. In this group, women's ages change between 53 and 57. Late menopause is not a very common term, especially in the medical area; however, my participants define their menopausal experiences as late. In this group, the menopausal difficulties and complaints are the lowest level. Women complain about why menopause occurs at that age because they want to experience menopause. Moreover, this group does not use HRT usage because they claim that menopause is an expected and desired event instead of other groups.

All these groups are based on age at menopause as an indicator. It is clear that menopause has a vital role in the experiences, and in this study, these groups are a typology of menopause. I will use them as an analytical data analysis to demonstrate the relation between age and gender. In that sense, typologies enable me to compare how menopause affects women's perceptions about the same concepts at different ages.

To conclude, I want to add that typologies of menopause will use in the findings part more broadly. In this part, I try to give information about the constitution process, which criteria are significant, and the points the experiences differentiate. Especially, using HRT and its frequency of usage, taking help from a doctor, and its frequency and age of menopause are primary criteria. In the findings part, these typologies will be considered under the main concepts.

3.5. Fieldwork Experience Under the Lockdown

When I started my interviews, COVID-19 restrictions has reinstated in Turkey for two months. In addition, the curfew on weeknights and a whole weekend were introduced as new restrictions against the second virus wave. Residents in Turkey aged sixty-five and over and residents in Turkey aged 20 were affected more than others because of the regulations. Therefore, my participants could be a high-risk group. In these

circumstances, I could not conduct face-to-face interviews because of the infection risk.

Consequently, I had to change my interview techniques. The online research methods were not new, but the researchers preferred to conduct face-to-face interviews because the field and the relations in the field are part of knowledge production. In that sense, our methodology, and research methods, are also about knowledge production. In other words, the relations in the field are not only about methodology but, at the same time, it is also about epistemology. Therefore, this tries to present background about the fieldwork and the relationships in knowledge production.

The existing conditions are not available for the traditional research methods. During the Covid19 pandemic, the most widespread communication tool become video conferences. My participants and I write the messages, make phone calls, and facetime before, during, and after the fieldwork. This situation creates a space for communication differently because, before the pandemic, I got appointments from the participants, and we have rarely communicated with each other. However, video conferences make interviews more flexible as we can arrange and change meeting dates or times with only a message or a short phone call. In that sense, our meeting has become a part of daily life, and nobody has to go to the meeting place. Everybody is in their homes, the strangeness feeling becomes lower, and both sides feel more comfortable during the interviews.

Reflexivity is an essential topic for feminist methodology. The relation between the researcher and the participant is also a social relation. During fieldwork, I can say that my researcher position is mostly outsider because of my age, social, and marital status. In the eyes of my participants, I am a young, single student, which means that I have not fulfilled the experience of womanhood yet. I am not married; I have no children, and I am so young for the menopausal experience. In other words, I am at the first step of the ladder of womanhood. In that sense, being a woman has different stages, and age can decide the hierarchy. However, this study is an excellent example of how the hierarchy between other age groups is criticized, denied, or blurred. Thanks to my

participants, they talked about their experiences which they consider private. For example, talking about sexuality with third-party people is not common in Turkey, especially the women who do not in their peer groups. Therefore, I can honestly say that menopause is not only a myth of middle-aged sexuality or their biological changes; it is also a myth about a particular hierarchy about being a woman through age.

The challenging normative ideas about womanhood change little my outsider position. In the end, I am also a woman, and I will experience the same things in the future. Hence, there is nothing "wrong" with talking about their experiences. Another important thing is that all interviews are base on voluntary participation. Some of the participants want to help because they support scientific knowledge, and they are happy to contribute to the social science on womanhood. The other participants think female students should be supported as their college life was more challenging because of their gender. Therefore, the women who participated in the interviews said that "I hope to help you and your thesis." At the same time, talking about women's daily lives encourages them to talk more because they are careful and willing listeners. Their main complaint is that young people do not want to listen to the older people, ignoring the middle-age.

Moreover, a hierarchical structure based on age is not an obstacle for his study because women think they help a woman researcher and support her. On the contrary, the participants answered the questions openly as a part of solidarity, and my age did not affect the interviews negatively. Gender is more effective than age because menopause is mainly shared among other women. Although I am a young person, listening to the participants' experiences is an advantage.

When pandemic conditions are added to these, the interviews become more profound; the participants want to talk about somebody, but they could not go out and meet their friends or relatives. At the same time, the pace of daily life slowed down the curfew. Consequently, we have more time and need to speak to each other to eliminate the pandemic's unfavorable conditions. Therefore, I believe that the fieldwork turns into

a solidarity area. After all, my participants support me because I am a woman researcher. At the same time, talking and listening to each other under the lockdown makes us more relieved and happier because we need socialness and want to know that we are not alone. Therefore, the interviews have a minor contribution to supporting each other.

3.6. Limitations and New Possibilities

The last part focuses on the interview process. Feeling solidarity is an incredible moment for me. However, everything does not go well, and I will concentrate on the limitations of the research. This part is base on my field notes, which enable me to remember how I feel and think when I struggle about the field. The most complicated thing for me is that I cannot reach some women. I want to give place to different experiences of menopause as far as possible. However, getting the women is not easy at all. The women claim that I cannot talk about menopause because I am embarrassed. At that point, the feeling of embarrassment has three different sources.

The first one is that women cannot appropriately express themselves because of their low-level socioeconomic condition. They highlight that they are uneducated or less educated, and asking questions means answering correctly for them. Although I informed them there is no answer to right or wrong, I cannot remove their discomfort.

The second reason is that women talking about menopause is a shame because it is about reproductivity. For example, I cannot offer my friend's aunt because she has no child; she lost her husband and never married again. My friend told me if you try to talk about menopause, she can misunderstand because of asking questions about sexuality or reproductivity. Another example is that my other friend's aunt has never been married, and talking about menopause is inappropriate. It is undeniable that if a woman is not married or has a child, she cannot speak about her menopause, menstruation, sexuality, or body. The worst is that other people can decide for these women, and I cannot ask directly to them about participation.

The third reason is that if a woman is old, she cannot express herself. When I asked my friend's friend whether his grandmother could participate in the research, he said my grandmother does not understand menopause. She calls you my menopausal girl because she has not heard menopause, and she can think that menopause is your name. The example shows that young people believe that older people are not eligible to participate in scientific research.

Moreover, I could not reach the women who do not identify themselves as heterosexual. I tried to contact them through an association, but there was no answer to my message. Therefore, heterosexuality dominates this research. When searching for somebody, I realize that to conduct middle-aged women who are not heterosexual is harder than young women.

Lastly, online interviews during the lockdown become an obligation because there is no chance to contact face-to-face interviews. Although facetime through Whatsapp provides more comfortable and flexible fieldwork, I could not have a chance to observe women's daily life and our interaction was very limited. Sitting on the phone and talking to a less-known person is not an easy activity. Primarily, facetime does not allow us to give a break frequently like a face-to-face interview, and they became shorter than what I planned.

To conclude, my biggest problem is that the hierarchy among women. If a woman is heterosexual, young, educated, middle-class, married, and has a child, she can talk about her body. I realize that "the appropriate woman" understanding requires more detailed studies because the discrimination of other women makes them invisible. The worst thing, people can quickly stigmatize these women. Therefore, I believe that this study is essential to questioning the intersectionality of sexism and ageism. However, other detailed studies are necessary to reveal further discriminative stigmatization.

CHAPTER 4

MENOPAUSE AS A TRANSITION PROCESS

In this chapter, I try to analyze the findings of the research. According to my results, menopause is a sign of aging, and its dynamic structure is analyzed in two parts. The first part enables us to discuss the biomedical understanding of menopause and how women experience the medicalization and biomedicalization of menopause. The critical point is to see how menopausal women interact, negotiate, or resist the biomedical model of menopause. The key point is that the aging body goes under the gaze of medical authority because the definition of menopause as a deficiency disease is not sufficient to understand menopause as a risk for health and the control and managing of menopause to prevent aging.

The second part focuses on the social and cultural construction of menopause, and the main argument of this chapter is that menopause is a blueprint of aging. However, the biomedical model argues that women's bodies change during the menopausal process. Women's menopausal age intersects with the changing social, cultural, and economic status of women. At that point, I question how women construct their midlife and in which context menopause occurs. This analysis aims to understand menopause in a broader context because when I asked questions about it, there were many labels and negative connotations about menopause and stereotyping of menopausal women. Therefore, there is a to clarify how menopause is related to women's gender and age identity construction.

4.1. Biomedical Aging and Menopause

This chapter tries to understand the relationship of women’s subjective experiences with medical authority. The tension between medicine as a structure and women as a subject is critical because the biomedical model ignores women’s subjective

experiences, and women have seen passive recipients. Medicine turns into a control mechanism over women's bodily experiences. Notably, menopause is defined as a starting point of aging, which is based on biological age. According to Jazwinski and Kim (2019) defines biological aging, that is,

> Several approaches to quantify biological age have been utilized, including the use of biomarkers in the form of serum analytes, epigenetic markers, and deficit or frailty indices. Among these methods, the deficit index possesses a theoretical basis grounded in systems biology by incorporating networks, with their emergent properties, to describe the complex aging system. Application of the deficit index in human aging studies points to the increased energetic demands posed by an aging system that is losing integration (p. 1).

The use of biomarkers and the emphasis on deficiency, fragility, and loss conceptualize aging as an unwelcomed issue. Menopause as a deficiency disease is not a coincidence, and on the contrary, menopause turns into a particular form of gendered biological aging. Calasanti and Slevin (2001) argue that the gender lens on aging is necessary to understand the unequal power relations because the embeddedness of gender at all levels of social relations enlarges from individual interactions to structural or institutional processes. After all, gender becomes an organizing principle that shapes the interactions (p. 36).

In that sense, the gender lens requires understanding how menopause becomes a symbol of women's aging process. This part divides into five subtitles to analyze menopause as women's subjective interactions with the structural level. The first subtitle is about the first impressions of menopause, and it aims to understand how women define their experiences without any leading question. The definition, description, and features of menopause become more apparent. The second subtitle is about the physiological changes after menopause, which enables us to analyze how women define bodily changes, which allows us to compare women's definitions with the biomedical symptoms of menopause. The third subtitle has a similar aim to the previous one, but this part focuses explicitly on psychological changes. The fourth

subtitle seeks to understand the conceptualization of reproductivity and sexuality. The significant issue is that this part does not equalize sexuality with reproduction. These two concepts are seen as two different analytical concepts. The last subtitle is about health and lifestyles, which investigates how women define health and wellbeing, what they are doing for being healthy and how their perceptions and practices change after menopause.

4.1.1. First Impressions of Menopause

During the interviews, I asked my participants what comes to mind when they think of menopause. This question aims to understand how the participants define menopause in their own words because their subjective definitions are interrelated to both medical and sociocultural meanings of menopause. At the same, this question enables me to open the menopausal experiences for deeper discussions.

All women in my sample define menopause as the cessation of menses. In the literature review part, I demonstrate that menopause has many stages: premenopause, perimenopause, menopause, and postmenopause in the biomedical model. However, my participants do not use these stages, and they refer to all stages as menopause. The significant issue is that women describe menopause as an entering stage, and all interviews go on before and after menopause. In that sense, menopause has become a new phase in women's life.

Women's entrance the menopause does not always happen smoothly. In some cases, menopause is an unexpected experience. This unexpected situation divides into two ways. The first one is that women experience menopause earlier age than when they expected. Piraye, who experienced menopause at 32 years old, mentions her reaction when she learned that,

> I mean, it was like that boiling water just poured out of my head. You know, there was a big confusion because I started to question who I was. However, I have never thought that

> menstruation is a part of my identity. Otherwise, that's how I did it. Of course, these realizations were interesting for me.

When menopause occurs unexpectedly, it becomes a shock for women because they are under the average menopausal age. Some participants who experienced menopause earlier argue that they applied to the doctor when they realized the irregularity or delay in their periods. After the examination, there was no concrete physical reason for early or premature menopause, and early menopause is not common in their family background. Becoming a menopausal woman early without reason can make women more stressed because the acceptance process of the situation lasts longer. The other group argues that they experience early menopause because of their genetic transmission. For instance, Gülay (54 years old) explains that,

> At first, of course, I had this fear that I always ask if we want a second baby. We thought about it. I had a fear when these menstrual periods became irregular. You know, the fear of not having a child even if I wanted to, but then I let it go. I chose not to think. I said that it was our destiny. I was a little fatalistic. I consoled myself so that it would end like this, but the side of menopause that I feared the most. It was the effects, of course, but I got over it successfully, thank goodness. Especially when I learned that my aunt experienced early menopause and had some physical difficulties, I felt relaxed because my mother had artificial menopause and used estrogen bands. After learning, my menopause was related to my genes, and I accepted my destiny.

The fatalistic approach is significant to understand the conceptualization of menopause. Women argue that genetic transmission is their destiny, and they cannot change it. However, if they accept their fate, they do not question what is wrong with their bodies. The cause of menopause turns from an individual issue to a generational point, which enables women not to accuse themselves. Another group argues that psychological problems cause early menopause. Significantly, the sudden changes in their life and unexpected situations can cause menopause. These sudden changes mainly divide into two. The first one is the loss of a family member. The crucial point is that the loss of a spouse and the parents bring a sense of deep sadness, and women's psychological state can upside down. When their emotional situation is unstable, they

can experience menopause earlier than when they expected. The second reason is that intensive stress can cause early menopause. Notably, work stress is very effective in that process. If women work in a stressful work environment, they argue that facing menopause can become inevitable. For example, Aylin (59 years old) argues that how work stress is effective in her menopausal experience like that,

> Menopause came during a stressful period. So it's a little early for me. At the time, I had just changed my job and was working with a stressful supervisor. I have always worked with ministers in private pens. I worked. Then I started working with that troubled supervisor. He loved me very much, but his love was like a butcher smashing the meat he loved. I was in menopause at that time. I had a bit of a hard time.

Aylin continues that she understood how mobbing at work and its stress over her changed her natural balance. When women experience menopause in their late 40s and the beginning of the 50s, the transition process goes more slightly. Women argue that they can overcome menopausal difficulties because there is no sudden experience, and everything happens smoothly. While some women say they did not experience any change or problem, other women claim they had some physical and emotional difficulties, but all issues are solved in time. At that time, their bodies had enough time to adapt to the new situation.

The other group experiences menopause lately, and in their situation, menopause becomes a desirable and expected process. Notably, after 51 years old, as an average of menopausal age, women expect menopause. Besides, women want to experience menopause after a certain age. For example, Nevra (65 years old) argues that,

> One of my problems during my menopause is that I can't go into menopause. I mean, some doctors were saying that you actually have to go through menopause, but after going to a few hospitals and doing tests, they said it's hereditary, that is, genetic. My mother was deceased, and she had entered very late. So did my sister.

Nevra's menopausal age is 55, and her sister, Neslihan's menopausal age is 57. I had two different interviews with these two sisters, and Nuran is another participant who

experienced menopause at 53 years old. These women claim that they experienced late menopause, and they went to the doctor to learn why they cannot go into menopause instead of postponing. Late menopause is significant in understanding women's relationship with medical authority based not only on negative situations like postponement or delaying menopause through HRT. Moreover, late menopausal women argue that they had hardly ever problems because of menopause. Therefore, the medicalization of menopause is not only limited to the prescription of synthetic hormones, and the doctors are the primary source of valid information source women to understand their bodily changes.

4.1.2. Physiological Changes

When I asked the participants about the physical changes experienced after menopause, they referred to their fears and concerns about bodily changes before menopause. Significantly, the worries about menopause increase when menopausal age comes closer. The knowledge about menopause is hearsay, which means that unofficial, unverified information obtained from a third party is not part of women's direct knowledge. Especially, hearsay is very common about bodily concerns. Ayçil (52 years old) performs an example conversation among women, that is,

> Now, when we talk about menopause, they probably fill our ears, Neclacığım. I mean, menopausal women around us said that "Oh, I'm shrinking, I gained 10 kilos when I entered menopause, uh, my sex life is over", so that's what they all were saying, I don't know. I mean, that's what happened in women's conversations. When our friends entered menopause, we asked how they felt because we were also candidates for it. Nothing has happened yet. Oops, you'll see when you enter, oops, I'm on fire, I'm shrinking when those things come when those days come. Here I gained 10 kilos, and I went through menopause, and so on and so on. We are always full of negative things.

Ayçil's sentences are good examples of how menopause turns into fear and how this fear is produced in daily conversations. However, hearsay knowledge is not the only

source of anxiety. Interestingly, the medical definition of menopause and symptoms about it become a fear factor for women. The fear which feeds from medical discourses differentiates itself from hearsay fear because medical fear goes deeper and diffuse very rooted. The power of medical fear comes from hormone levels and their decreasing process. The decreasing hormone levels mean that the body gets older very quickly and becomes easily ill. Although medicine is a scientific authority, it does not answer the questions about menopause. On the contrary, it produces new uncertainties. Aygül (52 years old) tells us what questions are mystifying menopause experience in medical discourse, that is,

> Well, if I get menopause, I mean hormones..., will my body age faster? It was a bit more about aging like this. You know, will my body age faster? Hormones are changing. When that happens, do I get sick more easily and struggle more with many things, my libido will drop (laughter). I mean, I wonder how it will be, that reluctance in the sexual sense, etc. Will something like this happen, how will it be, or will the body fluids decrease, or what kind of mood will I be in? I mean, I was worried about what mood I would be in when the hormones changed, but it mainly was about aging. In other words, with the change of my hormones, there was a concern that my body was starting to go down, I guess, mostly due to this.

Another significant finding is that blushing and sweating cause embarrassment feeling because women cannot hide their menopause. In other words, menopause becomes visible when women's faces blush and sweat. Menopausal women cannot control their bodies during the hot flushes, and this situation creates unknown embarrassment. Participants who experience this feeling said that they know menopausal symptoms, which are totally normal and natural. The highlights that they are conscious that menopause is part of women's life cycle, and there is nothing to hide. Their common point is that they are ashamed of blushing and sweating when working in a work environment. For instance, blushing in the lecture hall or sweating in the middle of a significant meeting leave women in a difficult situation. This finding has two dimensions. The first dimension is that although menopause is a normal, natural, and

ordinary event for women individually, menopause turns into a state of shame in the public sphere like workplaces or universities. To be more precise, in social life, there are prejudices about menopause. The second dimension is that women feel ashamed because they cannot control their bodies. Women feel guiltier if their bodies are getting out of control, and the people around them notice this situation.

Weight gain is another significant issue for menopausal women because being thin or protecting weight turns into a moral obligation. Women believe that being healthy is possible with no change in their weight. The crucial point is that women's primary motivation is being healthy, not only their appearances. In fact, the significance of appearance is rarely mentioned. Women highlight that not having too much weight instead of being thin. To be more precise, there is no ideal body size and shape like a model, and they do not mention that they want to look more attractive or sexually desired.

On the contrary, being fit and healthy is a more fundamental issue about weight. If a woman gains weight, she becomes an irresponsible person who does not care for herself and does not do her duty. In other words, women are obliged to protect their body size and weight. The only exception is pregnancy because weight gain is normal and natural during the pregnancy, but not for menopause.

When a woman protects her weight at a young age, she is proud of herself, but if not, she accuses herself. Weight gain during menopause cannot legitimize itself with biomedical explanations in the eyes of women. For example, women know that the body tries to keep estrogen in it when it decreases. To preserving existing estrogen, the fat is stored around the abdomen. They know that it is necessary and suitable for their hormone levels; however, it is an undesirable and fearful thing for women. This example clearly shows that all explanations and discourses about menopausal symptoms are not normal and natural for women. At the same time, being healthy includes some controversies in itself.

The participants also point out physical symptoms of menopause are temporary and manageable. When they compare what they heard before menopause and what they experienced during and after menopause, menopause is not a big deal, and it is a threshold to be passed. It is evident that there is a profound gap between hearsay knowledge and women's actual experiences. Interestingly, a significant portion of the participants does not have any physical problems with menopause. The other part who experience difficulties tries to minimalize these problems. The most common was to cope with taking warm or cold showers frequently, using cologne for cool down, doing physical activities, having healthy diets, carrying spare clothes with them, and changing clothes continually. Another strategy is that women learn their mothers' and aunts' menopausal experiences, compare them with their experiences and decide what is normal and what they can do in that way.

The participants who experience menopausal changes during Covid19 have some problems controlling menopausal changes. They say that they cannot go out because of the restrictions, and their physical activities are minimal. In that sense, they claim that gaining more weight and facing much more problems.

4.1.3. Psychological Changes

During the interviews, I asked participants what psychological changes they experienced. However, to claim that there is a direct relationship between psychological changes and menopause is a problematic issue. First of all, menopause is seen as a transitionary and temporary process. Although menopause is defined in many stages with pre, peri, and post prefixes, which almost comprise women's life cycles, women describe their menopausal process shorter than medical definition. According to the women, the menopausal signal is irregular bleeding, and they experience menopause after the irregular bleedings end ultimately. In that sense, menopause as a process takes a few years, like 1-3 years.

Moreover, menopausal effects are not constant; they fluctuate. Another significant issue is that menopausal years intersect with divorce, spouse loss, retirement, or being a grandmother, changing women's social roles, positions and status. Therefore, the relationship between menopause and sociocultural issues will discuss another subtopic more deeply. In that part, I focus on emotional changes. One group of the participants says that they do not experience any psychological problems or negativities. They point out nothing has changed psychologically like no change physically. Another group claims that they start to feel more relaxed, calm, and thoughtful after menopause. The most common example is that their attitudes and behaviors to their children change because they haven't get angry about something before they have.

Moreover, some of the participants share that they feel less stressed because of the physical changes of menopause. The cessation of menses relieves menopausal women in two ways. The first way is that women haven't felt pain because of menstruation. Especially, women who had problems with menstruation before menopause are happy to get rid of pain and stress. The second way is that menopause is a favorable issue for women's psychological health because there is no risk of pregnancy. Women who do not want more children feel free and comfortable. In that sense, some physical changes have positive effects on women's psychological well-being.

The last group describes menopause as a negative experience for their emotional well-being. The most common anxiety is about sexuality. Women concern about decreasing sexual interest and how their sexual life will affect by menopause, and this anxiety makes them really stressed. However, they add that they overcome the problems about sexuality and the fears decrease after a while. Another significant issue is that although some women feel furious and argue with their husbands or children, others think more resentful and show their emotions through crying. Gülay (54 years old) tells her memory like that,

> I mean, there was a change in the way of life-weariness, not an outburst of anger. I mean, why did I come to this life? What am I living, for now, that way? Uh, I'm fed up with it, so I've always used this to upset myself. So I didn't show it out much.

Well, what was the reason for not sharing it with other people? Did they not understand you?

> Well, most likely, they won't understand. In fact, once, when I did a bit of puff, and my husband said, you say ugh without stopping as if you were accusing, I suddenly started to cry. My husband was also very surprised because I wasn't doing anything and I wasn't saying anything. All of a sudden, I had such a crying crisis that you knew what I was going through. After that, that crying was good. I calmed down. He was a little more naive to me, uh. I mean, it's inexplicable. Well, it doesn't stay permanently.

In some cases, women highlight that they can cry despite no reason. Another important feeling during menopause is world-weariness. Women explain that they withdraw daily issues and question themselves. Interestingly, women's retrospective questioning is a prevalent finding during their menopausal process. Most of the participants added that they felt stronger after this questioning. Women also motivate themselves differently because most of them do not share their changing feelings with others. Mainly, the change of emotions can be observable in the house, and only family members can notice it. Women are alone to solve their problems, and they make suggestions themselves. In that sense, social roles like being a woman and being a mother or religious beliefs can influence motivation. Şahika (60 years old) summarizes like that,

> Well, I thought, I said I'm a mother, a woman, which God has given me. I said that I have children. At least I did not get myself into the psychological thing. I thanked my God. I was the mother, and I have my children. Now, another process that we have to go through has started. I said we would get through this. I always gave suggestions to myself; I paid attention to my nutrition. Then it decreased. I mean, I can say that these problems did not happen. Even if the stone cracked, it did not last for one year. Let's say one year. That's how I got through it. I mean, I always reassure myself with self-suggestion.

In conclusion, menopause does not mean that it always causes psychological changes for all women. While some women do not have any changes, some argue that bodily changes make them less stressed and feel relief after menopause. This positivity of

menopause is about disappearing the risk of pregnancy and ending menstrual pains and problems. Another significant issue is that social roles and status are not always related to menopause; they intersect and play a role in constructing the middle ages. Lastly, menopause can cause emotional fluctuations and mood swings. While some women feel anger and stress and project their feelings to their husbands or children, others think bored and weariness, and they become withdrawn and do not share their feelings with others.

4.1.4. Reproductivity and Sexuality

Reproduction has had a significant issue for women in Turkey. Delaney's (1991) anthropological study in Turkish village shows that the women's role in reproduction is devalued in Islam like other monotheistic religions. She draws an analogy between seed and soil. The seed represents the men whose roles are active because they have a *creative, life-giving* role. On the other hand, women are seen as the soil, which provides *the material substance* (p. 8). In that sense, women's role in reproduction is not seen as equal to men, and Islam justifies this understanding. Delaney's argument about reproduction as a sacred is still essential today. Being a woman is seen as identical to being a mother, and reproduction is sacred and vital in Turkey's rural and urban areas because sexuality, productivity, and gender intertwine. This intersection is embodied in the body's context. Women highlights that they do not have enough knowledge about their bodies, and the vital issue is that lack of knowledge is not only about being illiterate.

On the contrary, women point out that they live in urban areas, where you can quickly obtain information from different sources compared to rural areas. Moreover, they argue that people have formal education. Gülben (55 years old) explains this situation with her own words like that,

> Well, I have a habit. I think everyone knows what I know, but from the conversations, I realized that most urban women and educated women, but unfortunately, we are very ignorant

> about our sexuality, about the female body. Iıı, no one looks at his body in front of the mirror. She does not look at her genitals. She is not aware of her body, the hormones and chemical drugs given by the doctor she went to without question, all of them have side effects, without questioning what that doctor said is true in his thing, his approach. Such a thing, what they say, when I realized that it was unconscious, in quotes, in an attitude, I said let me share what I know. Everyone takes as much as they need and applies it in their own life.

Gülben argues that both pieces of knowledge of the body are simply about being informed. She also claims that women cannot decide what goes on in their bodies. She gives an example of medicine with full authority on women's bodies, and women do not actively participate in decision mechanisms. Moreover, women argue that menstruation, sexuality, birth, and menopause are part of their life cycles. However, this cycle has been strictly fragmented, and the body's knowledge requires following hierarchical steps.

Interestingly, there is an overlapping that this chronological age justifies social expectations. Similarly, Pamuk (2018) argues that the idiom of becoming an old maid (evde kalmak in Turkish) shows the intersectionality of age and gender that there is an age limit for women to marry. If a woman is over the expected age, Turkey perceives this situation negatively (p. 79). However, women claim that menopause, menstruation, or anything about the feminine body should learn before the expected and socially approved age. Nil (48 years old) explains that fragmentation of the feminine body like that,

> And now, having your period in puberty is something new. At birth, you get pregnant, go through that process, and see your body change. Here, you say that I am carrying a life, a part of me will be born, and you have curiosity about your child. Whereas you think it is the end of everything in menopause. When you hit menopause, you believe your fertility is over. You know after that, uh, you think you're getting old with it.

Women's fragmentation of the life cycle reproduces the body differently. It is essential because the body can be translated into the Turkish language in two words. The first

one is that *vücut* means corporality, and *vücut bulmak* has about come into existence. The second word is *beden* refers to the physical structure. Almost all participants use *vücut* term to talk about themselves. In that sense, the body is not only about physicality. It is about existence and the way of being. In other words, the changes of the body give meanings to women's identities. Menopause as an end of reproduction is a new phase that is the starting point of aging.

Another critical issue is that the socially expected roles in society determine when women can give birth or not. According to the Turkish Demographic and Health Survey (2018), the median age at first birth in Turkey is 23.3 years among women age 25-49. In other words, women in Turkey become a mother in young ages. Therefore, the end of reproduction through menopause does not affect far too much because they do not think to have another child around the menopausal period. Esma (52 years old), who has a child in her forties, argues that how a woman makes an effort being a late mother,

> ....Necla, nothing like that ever happened. You asked the question at a time when it started to break down. Of course, now that it's been two years now, I'm on certain acceptances. So let me try to rewind a little and get down to my feelings of that day. I'm going back to the early times, you know, two years ago, let me tell you something like that, I am a woman who had problems in terms of femininity, productivity, ıı, fertility. I became a mother with a test tube baby. Therefore, let me tell you that my feelings were damaged long before this menopause because I tried so hard. I mean, I know that feeling of loss because I had to put so much effort into it. Even a child of mine passed away. One of his twins passed away. Therefore, it did not create such a thing for me, but oh my god, what will happen now? For example, there were pads accumulated in the house like this. I'm trying to remember my feelings when I'm jokingly distributing them to my sister, cousins, nieces, and nephews, saying that these are yours, joking aside, I wonder if I felt a pang inside, but I don't feel anything deep at all.

Esma's situation clearly shows that there is pressure on women about having a child at a younger age, and she has had difficulties with reproduction before menopause. In

other words, being unreproductive because of menopause is not a big problem for women if they have had a child or children before. Being a mother at an early age has similar effects in the early and premature menopausal experiences. Remember that premature menopause occurs when women are under 40 years old, and early menopause is called if a women experience menopause between 40-45 years old is significant. Nine women out of 24 had experience menopause before 45 years old, and only Piraye (42 years old) could not have children because she experienced menopause at 32 years old. She never expected menopause at that time. She questions the meanings of menopause, fertility, motherhood, femininity, which are so intricately interconnected. However, when you look at it, they are all words, and people give that power. In that sense, she points out to understand the meaning of menopause took her a long time. She says that her menopause experience is a journey, and at the beginning of that journey, she felt exhausted because of the pressure of being a mother and being reproductive. Now, she is not sure about why she did fight with menopause and was afraid of it. There is a dilemma for her, whether she wants to be a mother or other people around her. She questions whether she remembers her fertility voluntarily or the people recognize that question.

Menopause at an early age can turn into a failure in the eyes of society because the woman cannot do her duty. In other words, early menopause can be a deviancy. There is transparent enforcement about femininity, motherhood, and fertility, and if the women have menopause earlier, they cannot play their social roles and become deviant actors. Society finds a right to accuse menopausal women because of the social norm that women should have a child earlier.

The legitimization of reproduction at an early age is widespread acceptance in Turkey because women accuse themselves of becoming late mothers or not having a child properly. Another significant issue is that women who experience early and premature menopause assume themselves lucky to have children of younger ages. For example, Nil (48 years old) experience menopause in 40 years old says that she ignores the link

between menopause and reproduction. However, she highlights that everything would be different for her if she experienced menopause in 25-30.

The relationship between menopause and reproduction does not have to be negative. As I mentioned before, fertility is about having children, and there is an unwritten but widely acceptable age range for being a mother. There is little expectation after 40 years old. From a different perspective, menopause turns into an advantage because the fear of pregnancy disappears. Ayçil (54 years old) explains how menopause is a neutral issue as the end of reproduction and how she relieved the anxiety of pregnancy and burden of abortion, that is,

> Now, nothing bothered me at this end of my fertility. Why will you say, Neclacığım? Uh, I already have two kids. I don't want any more children anyway. God predestines for who want to have children. May God give my children a long life. I also have two abortions. So, I have two births and two abortions. I mean, um, maybe if I didn't have a child, if I had such a longing, I would think that it's perhaps an advantage for me, no matter how late it is. So I don't know. I just think so. I mean, thanks to their souls, I also have children. I mean, since I don't even think about giving birth, it's OK for me.

Similarly, Nuran (60 years old) says that menopause is a luxury thing because menopause saves from her heavy bleeding, the fear of spillover of blood from the pad, and the menstrual pain. She does not suffer from the pain lack of bleeding and reproduction. Due to the nature of the qualitative research, the findings cannot be generalized, but seeing the repeated patterns are essential. In that sense, another pattern about the relationship between menopause and reproduction is the fear of deficiency feeling. The biomedical model defined menopause as a deficiency disease, and it is an umbrella term that signifies all symptoms of menopause. However, the deficiency, decreasing, and decline terms are only used about productivity in this research. The examples below show how the relationship between menopause and reproduction is used as a problem. Gülben (55 years old) claims that,

> Of course, I was impressed when I first got it. When the hormonal differences started in the body, I was away from the

> body, my body, and my female body. As I got to know my female body and saw that there was no decrease in it, I said yes, nothing lessens from my femininity, nothing less from my sexuality. Yes, an era is over for me. So one phase is different.
>
> Statements such as I am getting declined, I am getting older, I am no longer fertile, that is, I cannot have children, create a perception as if something important from your female identity is going away. If you stay in it too long, psychologically, of course, it also causes depression.

The example signifies that the real menopausal experiences of women differentiate themselves from the preknowledge about menopause and how the body, aging, sexuality, and reproduction come together and turn into a monolithic fear, which is menopause. After focusing on reproduction, the rest of the part includes the relationship between menopause and sexuality. This study methodologically is based on the life cycle approach. Therefore, the analysis of sexuality is not superficial and asks whether sexuality is over or not. The critical point is understanding how women describe their sexualities, what changes are before and after menopause, and their intersectionalities.

First of all, all participants agree that menopause is not the end of sexuality, and there is a sexual life after menopause. However, there are three different ideas about sexuality after menopause. Two groups are opposite each other. One group argues that nothing has changed after menopause, and their sexual life is the same. Other group claims that menopause causes severe problems because of negative effect on sexuality. These two opposite groups are a few in number. The last group, the majority of the sample, asserts that menopause changes something about sexuality, but the problems are achievable. The important thing for this group is that the strategies and motivations for the maintenance of sexuality.

The first group argues that nothing has changed with menopause, and their sexual life is going the same. Gülay (54 years old) argues that,

> So, I don't think anything changes. I mean, when I talk to my friends about it, I tell them too, so you're just losing your fertility. You know you don't lose another limb. Ten has

> nothing to do with it. So that's how it was. Nothing changed. It is the same way. Some of my friends are said to have experienced this dryness. I think it also depends on the body. After all, it's not the same for everyone. I've never had any trouble. I mean, we're going pretty normal, nothing about it.

Gülay's point is vital because she talks about menopause does not cause a loss of limb, and only monthly periods are over. She differentiates sexuality and reproductivity sharply from each other. From her perspective, menstrual bleeding has a function about fertility, not about sexuality at all. Ayçil (52 years old) also shares similar ideas that their (her and her husband) sexuality is normal because bleeding is not getting to anything. It does not add color to sexual life. It is only necessary for pregnancy. Nuray (60 years old) adds that she heard the negative effects of menopause on sexuality, but she did not experience it because she believes that she has a healthy sexual life. She does not have gynecological diseases. Piraye (42 years old) says that when she had menopause, she was 32 years old, and her hormone level was top-level, and now she highlights that her age is still young and hormone levels do not decrease to concern about sexuality.

The second group argues that menopause affects their sexual influence deeply. The vital issue is that women feel guilty. After all, they believe that they cannot perform their wife's roles well because they define their femininity and sexuality as a role of women. For example, Türkan (51 years old) claims that one of her motivations for taking hormones is sexuality because she experienced vaginal dryness and did not want sexual intercourse. She was worried about her sexual life, not because of her interest or body. She concerns about her husband's pleasure. Similarly, Müşerref (59 years old) says she felt bad about her husband because she thought she was not a woman. In fact, Aylin (59 years old) tells about how sexuality issue after menopause turns into a family crisis like that,

> So, for example, you don't want to be with your spouse at that time. You come to the stage of divorce, and there are big fights at that time. For no reason, for no reason. When you have not encountered anything in normal time, then you are stressed.

> You are angry with your children. You get mad about trivial things. Another?

The important thing is that women's sexuality does not belong to them. On the contrary, they talk about their menopausal experiences, but affected people are their husbands. At the same time, sexuality after menopause is not only about the relationship between the couples or partners and all family members involved. In other words, sexuality is defined in the family context, and sexuality is seen like that women have some duties to their husbands. If they cannot discharge their responsibility, they feel guilty because women's sexuality is attached to themselves. On the contrary, sexuality is defined as a familial issue instead of an individual issue.

The last group is more in number and has more variations. The common point of this group is the experience of vaginal dryness, which is mentioned as a physical problem and called drying, drought, dehydration, or vaginismus. Women agree that their sexual drive decreases or fluctuates. At that time, women develop different solutions to overcome this situation. The first way is that finding a solution from a natural way. Gülben (55 years old) explains how she deals with decreasing drive,

> Of course, there is a vaginal dryness problem in menopause. It also has very natural solutions, but it's okay. Ah, of course, there is a change in libido, but it's not a shame either. Without perceiving it as your fault, that is this transitional period. You can talk about this with your partner and bring it to the fore. You should explain the fluctuations in your desire openly. You know, when you're missing it again, it's not your thing, so nobody's, it's mutual. It is not a duty. After all, if this is a pass sharing, it should be with pleasure. Again, to progress by sharing, you should think about what can be used to continue that pleasure thing and relax. Here is what I learned about the body: dry body brushing increases blood circulation, which is the thing of the body, followed by aromatherapy, by adding base oils and aromatherapy oils. So it would help if you supported that joy thing a little bit too. You are doing small massages on your body, and you are touching your own body. So, you have to show some self-compassion during that transitional phase. It's not just a one-sided thing. It's not like waiting from the other side either. Thus, you open the door to take a path in that pleasure thing. That is, the woman should

> know her responsibility there. She needs to know it. She learns it, teaches it to other women. At the same time, it is clear that she needs to share this state.

In Gülben's experience, the key points are communication with partners, increasing mutual desire, and doing something to the body to relax. Another example is that eating gum like candy which is called *macun* in Turkish. In Turkey, generally, people believe that *mesir macunu or mesir paste* improves the strength of the body. Primarily, there is common knowledge that *mesir macunu* increases sexual drive and performance. However, the consumption of this food is really gendered because it identifies a typology in which men who have a problem in their sexual life use it, and primarily mesir macunu signifies to an older man whose sexual performance decreases or has erection problems. It is a kind of super energy food that triggers sexual drive and symbolizes power.

Interestingly, during my interviews, I learn that women also use *mesir macunu* as a natural way of increasing their sexual performance, despite seeing it as masculine food. These two examples show that there are different ways of realistic coping strategies. One of the more current and western styles, and the other is more about the cultural issue because *mesir macunu* is a traditional food.

The second solution is that taking medical help with vaginal dryness. Most of the participants use the cream as a medical solution. Talking about the medical professions and taking help are important issues because the source of knowledge becomes the medical authority that women believe is the most useful source of knowledge. Hasibe (63 years old) shares her experience like that,

> It wasn't fear, and it was curiosity. So, it was a curiosity out of ignorance about how it will be and what it will be. Of course, there were health-related people around me, I was asking them. We had doctors and nurses. I was asking them. Of course, we were getting the correct information from them. In line with that information, I continue to take care of myself and continue life. So we were trying to get it. When I first entered, I said, alas, the job is done. So, of course, as I said, since we have many health professionals, they were, in things,

> in suggestions. They were saying it wouldn't be so. Time passed; it wasn't like that yet. Okay, so we tried to think as if we were continuing and continue like that.

Hasibe's example is essential to understand how sexuality after menopause is rationalized with medical help. In that sense, sexuality after menopause defines as an unknown problem, and to solve its medical techniques and suggestions are critical. There is no clue about the body, sexual drive, or roles in the family. On the contrary, sexuality is seen as a medical problem that can be solved through objective knowledge from this perspective.

The third solution is that nothing to do about having a sexual life before menopause. In that group, women argue that aging causes the changing of sexuality perfectly normal and natural. Aygül (52 years old) explains the relationship between aging and sexuality through the distinction of hormonal sex and mature sex, which are,

> So, is the libido dropping? Well, the libido drops. So, yeah, you don't have sex like you're in your 20s, 30s, so that's a fact. Your libido drops, but what is actually going on there? In fact, your view of sex is also becoming more mature, more hormonal than sex. Actually, of course, I've been with my husband for 30 years. You know, we are a couple who know each other very well now. It is actually going towards more consciousness.

However, the relationship between age and sexuality is asymmetrical for men and women. There is an argument which women share similar ideas, and there is social pressure over men. This pressure is that although men are in their 50s or 60s, their sexual performance must be in their 20s or 30s. Nonetheless, we see how women are seen as responsible for the maintenance of sexuality up to nowhere. There is no stagnation point for them. They try to preserve their sexual capacity before menopause in one way or another. In that group, aging legitimizes the end of sexuality for men, not for women. More precisely, women who say their sexual intercourse frequency decreases or ends are not the agency in that relation. For example, Nuray (60 years old) states that,

> Now, here's something. Since your spouse is already older than you, your spouse's sexual things also decrease naturally or end. At my menopause time, my husband was scared. If he knew what menopause was like, my wife would be frightened. Umm, he stayed away from me. I said, what are we doing? He said, you're in menopause; what's going to happen? What does it have to do with you? He was afraid, but we got over it, but after a while, some things in my husband decreased physiologically, the impulses decreased. After that, I didn't feel the need so much, but of course, my sexual life continued for 3-5 years.

The most distinct feature of this group is that women are not concerned about sexuality because their husbands are older than themselves, and there is no desire from the husband's side. In other words, to starting and ending points are blurring in the sexuality of women. They explain their bodily experiences from their husbands' bodies, desires or hormones.

The third solution is that improving the state of mind. This group argues that menopause can cause physical changes, but they are not obstacles to sexuality. This group accepts that sexual desire decreases in menopausal, which does not mean there is no sexuality after menopause. Women highlight that the important thing is not to have sex; their husbands' attitudes and behaviors are remarkable for women. Suppose their husbands understand them and be more understandable, patient, and kind. Women say that a psychological statement is more important than physiological problems because a good mind can overcome physiological issues. In the previous group, there was a discussion about gender asymmetry in sexuality. In that group, this asymmetry deepens and turns into violence. If sexuality is seen as a duty of women and they do not want to have sexual intercourse, it can legitimize itself as a cause of domestic violence against women. Nihan (64 years old) tells us how violence scares her and change her perception about sexuality in marriage is that,

> Of course, the sexual desires decrease, the existing thing decreases with the effect of these hormones, but after that time, you can have sex with your spouse treating you well and taking your heart. I have been so myself. We had problems between us. My husband, of course, was a bit of an angry

> person. So, slowly I can say that I actually turned away from sex after menopause. I mean, it wasn't enough for my wife to be together after menopause. Before that, it was not enough, he was complaining, but it got worse after menopause.

Another critical issue is that whether sexuality does not have priority in intimate relationships. Even some participants argue that sexuality is not an instrument or medium to save the relationship. For example, Neslihan (59 years old) discusses sexuality as not the sum of the relationship or marriage. It can be in the second or third places, and it cannot prevent the relationship from the divorce like that,

> At menopause, I didn't know much about sex anyway because, in such a life, I wasn't a woman who thought about sex as a reconciliation issue, you understand? I mean, I think that when both parties were happy, they should have thought of unity. It was the opposite for us. That's why I never paid any attention to it. It didn't matter to me. The most important thing for me was communication. If we couldn't provide communication, it was something that came and didn't come by itself.

The remarkable thing is that divorced women do not want to talk about their sexual life. They only said that nothing changes or sexual desire decrease or referred the sexuality when they are married. There is a difference between divorced women and women who lost their spouses because widows emphasize having no sex life after their husbands' death. For example, Safiye (62 years old) says that her sex life is not good because of her husband's illness. After his death, she says that she never thinks about sexuality. In fact, Nigar (68 years old), who lost her husband, talks about sexuality like that,

> I have no idea about it. I mean, we didn't talk. The issue of sexuality in menopause is not discussed. I don't think my friends who are married were impressed. Well, you know, our generation cannot sit down and talk about their sexual life, but I believe that their sex life continues, my married friends.

In Nigar's example, her first sentence about her lack of idea about sexuality is that sexuality is a closed-door. She highlights that sexuality is not an issue that does not talk with third parties, even their close friends. Her statements clearly show that she

never talks about her own experiences. At the same time, she points out that sexuality is about married couples, not widows or single women.

Before finishing this part, I would like to explain my argument with the loss concept. Women used the loss term as a measurement to describe how their sexuality changed. The loss of sexuality or not is used to explain sexual drive, sexual pleasure, or femininity. It is clear that the relationship between sexuality and menopause defines as the loss of something or not in the broader context.

Finally, an important issue about loss is that women talk about their sexuality as the third party in their intimate relationships or something that does not belong. This point is critical because women's loss of sexuality is not the only concern of women. Even almost all participants talk about sexuality concerning their husbands. I am using husband with a purpose because sexuality defines the borders of the heterosexual family, and women measure their sexuality over their husbands' satisfaction or pleasure. Someone's else sexuality and loss feeling are omnipresent in sexuality discussion.

4.1.5. Health and Lifestyles

In that part, I question the relationship between health status and menopause. However, to avoid wrong generalizations and connections, I asked my questions from general to particular. First of all, I asked my participants what means being healthy for themselves and defining it. Secondly, I asked them what they are doing to be healthy and the changes in their health status and lifestyles after menopause. This order is essential because the biomedical model argues that menopause negatively affects women's health and turns into a risk factor. However, I consider that menopause is a transition process for women. It is about the midlife experience, which means that the conceptualization of health, well-being, and lifestyles is embedded in age relations. Menopause is that the embeddedness of aging, gender, and health relations become more visible and concrete.

The health definition of the participants varies. However, the common point is that health is the most prior thing for a living. In that sense, they argue that life requires health. Although participants agree that health is the first issue in their lives, their health definition is different with different focuses.

The first group conceptualizes health in the context of physical well-being. Most women in this group argue that losing physical well-being and having a chronic illness means losing health. Müşerref (59 years old) states that how her physical problems shape her health definition,

> Being healthy myself, I had rheumatoid arthritis for years. It has started with the birth of my little son. I've been shot for years. Then rheumatoid arthritis turned into muscle rheumatism. There are hernias in the waist. After that, there are things of old age in these knees or something, but these are painless. I am not so miserable that I can return my life, but I have always suffered from those pains. Know what I mean?

Like Müşerref, other participants talk about how physical problems cause the disappearance of health situations. Again, I would like to highlight that the loss of health comes from chronic illnesses instead of temporary or unexpected illnesses or health problems. The important thing is that healthy decreases through aging, and the body has not been like in the past. It is more vulnerable and open to catch diseases and illnesses. Health problems because of age are not temporary, and they are chronic for the participants. The relation between aging and health is fragile because increasing age is seen as changing health status irreversibly. Hasibe (63 years old) argue that,

> Off, don't ask that question. Honestly, being healthy is the greatest happiness of man. I can't find how to describe the word that we can hold in our most enormous hand. I don't know. I have some health problems, so losing health is the most considerable unhappiness and my husband. Being healthy, that is, you are very young. Now, the period is when you can take care of your health. I always recommend to young people, protect your health when you are young, you cannot restore this health in the future, you cannot find it. I am looking for that health now. I am looking for the health, youth, and dynamism of my youth.

In Hasibe's situation, the tension being young is the source of the body because health problems related to aging decrease causes not only physical problems but also affect the emotional well-being of the people. Another important thing is that people can invest their health in their younger period. In other words, health is a storable thing which means if people take care of their bodies well, they will be healthier in their older ages. However, according to participants, younger people do not know the value of being healthy. They behave as if they were stayed young forever, and their body preserves its strength and dynamism.

The second group claims that psychological well-being is vital for being healthy because people's feelings, state of mind, or perception, which look at the world from it, are necessary to have good health. Nuray (60 years old) claim that,

> To think healthy. When you feel healthy, it's something, um, you say metaphor, I don't know what you are saying. So, I think of it as a top-down recovery when you're feeling good in your head. Seeing everything well, seeing pink or white solves many things in your life. Yes, some people call it Pollenism, but I don't think so. You can even heal your health with the power of thought. Yes, perspective is, that is, seeing the grass next to the gravel on the ground. My life has passed with this perspective. It's always like that. I've recommended it around me. Therefore, I have no negative thoughts. There never was.

In this group, being positive is the critical issue despite some difficulties. There is a belief that perception and the state of mind change positively despite having physical health problems.

The third group argues that being healthy means that well-being both physiologically and psychologically. These two aspects are interconnected, and mental and physical happiness are seen as indicators of health. Something goes wrong if there is an emotional state or any of these two things that take away from this state of happiness. For example, Nihan (68 years old) shares us experience like that,

> If body health is first for being healthy, mental health is second. Head health is also essential. To be happy, to be at peace. Of course, when I say body health, it's total body health.

> That's why this period, for example, psychologically, I was very severely affected. I'm over 65, but there are some restrictions. Of course, I was also very impressed, but I'm trying to get over it. I'm better. I go for a walk, even if there is a curfew. Until the end of November, I was in Bodrum. I had the opportunity to walk there in the open air. I'm not a person who says I'm very hopeless, bored, or very depressed. I am grateful. I connect with the outside, so I come out, walk, and come.

Nihan's experience shows how the COVID19 pandemic and the restrictions turn upside down her physical and emotional well-being. She highlights that walking in the open area can decrease stress or stay at home, and the limitation of physical activities causes depression. Briefly, the argument is that the relationship between emotional and physical well-being is interconnected and equally important for human health.

The last group is that argues that social well-being is an integral part of being healthy. For example, when I conducted the field research, the COVID19 pandemic had exceeded one year worldwide, and my participants' definition of health was reshaped through the pandemic. For example, Mehpare (54 years old) argues that being healthy means breathing normally, especially what we experienced in the last event. Here you can stand up, walk, go out, chat, mingle with your friends, talk, and these are healthy. During the pandemic, people are aware that people are social beings and need to go outside, see other people, and talk makes them happier and healthier. Another critical issue about social well-being is that the well-being of the society in which we live. Neslihan (59 years old) argues that,

> So I'm healthy as long as I feel happy. I mean, I don't care about small things and troubles, but homeland issues are more important than my own health. So when I see the state of my country right now, I feel terrible. I am feeling. I am very worried not only for myself but also for my future children and grandchildren. When I compare my own childhood with my current childhood, I see that today's children grow in an unhealthy environment. I feel fortunate in that regard. So I am healthy both physically and mentally, but those guys (the politicians are part of the government) are driving me a little crazy. Sometimes I talk to myself while listening to the news,

> and I get very angry with them. I wish that my country will be healthy first and then I will be healthy. Being healthy on my own doesn't mean anything as an individual. If my country is good, I will be better.

Neslihan points out that if a society is not healthy, which means it is not governed well, there are many political and economic problems. The individuals of that society cannot be healthy and happy. Therefore, societies' happiness and peace are effective on the individuals. More specifically, some participants argue that health is related to welfare and economy is part of well-being. Aylin (59 years old) argues that,

> Being healthy means that you will not have any financial and moral problems when participating in an event. That is, to be healthy is to have a high level of welfare. If you experience economic distress and difficulties, you can neither act healthy nor be healthy. You can fall. In my opinion, being healthy means that having a quality life.

Aylin points out that physical and mental well-being depends on individual economic status because the quality of life increases through welfare. At that point, I would like to conclude the arguments about the definition of health. In this part, being healthy is defined as having physical, emotional, social, and economic well-being. Following the participants' experiences, the priority of type of well-being can change. However, being healthy has many dimensions.

The second argument about health is that what the participants do to preserve their health status. At that point, there are two ways in which the participants use both of them. The first thing is that receiving help from medical professionals if there is an urgent situation. At the same time, the participants say that they go to the hospitals for routine controls. These controls are divided into two. First, control must follow and monitor the existing illness or problem and renew their drugs with the new prescription. The second one is that controls are done periodically, like once in six months or one year. These controls are mainly to control their bodies whether there is something wrong or not. Generally, these controls are called check-ups.

Women's hospital visits divide into two purposes in their menopause experience. The first one is that women go to the doctor when they experience irregular or exceeding bleedings that are not normal according to their cycle and the suspicion of the pregnancy because their menstruation is late. These are the standard signals about menopause for women. At the same time, women can experience cutting their periods suddenly. Some of the participants give the example that their monthly bleedings ended like a knife cut. After they notice that there is a difference in their periods, they apply to the doctor. Almost all participants visited the doctor when their menopausal transition had started. After gynecological control and hormonal test, the doctors inform the women about menopause.

The doctor's suggestions differ from each other, especially using hormone replacement therapy. Although some doctors propose taking the hormone from outside, another group argues that menopause is natural and that women get over this process without using any synthetic hormones. According to my findings, hormone replacement therapy is related to menopausal age. Suppose women experience menopause at 40 years old and below. HRT becomes like an obligation. Three participants experienced premature menopause, and they used hormone replacement therapy for the longest time. The using time changes between 12-54 months. The common point for Piraye, Nil, and Türkan is that they doubt the carcinogenic effects of HRT, and they do not want to use it. However, their ideas change with the doctor's suggestions.

Nil (48 years old) says that she took hormones because her doctor warned her about the risk of cardiovascular disease, heart disease, or osteoporosis. She argues that she felt responsible because the rejection of hormone therapy can cause more prominent and more severe problems in the future. She perfectly used her hormones until she heard that the estrogen pill causes breast cancer or something. After that, she decided to quit. In her situation, Nil did not question why she should take hormones or not because she believes her doctor altogether. Still, she realized that taking hormones has side effects which her doctor did not mention, and she learned the side effect issue from her milieu.

Türkan's (51 years old) experience is different because she argues that her skin has deteriorated. She had abnormal dryness on her body, including vaginal dryness. On the one hand, she points out she felt incompetent towards her husband due to vaginal dryness; on the other hand, she felt miserable because of the physical hot flashes, burnings, which is how she blushes in public, you sweat, and so on. Her menopause, in a natural way, gets stuck, and she says that she had to take hormones because she was not happy in her private and public life. She needed HRT because my body was preparing to enter menopause, but my brain somehow refused to accept it. She also adds that her doctor is a good person because she did not force her to take hormones. Türkan decided to apply these suggestions after experiencing physical problems.

Piraye's reason is slightly different than the other participants because she claims that her doctor does not care about her, and she continues like that,

> Now, there is no such thing as a doctor's help. The actual feeling I got there was, it's like I've fallen out of the system, you know, I'm no longer the doctor's area of interest because I'm depriving of the doctor from the test tube baby income. He didn't even seem to call for a check-up after that. Honestly, I didn't get any exceptional help. The hormone is just the thing; take it, keep it up; from now on, your life is going to be awful. You'll get hot, and your bones will melt. It was a message like, take these hormones, and don't need to do anything else.

The relationship between Piraye and her doctor is problematic, according to her. However, she adds that in those days, she did not want to think about menopause. She experiences a shock, and she wants to forget everything by taking hormones. When she takes her pills, she feels everything is the same. She does not have to worry about menopause. She notes that after she recovers the shock, she decided to quit the hormones and get therapy from the psychological counselor. Moreover, she is writing a book, and one chapter is about her menopause experience. She adds that the doctors' attitudes and the medicalization of menopause encourage her to share her experience as challenging stereotypes of a menopausal woman.

The second group is that early menopause differs from premature menopause because it occurs 40-45 years old. In my research, while the 41-42 years old taking hormone from outside, other participants whose menopausal age is 45 do not use any artificial hormone. For example, Safiye (62 years old), Aylin (59 years old), and Müşerref (59 years old) experienced menopause in order at 41, 42, and 45 years old. Their common point is that their menstrual bleeding is cut suddenly because of the work stress, sadness of the husband's illness, the loss of the father, and cystectomy (taking the cyst through the surgeon). Therefore, their doctors considered appropriate to take hormone for accustoming of the body. However, this Aylin is regretful about using hormones at that time. She explains that,

> I had a bit of a hard time. There was a problem from that period. After all, I had cancer in my breast because I had taken the estrogen hormone. My doctor caught the cyst in my right breast when it was minimal. I had surgery in 2018 because I had cancer in my breast. I attribute the cause of cancer to the use of hormones. I don't know why or how (her eyes filled with tears). It was a complicated process.

Although her doctor could not detect Aylin's formation of a cyst, Müşerref's is an excellent example of how cysts start to occur after using the hormone drugs, and she explains that,

> I had cyst surgery in 2005, at Büyük Doğan Hospital in Ankara. We had a good family friend. She is a successful and famous doctor who did the surgery. After that, when there were interruptions in my monthly period, and I went to her. She prescribed the medication. I started, but cysts began to form on my breasts as I took medication for a while. After that, I went for a follow-up examination, and my doctor told me to stop use hormones. He said you could get over it naturally, or these cysts will multiply, and cysts are more dangerous than menopause. That's why we stopped the drug.

The opposite example of Aylin's experience is Gülay's situation (54 years old) because she experienced menopause at 45 years old, and she told her doctor that she wanted to take hormones. However, her doctor did not suggest it. Gülay explain this situation like that,

> Oh, of course, I went to gynecology because hot flashes started when I hit menopause. I had my menopause tests done. I even requested medicine for it. The doctor didn't recommend it because I have cysts in my chest, big and small. The doctor said the best thing is to get over it naturally. Therefore, do not use anything, even if another doctor prescribes it, because it is harmful to cysts. It can be bypassed naturally. That's what the older women did, which is the only recommendation of the doctor.

These examples show that doctors' attitudes can differ because of the women's existing health situation, doctor's detailed examination, or frequent examinations. Although the medical model argues that menopause is a risk factor for women's health both in the short and long term, the doctors do not inform women about the side effects of hormone replacement therapy. Especially, HRT is seen as the only option for women whose menopausal age is under the age of 45. I want to explain women's this situation with the bargaining concept, which Deniz Kandiyoti inspires me. Kandiyoti (1988) uses the patriarchal bargaining concept to explain how patriarchy is not abstract and stable. She argues (1988) that,

> Systematic comparative analyses of women's strategies and coping mechanisms lead to a more culturally and temporally grounded understanding of patriarchal systems than the unqualified, abstract notion of patriarchy encountered in contemporary feminist theory. Women strategize within a set of concrete constraints, which I identify as **patriarchal bargains.** Different forms of patriarchy present women with distinct "rules of the game" and call for different strategies to maximize security and optimize life options with varying potential for active or passive resistance in the face of oppression (p. 274).

To explain the patriarchal bargain in urban areas, I want to show two-scale ends and discuss coping strategies. The women who take hormone replacement therapy have to choose whether they blush and sweat in the middle of the meetings or workplaces. People will stigmatize the woman as an old menopausal woman, go to the doctor, take hormone replacement therapy, and preserve their status at work. Moreover, these women had problems with their partners because of vaginal dryness or lack of sexual

desires. In some cases, it turns into a family crisis. The fights, verbal violence, sexual violence, domestic violence, or the women will voluntarily use the hormone.

Additionally, they have to bargain whether women appear as old, ugly, unfit, and unhealthy individuals or change their hospital directions to preserve their appearances, roles, and status. In this patriarchal system, women's oppressions produce different relations. However, there is one choice. At that point, I question whether the menopausal women hit three birds with one stone or medicalization of menopause is a new form of patriarchy that legitimizes all different unequal power relations and smooth over the cracks under the scientific explanations. Lastly, I want to highlight what this type of medical bargaining is mostly about younger people under 45 years old. This point is essential because, in this system, older women are eliminated without questioning.

The coping strategies of women are not only limited to HRT. Therefore, I want to focus on the other relationship between health and menopause after 45 years old. I grouped the women whose ages were between 46-49 as a transitionary group. This research cannot be generalized, but the age pattern shows us that 45 is an actual age for hormone replacement therapy. After 45 years old, the usage time decreases drastically. Before 45 years old, the hormone usage has a ranged from 6 to 54 months. After 45 years old, this period shortens between 1-2 months. Especially after 48 years old, the doctor does not suggest taking hormone therapy. In that sense, menopause is seen as normal and natural around 50 years old by doctors.

The difference between 48 -50 years old is tolerable for the doctors because Turkey and the average menopausal are around 49 in Turkey and 51 in western countries. Therefore, according to the doctors, age ranges between 48-51, which is the natural and expected menopausal age. This distinction is important because around 50 years old, and doctors suggest natural ways to deal with menopausal symptoms. For example,

> With the doctor's advice, almonds were especially recommended, we introduced nuts into our lives (Gülay, 54 years old).
>
> He said just eat the flaxseed. My doctor made no other recommendations (Adile, 58 years old).
>
> The doctor told me to eat yogurt regularly. I also pay attention to it. Eating yogurt during menopause made me feel very comfortable. My doctor advised me to eat yogurt before going to bed in the evening. It is vital to eat regular yogurt before going to bed every evening against fever and sweating. When I don't eat it regularly or take a week off, I have a fever and sweat at night, but if I eat my yogurt regularly, I don't have a fever or sweat at night (Elvan, 54 years old).

Doctors' perceptions and approaches toward menopause can be different. Especially after a certain age, doctors recommend that changing lifestyles through healthy diets and physical activities. However, the effect of the doctors and their recommendations are limited in the shaping of the lifestyles. The most significant reason is that the medical examination lasts between 10-20 minutes on average. However, women live with menopause in 24 hours. In that sense, women prefer to see the doctor when they realize something wrong in their bodies or when their follow-up examinations once or twice a year come. The critical difference is that women who are taking hormone therapy see their doctors regularly. However, menopausal women who experience it naturally argue that they regularly visit the doctor once or twice a year, but women begin to delay their doctor's examinations after a while. These women say that they did their critical check-ups like cancer screening. However, the important thing for them is not catching the illness. Therefore, they try to learn healthy lifestyles to preserve their health status. Internet is the primary source for women. The frequent usage of the Internet is crucial because women claim that there was no source for the information in their mother's times. Then, menopause started to talk on TVs, and now, women learn most things from the Internet.

The participants also share the idea that a person becomes her doctor. Being oneself own doctor means that a woman is a person who knows her own body best. In that sense, women argue that the best doctor can be oneself because this person can follow

which food or drinks disturb the body or quickly notice the difference in their bodies. Piraye (42 years old) tells us how she establishes a bond with her body that,

> I mean, when a person understands that, she lives inside her own body. That is, as she looks at his house. Your body is already your home. Once you know it, I guess a better bond can be established. But this, of course, does not mean anything; there is no such thing as never going to the doctor. First of all, it is unfair to the body to expect everything from the doctor if you do not take care of yourself.

The body as the home where people live there becomes a metaphor, which means that the body has some limits, and if a person does not care for it well, the body's boundaries exceed. At that point, even doctors cannot do anything because people are responsible for protecting their bodies. Being herself own doctor means that the protection of the body well and listen to what it wants. It is a preventive approach that the body and its health should be protected and considered all time, the care and attention during the period of the disease. In other words, not catching a disease or not being ill become people healthy, not be recovered. The critical issue is that being her own doctor does not define her as a playing doctor's role. Gülay (54 years old) explains that that how being own your doctor is a balance point that is,

> This changes for everyone. It's not the same for everyone. For example, some people do Internet research when they have the slightest pain. Immediately, they investigate a problem and draw the worst result and panic. On the other hand, some people are very negligent. In other words, some people say that even if they have great pains, they will not go to the doctor and get awful results. So, I think people should listen to their bodies and decide when to go to their doctor. For example, she should know when to go to the doctor, which the doctor will determine, and take precautions accordingly. So, at least I think she should go to the health center and consult. After all, there are both ignorant people and very picky people around me. It is a fact.

Gülay's definition of being an own doctor is fundamental because she points out the extreme points about health behavior. Although one group is hypochondriac (hastalık hastası in Turkish), people exaggerate their slight pain, search for their symptoms on

the Internet, and decide their illness and how to treat it. Oppositely, other groups are negligent that they have never accepted to take medication even if they have genuine health problems. In that sense, being her doctor is a balance point, and women argue that they are the best known about their bodies. They listen to them and notice it is a severe problem to apply to the hospital or not.

Women share the same ideas about being their own doctor, but another critical issue is knowing when their bodies do not feel good or need to see a doctor, listen to their bodies, prevent illnesses, and keep their health status. In that sense, being own doctor argument goes into deepening. Women talk about their healthy lifestyles enable them to understand the changes in the body. I encounter two fundamental principles, which are eating habits, physical and social activities.

First of all, I want to start with how eating healthy is the most fundamental issue. All participants argue that eating habits directly affect the health of human beings. Anymore, eating is not the only concept of the survival need. It is the principal determiner of health. In that sense, women do not change their eating habits totally because of menopause. They try to have healthy eating habits to be healthy, fit, look younger, and be more active. Gülben (55 years old) adds that,

> Well, eating healthy is important because there is a definition that we are what we eat. I very much agree with this definition. What you eat soon becomes you, it penetrates your cell, and as you become more aware of what you eat, you begin to pay more attention to the food you eat. Here's what I just said I live in this body. I am in this life with this body. Therefore, I should be more sensitive to it because it starts to decline. With menopause, this decline becomes more intense.

Gülben's point is crucial because she argues that in the menopausal period, the body becomes more vulnerable to the decline process. Although healthy eating is necessary as a lifestyle, there is a need for more attention. Significantly, Esma (52 years old) also adds that menopause can control by observing the body. After careful observation and listening to the body, it signals what is good or not for itself. For example, drinking tea or coffee in the late hours of the day triggers sweating and hot flashes. Esma

highlights that menopause is a touchstone that gives an ear to the body in the hustle and bustle of life.

The last coping strategy of women is that staying active through physical activities. Like having healthy diets, physical activities have a significant role in decreasing the effects of menopause. Women say that physical activities are necessary to eliminate weight gain, keep the body's fitness, and stay healthy. Physical activities decrease hot flashes and sweating, and women say that they feel more comfortable doing exercises.

The most widespread physical activity is walking around the parks in their neighborhoods. These parks are social areas which are come together and do their exercises. The usage of the urban space is a significant issue because most women use these areas, and some cannot do heavier activities like pilates or gym, which causes imbalances in women's heartbeats or forcing their legs. At the same time, the parks as a green area and fresh air. For example, Nuray (60 years old) regularly walks in the park closer to her house; after the exercise, she hugs the trees for relaxation. She points out that hugging the tree is a meditation for her, making it easier to decrease the physiological and psychological effects of menopause. Other exercises can line up pilates, swimming, zumba, fitness, and folk dances.

4.2. Sociocultural Aging and Menopause

This part tries to investigate the social construction of menopause. Menopause is isolated from socio-cultural aspects in the biomedical model, becoming homogenous, universal, and unified conceptualization. However, if menopause is seen as an aging process of women, biological aging is not enough to understand the complex structure of aging. Intersectional theory enables us to see how different social statuses are intertwined and various social categories produce inequalities (Cohen, 2021, p. 1). To grasp the background of menopause with aging and other changes of social roles and status, I divided this part into five subtopics.

The first subtopic argues what the meaning of being a woman is. This question is vital to understand because menopause is about women's experiences both biologically and socially. The subjective definition gives significant clues about women's positions where they live in society. The second subtopic elaborates on the aging and maturing concepts and their relationships with menopause. The third subtopic argues that being a grandmother affects women's social status and changes their daily lives. The fourth subtopic questions the intersectionality between retirement and menopause because menopausal age and retirement age occur similarly. The last subtopic tries to analyze how women's experiences were affected by the previous generation and how menopausal practices and the sources of knowledge change.

4.2.1. Being a Woman

When I asked what the meaning is of being a woman, I aimed to learn how women's perceptions about their femininities change or not after menopause. Mostly, I expected answers like defining women's perceptions about their bodies, appearances, or material things. Surprisingly, the women who participate in the workforce argue that being a woman in Turkey is divided into working women and housewives. The typical pattern for working women is that they started to work when women graduated from high school or university. They married at a young age and had children with short-range.

In some cases, women work and try to obtain their graduate levels from open universities. At the same time, they are responsible for growing their children. Mercan (53 years old) clearly refers the what is being a working woman like that,

> Now I think being a woman is divided into two. One is that being a working woman, and the other is that being a housewife. When you become a working woman, you forget your femininity a little bit. I mean, you have a life like this, you do all the work both at the workplace and at home. So, you have no chance of falling behind or missing from both. That's why it's hard to be a working woman, I say. I say not

> working is a right for women. Raising a child by working is very difficult.

Nigar (68 years old) also defines being a woman as hard labor, both rural and urban women, because they give out. Although women work very hard and have knowledge and skills about the job better than men, women are thrown into the background because we live in a male-dominated society. She adds that women in her generation were also wildly crashed in our working life. They worked hard but got underpaid. At the same time, Nigar continues her argument that the woman was also crushed at home. She comes home, and she has a hefty load at home. There is a child problem, and there is the burden of housework and preparing the food.

Similarly, Nuray (60 years old) narrates her daily life after work, and she says that she was unzipping her skirt in the hallway and did everything at home when running because she claims that there were three men in the house means that serving three men. She says that she has to do domestic work well because she talks about that there was such working mother guilt, working spouse guilt. She was under the pressure of not miss anything because of work. This pressure is undeniable because she cannot neglect her home if she wants to rise in her career. It is a condition for working women. Moreover, performing femininity at home become reversed in the workplace in Nuray's situation, and she claims that,

> I put in a lot of effort. It is the same as a working woman and in the workplace. To stand upright, for example, when I argued with my husband that day, I would do my makeup in the elevator to not look upset. I mean, when a man argues with his wife and can come to the office despite being sullen. My co-workers do not have any questions for him. However, I go to the office as a sullen they say that she has a problem. So, I always tried to be upright like that. Moreover, I am a young and beautiful woman, and the men think that you are welcome to all kinds of things. You are open in the eyes of men. Uh, I had to set my limits for him too. Iım, intimacy, it's pretty hard to put the distance, the people you've been with for eight hours. The distance of intimacy is complex and requires drawing boundaries. You will be both sincere and distant. It's like a

> knife-edge situation, and this knife is always on my back. Could I explain?

The working women situation shows that femininity can perform within family boundaries, and women are responsible for domestic work and care. On the other hand, women limit their performance at the workplace because of two reasons. The first reason is that women at work are not seen as professionals because of their gender. Any emotional change in women's lives can be perceived as women are not rational beings to decide crucial decisions. The second reason is that being beautiful, young, or attractive can disadvantage women. The performance of femininity is seen as a knife-edge, which means the women control themselves not to understand wrongly. In that sense, the working women are aware of the male gaze, trying not to draw attention.

When women define themselves as working women, social norms and roles at the house are expected par excellence, and these performances are checked by society. Especially, mothers-in-law are the inspector or gatekeepers about performance checks. Gender and work relationships are different from the private sphere because women argue that the work system is based on male rules. For example, Gülben (55 years old) claims that,

> Men are more active, more goal-oriented. You see this difference more in working life. You know, since working life is a more masculine state of action, people are confused about the identity of a woman working there as a woman. So, when we return home and reflect on the state of being focused and control-oriented, that's where identities start to get mixed up. That's when you start conflicting with the man in your life. By the way, it does not matter he is your spouse or your partner. You know, the two men are starting to face each other.

Gülben's example is essential to understand that the work system is designed according to male rules and that women have to obey these rules. The adaptation of work rules means that women's identities changed and at home, women experience the identity confusion because, at work, she is forced to be like a man. However, at

home, there is an expectation of the performance of the traditional feminine roles. At that point, to focus on the meaning of being a woman out of work context.

Some women argue that being a woman is a privilege to understand and experience different from men. This group argues that women are more sentimental and sensitive about their environment. The significant point is that women do not use being emotional in a negative context, that being rational, which is attributed to men, is not the superior feature. On the contrary, women argue that being emotional enables being creative. For example, Esma, an academician, claims that she is sensitive about social issues and being a woman allows her to improve another perspective in her works. The appropriation of the emotions means that women embrace the features attributed as a feminine but secondary position. In that sense, this perspective breaks the hierarchy between being rational and emotional. In other words, women's descriptions of being a woman are not about a comparison with men. Instead of gender duality, women focus on their own identities, experiences, thoughts, and feelings.

The second argument is that being a woman in Turkey has particular features instead of a more general or universal definition. In Turkey's context, being a woman means insecurity because women claim that violence against women is pervasive. Violence becomes a daily issue because women see everyday violence against women or feminicide on TVs or social media. The adds that violence is only one part of the feeling insecure because they claim that the perpetrators are protected and are not punished adequately. The critical point is that women argue that the value of being a woman in Turkey decreases because they believe that there was respect for women in society in their times. Still, the increasing violence against women is an indicator of the decreasing value of women in society.

To conclude this part, the mutual concept about being a woman in Turkey is constructed on hardship. Being a woman in Turkey is challenging because of two reasons. The first is that women have many responsibilities like domestic work, children and elderly care, and work. Moreover, there is a necessity of not confusing identities. For example, a woman in the workplace can be competitive or ambitious,

but not at home. The second reason is that feeling insecure because of the violence against women is common in private and public spheres, and there are no deterrent measures to prevent women. After a while later, the Turkish government declared to the public that Turkey would withdraw from the Istanbul Convention, a human rights treaty for preventing and combating violence against women and domestic violence. In that sense, the argument in my field about gender insecurity becomes more concrete in this example.

4.2.2. Being a Retired Woman

To open a subtitle becomes essential for two reasons. The first reason is that women define themselves with their work identities and how their other identities conflict with each other. I do not expect that because the literature focuses on women's identity related to their bodies, mostly about their appearances or sexualities or their traditional roles like being a mother or reproductive. However, my participants argue that social expectations from women and work-life come together and produce more complex inequalities. However, the crucial point is that if women primarily identify themselves as working women, their perceptions have changed through the retirement process. In other words, after a certain age, women have to quit their jobs because of their chronological ages. Still, the significant issue is there to see how this transition period happens.

The second reason is that women's retirement age and menopausal age intersect each other. In other words, chronological age overlaps in the biological situation. This point is crucial because changing social policies about the retirement age and women's menopausal age cannot intersect in the future because the retirement age depends on the policies. These policies can increase or decrease the existing conjuncture. At the same time, women's menopausal age can change. However, the rate or pace of the change of retirement and menopausal age cannot intersect each other as well as today.

The intersection of retirement and menopause is not always welcomed for each woman. Some participants argue that they experienced depression in their menopausal experience because they felt inactive. The main reason for inactivity comes from being outside of the work because women match that a person can be productive when she is actively working. Similarly, Nuray (60 years old) argues that,

> I actually slipped at that time because I was depressed. When you are a productive woman, you become an inactive woman, and in the meantime, some things in your body are changing. In other words, like puberty, menopause is a separate period.
>
> *Well, what happened that made you feel unproductive?*
>
> It's like this, baby, when I get up in the morning or go to bed at night, I've planned so many things—thinking about what I will wear tomorrow or how I can prepare for the next meeting made me always busy. I had to program constantly for doing something. Otherwise, you have no purpose in lying down. You look at life from a different perspective when you're working. You say I have work to do. E, now I am retired, and when I wake up, I have nothing. Therefore, I ask myself why I should get up, and I say stay in bed.

Retirement during coronavirus restrictions and being menopausal can be disincentive factors to postpone retirement. For example, Türkan (51 years old) argues that before the pandemic, she thought being retirement to spend her time for herself. However, she changed her mind after the restrictions because nowadays, there are not many more social relationships, and many problems will occur if she does not do something productive. Then, she highlights that I abandon retirement because she is afraid of being a lazy person.

However, women's participation in social life and their definition of being productive can change. The first of them, women's roles in domestic issues, and they can take more active roles in the relationships in the family. For example, Şahika (60 years old) explains that,

> I don't understand my menopause and retirement because I have no time to think. I am always in a rush. Here I am running around. While I was trying to prepare for my nephew's

> wedding, I was also dealing with the family situation of my daughter. I love my nephews too. I also make sacrifices for them, but I do not do anything I do not want to do.

Şahika's experience is significant to understand that women are busy in their work. Sometimes they can keep themselves busy with domestic issues. The expected traditional roles from women can take a new form. At the same time, women can enlarge their care outside of their children and take care of other relatives voluntarily. Another situation is that women can actively participate in political, intellectual, or social activities. For example, Nihan (64 years old) says that menopause and retirement are not the reasons for feeling inactive; she tells us that,

> I have not been one to stay at home after menopause or retirement. Before I retired, I was working at the Women's Solidarity Association in Izmir. After I retired, I started going to the Women Writers Association. I was attending a writing workshop there. Our joint storybooks are out. Still, I continue to write my stories. I am a good reader. I've been reading for years. After retirement, I did more than reading. So, I do whatever my heart desires. I can be productive to be useful for myself and other people. By producing, I don't mean making for money. I am currently producing. I knit, I write stories like what I create, and I enjoy what I do.

Like Nihan's situation, other participants talk about although they were sensitive about political or intellectual issues, they did not have enough time to participate in the activities. However, during retirement, they can realize whatever they postponed before. Especially, women are compassionate about politics and current events, and they also add that they sometimes participate the protests. Especially, women who are retired from the public officer position feel more accessible because there is no restriction about the participation of protests or there is no fear of losing their job despite criticizing the existing government.

Another group argues that menopause is a wisdom period in which women can share their experiences with other people, especially with other women. Gülben (55 years old) explains the meaning of menopause as a wisdom period like that,

> Menopause is a woman's wisdom period. Now you are slowly coming out of that working tempo. Menopause begins, on average, in the 50s. Gradually, your retirement time is coming, or you are entering a period where you have the chance to reduce your working tempo a little more at that time. This period coincides with the age when you are raising your children. Therefore, it is a time when a woman returns to herself and increases her self-awareness. In other words, we are talking about a period in which she can look at herself and live with awareness. She can enjoy the pleasant side of life. Moreover, in this period, women can find the courage, power, and inspiration to share their experiences. The accumulation of those years is gradually spreading around her. I see it as an enjoyable time.

There is a different type of woman solidarity because women come together to talk and listen to each other without judgment or gossip. These solidarity networks differentiate themselves from the tea parties, which are commonly known as *gün* in Turkish. At the same time, women share their knowledge or abilities for empowerment. The significance of this solidarity group is that to affirm the feminine body, both all physical and emotional changes, they try to understand their bodies and increase their wellness. The most significant issue is women's own experiences instead of social norms, cultural beliefs, or religious rules. In other words, the lived experience is at the center instead of taken for granted knowledge.

Lastly, I would like to add that retirement from one job does not have to mean that a retired person cannot work in different jobs or gain money. For example, Hasibe (63 years old) argues that how she started a new career after retirement and at the same time did different activities simultaneously like that,

> I retired a year after entering menopause. During this period, I attended various courses. Of course, I could not do an extreme sport as a sport, but I tried to do my walks. My husband retired a year after me. We tried to do different activities with him. We opened a business and worked together. We operated for a while, and then we closed it because my husband had some health problems. We are now at home because of these inconveniences.

Hasibe's example indicates that women can continue to participate in business and earn money from that. However, serious health problems can be an obstacle for the business. The significant issue is that women after menopause and retirement can preserve their entrepreneurial spirit.

I want to finish this part by highlighting some significant issues. Although menopause is defined as being inactivity, the context of being inactive is vital. In my research, most of the women described themselves with their work identities. The age of retirement and menopausal age are closer, and sometimes they can intersect and get knotted. At that point, both menopause and retirement are transitional periods in women's life. They can overlap because both of them are related to the chronological and biological aging process. Therefore, the definition of being inactive is not a coincidence with coming from the economic and work status change.

4.2.3. Being a Grandmother

In the previous chapters, I argue menopause in the context of being a working and retired woman. Working and being primarily productive is shaped by economic relationships because it is based on paid labor. However, women's experiences show that women work both paid and unpaid labor simultaneously. The crucial question is that whether women are retired only from paid labor or both paid and unpaid labor. The chronological age is the distinction point between working and retirement. However, there is no clear boundary for unpaid labor. In that sense, I argue that menopause legitimizes that women's unpaid work. First of all, the demographical features show that most women married and had children of younger ages. When women are in their menopausal ages, their children grow up. These children graduated from school, they have started their jobs, and even they have married. In other words, these children become adults who can stand their own feet. At that time, the rising of children ends for women. At the same time, the possibility of the newborn disappears with menopause.

Up to here, we see that chronological and biological aging; however, being a grandmother for a woman means aged by culture because women's roles enlarge from mother to grandmother. There is no legal or biological age for being a grandmother. In that sense, being a grandmother depends on the societies' demographical, social, cultural, and economic changes.

I want to start with how the relationship between aging and grandmotherhood is constructed. Adile (58 years old) has a grandchild after two years of menopause. She claims that menopause is not a sign of her starting point of aging. Although being a grandmother is good news for her, the social status change is confusing for her,

> When I entered menopause, I didn't think about aging, and I had concerns more about my duty toward my husband and dryness. I guess I don't accept aging either. Seven years ago, I had a grandson. When I heard that I would have a granddaughter, I said, will this call me grandma? I said, please get in touch with my aunt instead of my grandmother.

Calling aunt instead of grandmother is about women's narratives. They argue that they remembered their grandmothers instead of when I asked to be a grandmother because this role is related to older people. For example, Nevra (65 years old) claims that she remembered her grandmother as the concrete form of older people. She draws a picture of her granny, who was the 70s or 80s years old. She had limitations of movement because of aging. The women argue their experiences are different from the past, especially from their mother and grandmothers. I want to give place to two different experiences, those who are already grandmothers and those who have not yet become grandmothers. All women in this group want to have grandchildren, and this is a positive thing for them.

The first group that the already grandmothers is the minority in this research quantitatively. In this group, women argue that taking care of their children does not mean that their life changes totally. On the contrary, the emphasis is that women can more stay active with their grandchildren. For example, Şahika (60 years old) explains that how caring for children is enjoy for her instead of the obligation during four years,

> Yes, I satisfied myself there as I took care of my children while caring for my grandchild. I was in Izmir while I was looking at my granddaughter. So I had a comfortable and beautiful life. I was spending time with my grandchild, so I did it with pleasure. I didn't regret anything. I also took time to look at myself. My daughter was also careful about this. I was going to my hairdresser, doing my makeup, going to walk, and reading my book. So I took time for myself. I arranged to look after my grandchild accordingly.

In Şahika's example, she highlights that she learns new things about raising children. The old knowledge replaces the new one, and the Internet is the primary source of raising a baby, and her daughter decides how everything goes. The significant point about caring for a grandchild is different from caring for their children because the grandmothers' roles are secondary. They support their children instead of taking responsibility for care. For example, Nevra (65 years old) argues that she raised her one grandchild when he was two years old because her daughter-in-law was working, and she adds that when her friends were going on holiday, Nevra participated in this holiday with her friends and grandson. She points out the solidarity between the friends is vital because they helped her during the holiday. After one grandchild had grown up, she went to Australia to help her other son because she had a granddaughter and helped her other daughter-in-law during the six months.

All these examples show that the role of grandmothers is crucial for the newborn period and the following a couple of years, which does not mean that women do not take care of anymore their grandchildren. On the contrary, they are ready when there is a need. At that point, being a grandmother is part-time care because women say that when their husbands, their parents' or their husband's parents need care, they have to give up looking for their grandchildren. In other words, women's unpaid labor occurs in both part and full time. Spouse and elderly care have more priority when comparing with grandchild care. I think there is a hierarchy or gradation between the caretakers. Although the spouses or elderly care requires full time, the grandchildren care can be part-time.

Another significant finding is that there is a severe demographical change between mothers and their children. Although women had a child at a young age, their children do not prefer it. In my research, there is an example of late mothers, but it is not very common. However, my participants argue that their children do not prefer to marry and have children before at least 30 years old. For example, Aygül (52 years old) claims that,

> So, my eldest daughter is also single, and she is just at the beginning of the road. She went to school, graduated from it, and started her career. She is trying to stand on her own feet. You know, a grandchild thing is far from us right now. So, of course, it is essential and very nice for the support of our grandparents in Turkey. We also received these supports, but, especially at this age, I don't think that any woman's only job should be to take care of grandchildren because we are at an ideal age to produce, share, serve and pay off our debt to society. I mean, I'm talking about the 50s years old. Yes, of course, this support is good, but I think we continue to produce. I believe that every woman should present her talents to life somehow because unless we are creative, we will be happy when we are not fueled by creativity. I don't think so.

Aygül's notion is significant to understand culturally taking help from the parents is good, but an old thing. On the other hand, there is a current fact that the young generation's age of the marriage and the age at first birth increases because of the postponement. At that point, focusing on the work career and the unstable economy of Turkey are significant factors. On the other hand, women do not want to spend their free time caring for their grandchildren. While Aygül points out that women need to share their success and creativity with others, Gülben (55 years old) argues that how a woman improves and realizes herself, that is,

> Here, it is a cliché for menopausal women that we have already sifted our flour and hung our sieve. Oh, wait, 50-55 years of age is not the age I sifted my flour. So your hand is still holding, your mind is working brilliantly. There is so much to do for yourself. You know, everybody's waiting to step aside and be a grandma. Let her grandchild be given her lap. Again, there is the dynamic of dedicating herself to a child and sacrificing herself. Women have always brushed their hair

> for their children, and now their grandchildren have appeared. Aaa, for example, it is something that I react to a lot. A, here will be grandchildren we will look at them. No, I don't have any such contract.

Gülben touches on grandchildren care as unpaid labor because there is no signed contract about it. However, there is an expectation of the dedication of women to their children. In the 50s, women can be infected with menopause or grandmotherhood, but these changes do not directly affect women's aging process. She argues that the cultural construction of aging women is based on old categories like traditional roles and expectations of performance. In that sense, women do not think they are older, and their age is available only to stay at home and take care of the grandchildren. They argue that our culture named women as aged easily. Another significant point is that economic conditions and status can be highlighted as influential, demographical, and cultural needs. For example, Ayçil (52 years old) argues that,

> I wish I were a grandmother. (laughs). No, but like this, let me explain; my children bring my grandchild, I love them, then take them back to their parents. (laughs). For example, I have a friend who goes to the Anatolian Side (Istanbul) 4-5 days a week. She is staying at his son's house and looking at the kid. His son and daughter-in-law are working. In the remaining days, she comes back to her house and does her housework. Such a life is very tiring. I don't do that because there are no such obligations. I don't know what to think, but my children, even if my children are in financial trouble, there is nothing to do. I make sacrifices, so I go and look after my grandchild. For example, I don't care if their financial situation is good. For instance, if Polen has a child now and works in a perfect position and earns more money, she can have a babysitter take care of her child, so there is no problem. In that condition, I'm sorry, I cannot do anything. However, if she has an average salary, I cannot be unconscientious, taking care of her child. The conditions are essential.

Ayçil's perspective differentiates itself from the other ideas that are caring for the grandchildren depends on economic conditions. At that point, she argues that her unpaid labor has an economic value. If her children's income is higher than specific standards, another woman will give the care as a babysitter. From Ayçil's point of

view, there is no problem with taking help from other people within the price. Rationality is a significant point in that relationship because the role of caregiver can assign to other people. There is a distinction between care and love because when a babysitter takes care of the child, a grandmother does not love her grandchild. On the contrary, the increasing welfare makes women freer about spending their time. In the reverse situation, if women's children have financial difficulties, the role of the mother and its protective function gets involved the care system.

To sum up, talking about the relationship between menopause and being a grandmother is very hard because women argue that the intersection of menopausal age and being a grandmother is about the previous generations. In their generation, they become a grandmother in the later ages because of the demographical changes. At the same time, women in their 50s do not define themselves as older people. Today's 50s years old is not the same age 50s years old as the past. At that point, the traditional roles and duties reproduced through social, cultural, and economic changes. The critical point is that there is no discussion about middle age. All participants use the duality between young and old or now and the past. This finding is vital that middle age is not common usage in daily life. In the literature, I mentioned that midlife or middle ages both biomedical model and sociocultural model. In practice, there is no exact usage of this term. The arguments go on the tension between being young or old.

4.2.4. Aging and Maturing

In the previous chapter, I conceptualize the relationship between aging and menopause in biomedical and sociocultural models. This part seeks to understand how women define aging with their own words. When I asked women what the meaning of menopause is aging, the participants corrected my question that they grow older but get on in years. This point is significant to understand as an opposition to the negative conceptualization of aging and ageist practices.

Women argue that getting on years is more applicable because the increasing chronological age cannot change women's feelings about age. At that point, they feel younger despite their age. Especially, not losing the childlike is a significant pattern because women argue that although the years pass quickly, their spirit feels more youthful than the body. For example, Esma (52 years old) argues that,

> Well, I told you, Necla. I mean, I still have my childhood, like when I was in my 30s, 40s. I mean, I don't feel much of a change, but, of course, how can I say? Maybe, I've become a little more accepting of my life issues. As if after menopause, I began to accept everything a little more as nature and God gave. This acceptance is not submission. In that sense, I started to develop myself a little more. I see it, but I still have that childish, cheerful mood. It's just like that, and I did not say that oh no, we are old, a period is over. There is no such thing that the Middle Ages have ended, and the new age has opened.

Esma claims that with menopause, she does not become older suddenly. At the same time, there is no concurrence between the chronological and subjective age. Another example is that Gülay (54 years old) calculated her age for the interview. She does not think how old she is in everyday life because the age calculation does not mean anything for her. She points out that if she accepts the aging, she faces changing her clothing style, being dignified, and acting her age. The ageist discourses focus on how women's bodies appear, how they wear, look, and behave. Nuray (60 years old) argues that there is pressure on women about their ages. She claims that,

> Let me tell you something exciting. I wanted to dye all of my hair blue. Well, I wanted to be the blue-haired woman, you know, not a pinch. Well, people around me said they were surprised. What else did they say? For example, they said that we definitely do not know you, we do not want you to see you like that, we are ashamed of you. So, for example, you will be a grandmother, you will be a grandmother, just don't do it, sit aside, take your job, it's not for me. Is it the people around me? Yes, like that.

Nuray's example shows that there is an acceptable appearance for older women in the eyes of society. When women cross the line of expected appearance and behavior and do not act their ages, there is an exclusion system. In this system, there is a threat of

social exclusion that is a punishment because of the breaking rules. The pressure over women is not limited to that how women look. At the same time, being single, a widow, or living alone at a certain age are significant for women to shape their lives. For example, Aysu (77 years old) moved from her house to her son's student house after retirement, and her husband turned back to the village and spent his retirement time farming. Aysu argues that although she was a married and older woman, she had enormous social pressure over her because she did not live with her husband. She claims that,

> Our door was broken, and I was very anxious. However, our economic condition was not enough to fix it. After a while, we had the door fixed, we had it done, but I could not get out the troubles, economic and environmental pressure. I am neither single nor a widower. I was married, but I didn't live with my husband. I mean, you're trying not to attract attention around you, against the people. Top it all off; you had to defend yourself from the gossip. My husband lived in Konya, and people there knew that his wife was over there, and Konya is a more conservative and oppressive place. They shouldn't hear negative things about you. To be honest, I didn't even notice among those problems, and I went into menopause. I mean, there are fevers, but I don't understand what's going on because I have other issues.

Aysu's experience shows that although a woman has a job, a regular income, a marriage, children, and middle age, women's oppression does not disappear. While she was living with her son, her husband's absence created pressure on her. The social anxiety and economic troubles become concrete in the women's health situation. In other words, the oppression of women can be a cause of menopause, and women cannot be interested in themselves or their bodies. The highlighting point is that increasing the age does not make women freer than their younger ages. Either this or that way, social norms, and cultural beliefs reproduce for older women. In that context, living alone can turn into pressure because of the negative perspective about single or living alone women. However, women argue that aging gives place to fight the social and cultural norms about the intersectionality of gender and age. Women say that they

complete their duties towards their family members, relatives, and the society they belong to after a certain age. For instance, Ayçil (52 years old) claims that,

> Oh, it's gone from me, so it doesn't matter anymore. Even if a person is 50 years old, her heart is still 20 years old. Even though he is 100 years old, her heart is still 20 years old. I love myself. I like being well-groomed, traveling, and having fun, so that I can do these things is healthy, right? My responsibilities are decreasing. That's why I can take time for myself. While doing this, no one can force me. Nobody can't suppress it like that, once by the family. No one can interfere. Why is that? What about them? I mean, I worked, I gave birth to a child. I have come so far. Nobody cares about me.

Ayçil's statement is important about women's empowerment through aging because of having less familial and work responsibility. In some cases, middle age means that spending their time, energy, and money for themselves. Especially, menopause can be a warning about the need for care themselves. Most women describe aging as a physical restriction, and they state that they cannot do their activities after a certain age because their bodies will not allow them. For instance, climbing up the stairs and cleaning the house are significant indicators of how women's bodies change and lose their performance.

Another significant pattern is that women argue that getting on years differentiates itself from chronological aging because women argue that life experience makes women more mature instead of getting older. Therefore, the difference between aging and maturing is that experience and the change of perception toward the world changes through life experiences. At that point, chronological age loses its importance which is more associated with physical abilities and capabilities. When women are getting on in years, they can critically analyze their lives and decide what is good or bad for themselves by criticizing their past. For instance, Neslihan (59 years old) argues that in Turkey, women easily and early become matured instead of their age are younger. She claims that,

> At the age of 18, I was a person who knew myself and thought I was mature. At 17 years old, I finished high school. I started

> work at the age of 18. My business life lasted until the age of 40-odd. I mean, I always think I'm mature because my parents always treat us like adults. I mean, the only thing I remember in my childhood is my mother, who used to dress up as very clean, take us to the playground, but she would bring it back sparkling. We couldn't get ourselves dirty. When we went to a guest house, Necla, my mother, used to say, eat your meal at home, go to the guest house complete. I mean, even being hungry at the guesthouse was not tolerated. Maybe because of their influence, we have matured at a younger age. We couldn't do anything as childish. It seems like we have entered the maturity period before we can live. We dived into direct responsibilities, sounds like. We made an effort to fulfill those responsibilities perfectly. So, for example, we have never lived such a crazy life.

The pressure of behaving good girl roles in the society has become earlier for women. Being clean and tidy are ingrained from childhood. At the same time, children have the responsibility of representing their parents in social relations. For example, eating before visiting the relatives or neighbors' houses means that if a child eats a lot in the quest house, the host family thinks that this child is not nourished enough by her parents. This situation has been named a shame culturally. Briefly, a girl grows up with the consciousness of her responsibilities. Another significant issue is that being 17 or 18 years old is seen in the adulthood period. There is no distinction between young or late adulthood. In other words, women start life younger and after a certain age, growing old earlier. The significant point is not chronological age. A woman in her 40s or 50s can see herself as old because she faces responsibilities early and completes them at a certain age.

Another critical pattern about being mature is changing emotional fluctuations, and women become more self-confident, calm, and independent in the decision-making process. Adile (58 years old) states that,

> Of course, of course. Once again, there are no whims, no stubbornness, just understanding. So now there is experience. The person in front of me is talking, and I don't even react to them because I know the truth. Very calm. So there is no whim, no anger, calmness, and patience. You are learning

> patience. I mean, you accept everything with understanding. You are given ideas, ok I heard that, but my opinion is more important, but that's how it used to be. It wasn't. We were getting angry very quickly. We were getting stubborn, with no patience, no understanding, but that all changed. Mature now. Mature. I feel more confident when making my own decisions. I'm not afraid of anything anymore, and I have nothing to lose. I don't think what will happen tomorrow.

Being become more calm and patient affects their roles in the family. For example, women argue that they become more tolerable toward their children. They said that when their menopause and the puberty of their children co-occur, the conflict is sharpened between two generations. Significantly, the participants claim that their children blame to menopausal women as being an adolescent. However, the fluctuation of the mood and emotions is temporary. When women feel more matured, they point out the familial conflicts become less visible. A similar thing is acceptable for other social relationships for women. In that sense, they can speak about their problems with their husband more openly. At the same time, women become more persistent in their thoughts and decisions. They assert that women give more importance to their ideas in both private and public life and prevent themselves from all negativities. The last important pattern is that women's relationship between their bodies through aging is not entirely negative. Especially with their menopausal experience, women argue they realize their bodies and think about them. For example, Aygül (52 years old) states that,

> I think menopause is a woman's maturation period. I believe menopause is a time for a woman to give what she has taken into life. So, now I think of it like, the first period is blooming. Currently, in menopause, the flower turns to seed and pours its seeds into the ground, and those seeds are pregnant with new flowers again. In fact, with menopause, you may be a mediator in the blooming of other flowers by sharing your knowledge with other women. So, you know, menopause is a maturation period, a wisdom era. I don't see that getting older is an inactive period because I mean those 30s or 20s of life are constantly going through struggles, so you have to prove yourself, make a career, get married, and become a mother. We realize our femininity a little late, and maybe this is how

> it is in Turkey. For instance, the meaning of femininity, what it means to be a woman, to be a woman, and to take care of yourself, what does it mean to take care of yourself. We realize these are a little late, or I'm late. I don't know. These are the ages when people can see themselves better. Therefore, more mature, age wiser. Yes, maybe physically, of course, so those stripes, whites, etc., but nothing at all. It doesn't bother me. For example, I don't dye my hair. I am happy with my whites. I'm trying to live. So, I am at peace with my age. I am happy about my age.

When menopause is considered a maturation, women's relationship with their bodies changes because the focus changes from appearance to caring. When women define the meaning of being a woman in Turkey, they talk about care in detail. Nevertheless, women's conceptualization of care is only for other people, not for themselves. The negative relationship between aging and menopause gains a different meaning in the conceptualization between maturation and the care of the self. Additionally, the concept of self-care is not a directly individual issue because women argue that sharing the knowledge is significant against the myths and prejudices about menopause. In the literature review, menopause is seen as a starting point, and the body starts to decline in this process. Anti-aging is the central concept against to decline process. However, in this research, women argue that they are happy with their white hairs, wrinkles, or crowfoot. While women are at peace with some of the signs of aging, the other health risk factors are considered negative. For example, weight gain is the most dangerous thing for women's health because becoming fat means less physical activity and more health problems.

As a conclusion of this part, there are two different perspectives toward the aging process. The first one is that getting older is a negative concept because it signifies the body's decline through the impairment capital of health. However, maturing means getting on in years and having enough experience to develop self-esteem and self-confidence and feel more patient. In that sense, middle-age does not only consist of the negativity of aging and menopause. On the contrary, in practice, women feel more

balanced and powerful retrospectively because of completed responsibilities in both personal and public spheres.

4.2.5. The Intergenerational Ties

In previous parts of the study, the sources of knowledge about menopause are mentioned slightly. In that part, the comparison between past and present is discussed by comparing the menopausal experiences of the participants and their mothers. Analyzing generational ties enables us to understand how menopausal experiences are transmitted from mothers to their children and how menopause is constructed in different periods.

First of all, I would like to start with how women's mothers experienced menopause in their daughters' eyes. The relationship between mother and daughter is significant because the participants argue that their mothers did not talk about their menopausal experience because talking about femininity or feminine things was not widespread in their mother's time. On the contrary, talking about womanhood is a shame, especially in front of their children. There are two ways about learning their mothers' experiences. The first one is that their mothers said this room was so hot or I got hot all over (ateş bastı in Turkish). Hot flashes were significant to understand that whether a woman experiences menopause or not. A similar finding is valid for the participant's experience. Although hot flash is not the only physical symptom of menopause, the visibility of the hot flash makes it the symbol of menopause in both generations. The second way is that going to the doctor. In my research, almost all participants visit the doctor in their menopause experience. The medical approval of menopause requires women to understand that there is no pregnancy or problem with their bodies. Menopause is seen as a natural transition despite all medicalization discussions. Nevertheless, my participants added that going to the doctor and receiving medical was not common in their mother's time. For example, Mehpare (54 years old) states that,

> My menopause is entirely different from my mother's. My mother had health problems. My mother's living conditions and mine are completely different because my mother gave birth ten times. Her uterus was removed at the last birth because she had health problems. Early menopause because the uterus was released at the age of 30-35, but my sisters and I entered in our 50s. In particular, menopause was not talked about at home. In any case, one would not go to the doctor unless it was an emergency.

Similarly, Nevra (65 years old) says that she learned her mother's menopause from the doctor when her mother had purples spots in her breasts, and Nevra takes her mother to the hospital. In that sense, the participants learned their mothers' experiences through the surgeries or doctor visits. There is a crucial point which should be underlined. Not only did the participants' mothers hide their experiences from their daughters. At the same time, the participants were not interested in menopause because they experienced puberty or left the mother's home by marriage. In any case, menopause was too far away from my participants. Therefore, they did not possess enough knowledge about menopause. Şahika (60 years old) tells us how she had no idea about menopause when her mother experienced it. She replies, how was your mother's menopause was like that,

> Off, it's a wound in my heart. My mother also worked, and she was taking care of her grandchildren. He also became menopausal at the age of 48. After retirement, my mother started to sweat and feel uncomfortable. Why didn't I understand although I was working too? I always regret why I didn't take her to the doctor, you know? I did not have time for my mother. She was angry when looking at her grandchildren. The woman who had never flicked to her grandchildren started beating her grandchildren until that time. She was so nervous in a way we couldn't understand. I asked her: Mom, what are you doing? You never hit us once. You were a honey-tongue person; why did you do that? Well, she was told that she was going to kill my daughter, he was getting so angry. I always feel sorry for her. I didn't take that woman to the doctor. There was no such thing as menopause. I did not know anything.

Şahika highlights that she and her mother are educated, urban women. However, they had no idea about menopause in the mother's menopause experience because she had

never been interested, and there was no concept about menopause. At that point, receiving help from outside of the house or from a third party was not possible because not even menopause, everything is hidden and not spoken about the changes feminine body. At that point, the discussion of the changes the talking about menopause is critical. The participants highlighted that nowadays, women could obtain knowledge from their doctors, TV programs, or the Internet. Google is the primary source for women as the most practical way. Before the widespread usage of the Internet, menopause became more visible with television programs for women in prime time. Now, TV programs are replaced with Google. The significant point is that the sources of menopause can vary, but this cannot be informed us about how women's experiences of menopause change through the information variety. Women's experiences are significant to understand their subject position; therefore, their interaction with this knowledge is critical to understand the changes in their bodies. When comparing to past and present, the participants agree that women can easily talk about their experiences. For example, Aygül (52 years old) claims that talking about how menopause and menstruation differentiate each other like,

> There was no such taboo in my circle of menopause or menstruation among women. Ha, of course, at this age, yes, it was not for menopause, but of course, it was for menstruation. The way menstruation was taught during periods, the way it was given to us, what we heard, actually showed how taboo it was, but the same thing for menopause. I cannot say because the women around me expressed their menstruation quickly, but for menopause, yes, they can talk. I heard something like that. Oh, my libido has dropped. I don't want it anymore. I mean, that's what's going on. In other words, women were expressing their complaints very quickly.

Most women argue that they could not talk about their menstruation because it was taboo. For example, Şahika (60 years old) never heard anything about menstruation, and nobody had told her. Only a nurse came from Hacettepe University and talked about menstruation in the course. However, she was studying in high school, and she

already had experienced it without knowing anything. Hiding and not spoken about menstruation causes different practices. For instance, Nuray (60 years old) says that she hid her underwear in the laundry basket if there was menstrual blood. She is aware that hiding bleeding can be outdated today, but she always hides her menstrual bleeding from her husband, and it turns into a habit, and she does it without question.

Not only menstruation, sexuality, pregnancy, or birth was not taught to the women properly. For example, Aylin (59 years old) claims that her generation was married without knowing anything about their bodies, their sexualities, and they had experienced many problems. These problems cause to divorce of her many friends. After all traumatic and challenging experiences, talking about menopause is a more manageable issue for women. However, thanks to the qualitative method, I realized that women share their experiences mostly with their friends. It still is talking in the private area, not public. For example, Aylin (59 years old) argue that,

> Menopause can be spoken around me. Maybe, it is effective that we are working women. We talk about menopause with the group mates we have established, but of course, we do not speak to people with whom we have official relations in the work environment. It's mentioned up to a point, but your friend group is significant. If the environment that will relax you is with you, it is comfortable. There is a problem with talking about menopause in the family. Children said my father is in andropause, my mother is in menopause, and we also have puberty problems. They said that enough is enough and revolted because they thought there was so much pressure on them. They did not have an easy time, and it was a difficult period.
>
> *Were you able to talk to your children?*
>
> Of course. I mean, it's not apparent, but maybe my children are researching it themselves because they know its name. I don't know, but you don't sit down and talk about these reasons why women go through such a period or why men enter it and so on. We only said, please, tolerate your parents. We did not go into details, of course. We never talked about how we experienced menopause and andropause because I had two boys and, I wasn't very open to my children. But now we're

> talking about everything. Of course, they already know because they are married and also had children.

The interview with Aylin is longer than other quotes because talking about menopause is not the question with replying yes or no. Although she claims that she can easily talk about menopause, there are some limitations. For example, menopause is a hidden issue in the work environment. Women are cautious not to externalize their personal problems, and menopausal symptoms are included in the category of private. At the same time, talking about menopause or andropause has an age limit, and these kinds of bodily and biological changes are not discussed with unmarried children.

The privacy issue continues when talking with the children. Although some participants say that I can easily talk about menopause, there is no open discussion, conversation, or chat. For instance, Nihal (64 years old) argues that she never spoke about menopause directly. Still, her husband understood because throwing the quilt and saying go hot all over are enough signs of understanding menopause. Talking about menopause includes hints, and using the hints is the way of telling menopause covertly.

According to the participants, they can talk about menopause overtly with their close friends because of two reasons. The first reason is that a woman can understand another woman. The men are so uninterested in feminine issues. Especially, women argue that their husbands are not interested in menopause, and they do not make an effort to understand the women. The second reason is that experience and shares the experience. The participants claim that only women who experience or are experiencing menopause can understand each other because experiencing bodily changes, develop coping strategies, and share these experiences are the key points for the discussion of menopause. At the same time, women argue that up to a certain age, menopause is ignored by women because menopause is not an issue for young women. Almost all participants say that menopause can easily be spoken in the friend zone. The generational difference is that women can obtain knowledge more quickly, and there are many sources for expertise from the doctor to the Internet. Therefore, they

have more ideas about menopause, and women are not ashamed when they share knowledge with other women. The participants' highlight that is talking about menopause was seen as a shame in cultural codes in their mothers' time. However, today, not talking about it even with closer friends means that menopause symbolizes lack. Ayçil (52 years old) states that,

> So at this time, it's weird not to talk about menopause. The reason for hiding is that women perceive menopause as a deficiency. So, okay, I said my mother wasn't talking, but my mother lived fifty years before me. If I look at that generation, they would say that it is a shame and a sin. It was not usual to talk about these issues with children. For those who do not speak now, entering menopause in women is a problem. They create a perception as if they are lacking. It's not like that.

Gülay (54 years old) shares similar thoughts about menopause when comparing past and present differences. She adds that the cultural and religious pressures are decreasing now. Primarily, there is progress in the ideas about menstruation. She says that she had bought a pad from a market; it was wrapped in a package and carried it secretly. However, purchasing a pad is comfortable and natural. In fact, some men can buy the pads, and which is very normal. In that progress, hiding menopause cannot be about the same reasons. According to her, some women see talking about menopause as a confession because they feel like they're missing out or feel a lack of femininity. She gives an example of her old neighbor in Ankara, and she would ask if you have become an uncle instead of asking if you have reached menopause. According to Gülay, talking about menopause as becoming an uncle is the expression of being unable to say menopause because some women think that the lack of menstruation makes women less feminine. Therefore, they try to hide menopause and do not speak about it.

Another difference is that both men and women did not speak menstruation and menopause compared to the past and present. However, today, some men ridicule menopause instead of supporting women. For example, Esma (52 years old) points out that,

> I mean, a mockery; the exclusion is always there. It's like that in menstruation. It's an attitude like the woman on her particular day (muayyen günü in Turkish) will always be like this if she's seen nervous. This situation can happen even between married couples. In menopause, her menopause period has come, as if her nervousness is due to it. I think there is prejudice in society. Maybe not so much for the new generation, but for me and the generation above me, there is such an unpleasant approach from time to time. If you're in traffic, somebody can say that I guess you are on a specific day or you're in menopause because of your irritability. For example, there was an argument somewhere, if it is a woman around 45-50 years old, and defends her opinion in a bit of an outburst. Men say that it's time for menopause; there can be ugly expressions in quotes like this sister needs to calm down. There is a prejudice about menopause as a period in which the active sexual life of women ends. Therefore, the need for men reaches the limit. Unfortunately, I think it is a mockery in this society as if it were time.

Esma's point is significant to understand how women in their middle age are stigmatized as a menopausal woman who is aggressive and unhappy because she does not have an active sexual life and is unsatisfied. The mockery about menopausal women signifies how gender and age intersect and produce ageist and sexist discourses. The discriminative discourses overgeneralize menopause as the end of sexuality and ignore other dimensions.

To sum up, the intergenerational ties are significant between the participants and their mothers for two reasons. The first one comparing women and their mothers' experiences as two different periods, and women argue that menopause can talk more easily and freely today. The second one is to understand women's childhood and adolescent periods which are still effective because women argue that their experiences are constructed on silence. Moreover, they argue that having less information about their bodies and bodily changes.

CHAPTER 5

CONCLUSION

This research aims to understand women's menopause experiences in Turkey in the context of the intersectionality of aging, body, and gender. Although menopause is seen as a biological issue, feminist researchers argue that menopause is not only about medical issues but is not a universal experience shared by all women. Social and cultural aspects are vital in the construction of menopausal experiences. The existing literature argues that gender perspective is necessary to understand women's menopause experiences. I try to demonstrate how gender and aging intersect and how women explain their bodily changes in that research. The crucial point is that the biomedical and sociocultural models are considered dynamic structures because the social relations construct them. In that relationship, women are taken into account as the subject, and the research is built upon the women's experiences. Therefore, there is no determinant structure such as medicine or culture. The interactions of women with these structures and how women's menopausal experiences are constructed through these interactions are significant.

Any participants mention that menopause is a disease. All participants agree that menopause is a natural process, but they go to the doctor when they notice irregularities in their menstrual cycle. The significant point is that irregularities such as long cycles, short cycles, spotting, and heavy bleeding can signify a medical problem, or pregnancy can cause a menstrual delay. To be more precise, women do not go to the doctor because they are menopausal. On the contrary, they realize the irregularities, and the doctors inform women about menopause. The medical treatments and suggestions change due to women's age. Women argue that they go to the doctor when they need. The strong emphasis is that women are against calling them hypochondriac (hastalık hastası in Turkish), especially in their menopausal

process. Women agree that the best doctor is a person herself, which does not mean women do not diagnose themselves by pretending to be doctors.

On the contrary, women believe that if they have a healthy life, they can be prevented the illness. They prefer to go to the doctor in an urgent situation and aim to take fewer medications. A typical pattern is that healthy diets and regular exercises are preventive against illness, and women prefer healthy lifestyles instead of lots of doctor visits and using drugs or pills. Notably, the eating habits and types of diets vary. For example, women are quit eating pastry, fatty food, and deserts. Most women argue that they change their traditional eating habits, and they consume healthier foods like vegetables. The food types and their qualities change due to socioeconomic class. For example, women who have high socioeconomic status prefer imported food like quinoa instead of bulgur wheat. Middle and lower socioeconomic classes argue that they prefer healthy food in the allowance of their budget.

The most frequent mark of menopause is hot flashes because women's bodies alarm and start to get hotter and sweat. The unique character of hot flushes is that other people can notice the blushing and extreme sweating. Menopausal women feel ashamed because they engage other people's attention and are automatically labeled menopausal. The stereotyping of the menopausal woman in Turkey as seen older, a nosy parker because they have no sex life and feel unhappy and project their unhappiness and unsatisfied mood project to the other people. The term of menopausal aunt is used as a label of the attitude against menopausal women. The intersectionality of sexist and ageist discourses, attitudes, and behaviors make women hide their experiences. Nobody can notice who is menopausal from outside until starting hot flushes and blushing. Women do not feel comfortable themselves when they cannot control their bodies. Another significant finding is vaginal dryness, and women feel guilty because they argue that they cannot fulfill their wife's duty towards their husbands. Therefore, they can use vaginal creams, which include estrogen, lubricants, or more natural techniques.

Some participants argue that they do not have any physical symptoms and nothing changes in their bodies. The only difference is the cessation of menses. Unchanging of nothing situation is similar to psychological changes. Women argue that their emotional mood was stable in their menopausal period. However, some of the women claim that menopause causes anxiety because of vaginal dryness. Most women argue that they are afraid of the relationship breakdown with their husbands before they experience menopause. They argue that physical change can turn into psychological pressure or problems. Moreover, the feeling of world-weariness is a pattern because women argue that they question their life retrospectively and withdraw from daily issues. However, women argue that self-examination does not last long; it is temporary. Remarkably, women claim that they go through that process of becoming stronger.

Another significant pattern is the relationship between menopause, sexuality, and reproductivity. In this research, sexuality and productivity analytically differentiate because menopause is the end of reproduction, not sexuality. Being fertile is a significant issue for women who experience menopause at an early age. However, most women argue that they have become early mothers, and the loss of fertility does not have a crucial role in their women's experiences. In other words, late mother practices are not common practice in Turkey. There is an expected age that is culturally approved for marriage and pregnancy. The intersectionality of gender and aging becomes a norm for a mother at a younger age and limits being a late mother, although women's biology allows for a child. In that context, if women do not experience menopause at an early age, the end of reproduction does not become a problem. On the contrary, menopause is a luxury thing because menopause means that saving from her heavy bleeding, the fear of spillover of blood from the pad, and the menstrual pain.

Another crucial aspect is that menopause is seen as the end of sexuality. Women argue that this knowledge is taken for granted, and it is not valid. The end of sexuality is called a myth, and women claim that this myth creates pressure over women before

menopause. The crucial point is that sexuality continues during and after the process, which is not the same thing as changing the sexual life of women. Although some women argue that their sexuality is not affected by menopause, another group claims that vaginal dryness and the decline of libido can cause changes in sexuality. The significant point is that women do not talk about sexual desire or pleasure; they worry about how their relationship with their husbands will change. Women's sexuality does not belong to themselves, and it is seen as a duty towards their husbands. When they cannot fulfill their duty, a familial crisis can occur. In that sense, women's sexuality is limited in the family context. Women also add that their husband's attitudes are highly effective in sexuality, especially in older ages. Women can solve their sexual problems with their husbands' positive, kind, and understandable attitudes and behaviors.

The sociocultural model enlarges the peripheries of menopause and tries to conceptualize the background of menopausal experiences. First, the existing literature focuses on women worrying about body shape, body size, younger appearances, and being sexually attractive. Menopause is identified as a loss of femininity through aging bodies. In this research, the definition of being a woman does not refer to signify only appearances. Remarkably, women argue that their changing social roles, status, positions, and interactions are highly effective in their menopausal experience. The first argument is that being a woman in Turkey is complicated and challenging because of two reasons. The first reason is that working women differentiate themselves from housewives because they work both in and outside of the house. They are seen as responsible for caring for children and doing housework; simultaneously, they have full-time jobs. The participants have started to work and become a mother in younger age. Under these conditions, women claim that they overlooked their femininities and focused on their bodies. The second reason is that women feel insecure because of the gender inequality in Turkey. Mainly, the violence against women, femicides, and insufficient punishment of the authorities are the primary concerns. At that point, women are susceptible to the security of their lives.

When working becomes a significant part of identity construction, the retirement of women requires a specific analysis. Retirement is based on chronological age because women have to quit their job after a certain age due to social policies. Menopause occurs in the retirement age, and chronological and biological insect each other. In other words, becoming a retired and menopausal woman intertwine, and women can feel unproductive because of retirement, inactive because of staying at home, and infertile because of menopause. When these all negativities come together, women can experience some problems since different transitions experience simultaneously. During the menopausal process, women try to stay active and productive to decrease aging and become social.

Another important pattern is that women gain a new social role around menopausal age: being a grandmother. Women refuse that taking care of their grandchildren is not a compulsory thing, and they did voluntarily. Notably, women argue that their children can receive help from babysitters; they do not worry and are sorry about it. However, if their children need help and do not have any budget for paid labor, women can take responsibility. Most of the women claim that economic condition determines their care action. Taking care of children is part-time labor for women because their children have primary responsibility.

Moreover, The argument is commonly shared by almost all participants that the menopausal period is not the time of staying at home and taking care of children. The previous statement is valid for the past generations. However, women argue that women want to spare time for themselves after retirement and raising their children.

Women's definitions of being a woman, retired woman, and grandmother signify different types of aging processes. When I asked about the relationship between aging and menopause, women define aging as a physical decline because getting older means limiting physical activities. However, aging does not start with menopause suddenly, and menopause is not considered a cause of aging. However, menopause is taken into account as a warning to take care of the body well. Women link a more positive relationship between aging and menopause as maturing. The denial of getting

older and using the term " getting on in years " indicates having more experience than physical abilities and capabilities, more related to chronological age. The definition of being mature is that feeling more self-confident, calm, and independent in the decision-making process. The participants say that social pressures and other people's effects decrease because women are based on their own experiences. In that sense, maturing is contextualized as an empowerment of women.

The last concept is that the transitional ties show that women have various sources about menopause and can talk about menopause with other people. In the previous generation, women did not talk and complain about menopause. In that research, there is an agreement that menopause can talk freely today compared to the previous generation. However, when the conversation got more profound, the participants said they could talk menopause with their women friends and neighbors. The friend conversations about menopause are seen as a sharing environment for women because they claim that menopause is not talked about in the public area like the workplace and, at the same time, in the private area. The participants say they cannot share their personal situation with their children because speaking about feminine and masculine issues is not shared.

Moreover, the participants argue that their husbands are uninterested and inconsiderate about menopause. Therefore, women prefer to talk about other women who share the same experience instead of their husbands. The last argument is that the participants highlight that they grew up in a more conservative area. They did not talk about menstruation, sexuality, and pregnancy and hid them in certain conditions. After that, all, hiding menopause or less talking, is seen more natural. They claim that they are more open and less conservative due to their upbringing.

To sum up, the biomedical and sociocultural models define menopause differently; however, their intersection point is gender, age, and body. Notably, menopausal age affects the founded relationships. The most critical finding is that three are three different typologies that shape according to the menopausal age. The first typology is being a menopausal woman in her 30s. Medically, it defines as premature menopause,

and it occurs under 40 years old. Although premature menopause is defined medically, the experiencing of menopause at different timing affects social relationships. This type of menopause is seen as pathological by doctors, and they strongly suggest taking hormone replacement therapy because of a sudden change in hormone levels. The most prolonged hormone usage is founded in this group. At the same time, this group has the most frequent and regular doctor visits because of using HRT. Women argue that they use it for a long time because their doctors say their bodies are not ready for menopausal changes. From the women's side, premature menopause is an unexpected and unprepared situation. These women feel more isolated because there is no peer group to share this experience. At the same time, premature menopause is seen as an anomaly in social life because there is common knowledge which menopause is an issue for later ages. The end of reproductivity can be a severe problem for those planning to be a mother after 30s years old or a late mother. Moreover, menopausal in the 30s is considered an unwanted label because women argue that they do not have any symptoms or features about aging; they are only menopausal. In other words, premature menopausal highly criticize the existing definitions and treatments of menopause because of the stereotypes.

The second typology is being a menopausal woman in her 40s. Early menopause which women experience menopause between 40 and 45 years old. Although theoretically, the upper limit of early menopause is 45, the doctors' approaches are the same for the late 40s. The average menopause age is 49 in Turkey. Most probably, the doctors are based on this age. Therefore, being a menopausal woman in her 40s years old divides into two different axes. The first is that women who experience menopause at 40 and 45 years old are closer to premature menopause. The slight difference is that the end of reproductivity is less effective because women say that when they enter menopause, they have not thought of having children anymore. The doctors' suggestions are also different because hormone time is shorter than the premature group. Women argue that their doctors suggest using hormones as an adaptation period, which is very contradictive when comparing premature menopause because

menopause is seen as destructive for the body. However, after 45 years old, using hormones decreases, and women can experience menopause without using synthetic hormones. At that point, women can experience more physical symptoms because of the change in hormone levels. Women and their doctors agree that changing lifestyles is highly effective in avoiding negative physical changes. In that context, women argue that their doctor visits are specific about menopause in the first years of menopause, and then, they go to the hospital for annual check-ups.

Being a menopausal woman in her 30s and 40s is significant because women argue that they actively work and have a professional job. They argue that blushing and sweating are the main problems for them because other people notice them. The labeling of menopausal women in the workplace is an unwanted situation. The stereotyping of menopause in a negative way is the main reason for hiding menopause experiences. Women add that they cannot control their bodies and blush and sweating, and blame themselves because of uncontrollable situations. It is clear that work is not designed for the need of women, especially middle-aged women. The labeling and stereotyping of menopause as sexist and agist practice occurs as an urgent problem.

The last group is natural menopause which occurs around 50s years old. Being a menopausal woman in the 50s is different from the other groups because, in that group, menopause associate with aging. Therefore, women argue that they are more careful about their bodies. Healthy diets and preserving active life are critical against to decline of the body. Economic and social status can change at that age. Therefore, being a woman in the 50s brings specific notions such as being retired or a grandmother. In that sense, the aging process comes with biological, chronological, social, cultural, and economic aspects. When women are retired, they feel they as unproductive. However, their unproductivity is about only paid labor. Their unpaid labor in the domestic area can enlarge with caring for grandchildren and grandparents.

Most women claim that staying active is crucial because working life to retirement is a sharp transition. Another different finding is that women who are 53 and above years old argue that they called their experience late menopause. They argue that menopause

is not always an unwanted and unexpected situation. After a certain age, menstruation becomes a burden for women because they do not want to experience premenstrual syndrome, pains, and the fear of pregnancy. While premature and early menopause causes a shock or contextualizes with negative connotations, natural menopause is described more with cleanliness and relief. In these groups, women do not prefer to take hormones from outside, and they add that their doctors' do not suggest it.

In conclusion, menopause experiences depend on menopausal age, and biomedical and sociocultural aging are embedded in menopause experiences. The menopausal experiences are constructed through timing. However, the participants agree that menopause is a negative label because it signifies unproductivity, infertility, and inactivity. However, women argue that menopause can turn into advantages in some cases. They define the middle ages as a maturing period, the medicalization of menopause, and sexist and ageist discourses and behaviors about menopause in society assign that menopausal women are unstable because of their bodily changes and their decisions are unreliable. At the same time, middle-aged women are seen as nonfeminine and suffering from a lack of sexuality even though previous experiences about sexuality are highly effective instead. Menopause is not a cause of sharp changes in practice.

This study shows that the shift of retirement age transforms the menopausal experiences of women. As I have mentioned before, the work becomes significant in the identity construction of women in Turkey. For further research, menopausal experiences of working-age women are worth detailed investigation. At the same time, the participants' life cycle is not medicalized totally because the knowledge about the body was learned by the social environment, especially from family members in their childhood and adolescent years. There is a need for cohort studies to understand the contemporary knowledge about the body and medicalization of life.

Additionally, this study is based on women's experiences. Nevertheless, to investigate women's health in more detail, the relationship between healthcare professionals and women during menopause requires new studies. Lastly, young people's perceptions

about menopause are significant to elaborate the increasing sexist and agist attitudes and behaviors.

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APPENDICES

A. APPROVAL OF THEMETU HUMAN SUBJECTS ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
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29 OCAK 2021

Konu : Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi : İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Ayşe Gündüz HOŞGÖR

Danışmanlığını yaptığınız Necla GÜÇLÜ'nün "Yaş, Toplumsal Cinsiyet ve Bedenin Kesişimselliği: Türkiye'de Kadınların Menopoz Deneyimleri" başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve **028-ODTU-2021** protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız.

Prof. Dr. Mine MISIRLISOY
İAEK Başkanı

B. FIELD GUIDELINE

SORU KAĞIDI

Adı:

Yaşı:

Menopoza Girme Yaşı:

Medeni Durumu:

Çocuk Sayısı:

Eğitim Durumu:

Mesleği:

Gelir Miktarı:

Yaşamınızı anlatır mısınız? (Yaşam Öyküsü'nde Dönüm Noktaları Nelerdir?)

Kadın olmak sizin için neyi ifade etmektedir?

Menopoz deyince aklınıza ne gelmektedir?

Menopoz hakkında bilgileri hangi kaynaklardan öğrendiniz? (TV, arkadaş sohbetleri, vb.)

Bu süreçte neler hissettiniz?

Fiziksel olarak ne gibi değişiklikler oldu?

Psikolojik olarak ne gibi değişikler yaşadınız?

Yaşlanma deyince aklınıza neler geliyor? Menopoz sonrası fikirlerinizde değişme oldu mu?

Olgunlaşmak sizin için ne ifade etmektedir? Menopoz sonrası fikirlerinizde değişme oldu mu?

Menopoz ile birlikte sizi güçlü hissettiren durumlar oldu mu? Olduysa neler? (aile içi karar almadaki rolü, sözü dinlenen kişi olma, toplumsal roller, vb.)

Menopozun, adet olma, hamilelik ya da doğumdan farkı nedir?

Annenizin menopozu ile kendi menopoz deneyiminizi nasıl karşılaştırırsınız?

Menopoz süreci yeteri kadar dile getiriliyor mu? Eğer az dile getiriliyorsa neden böyle olabilir?

Menopozda cinsellik deneyimlerinin değişimi hakkında ne düşünüyorsunuz?

Adet döngüsünün sona ermesi sizin için ne ifade etmektedir?

Menopoz belirtileriniz başladığında ve sonrasında doktora gittiniz mi?

Hormon kullandınız mı? Kullanmadıysanız neden?

Sizin için sağlıklı olmak ne demektir?

Menopoz sonrasında ortaya çıkan ya da şiddetini arttıran hastalıklarınız oldu mu?

İnsanın kendisinin doktoru olması hakkında ne düşünüyorsunuz?

Menopoz sonrasında yaşam biçiminizde değişiklikler oldu mu? (Diyet, spor vb.)

C. TURKISH SUMMARY / TÜRKÇE ÖZET

GİRİŞ

Türkiye'de menopoz hakkında araştırma yapmak çok sıradan bir yaşam olayı gibi göründüğü için ilgi çekici olmayan bir konu olarak görülebilir, ancak aynı zamanda çok önemlidir ve günümüzde bu önem iki şekilde artmaktadır. İlk olarak, kadınların ortalama yaşam beklentisi artmakta ve menopoz döneminde geçirilen süre de uzamaktadır. Dünya Sağlık Örgütü'nün (DSÖ) yürüttüğü Dünya Sağlık İstatistikleri 'ne (2019) göre kadınların yaşam beklentisi düzenli olarak artmaktadır. Menopozun meydana geldiği yaşta da benzer bir eğilim görülmektedir. Kadınların ortalama yaşam süresi arttıkça menopoz sonrasında geçirdikleri süre de artmaktadır.

Bu istatistikler, bir ülkeden diğerine göre değişebilmektedir. Klasik demografik çalışmalar, gelişmiş ve gelişmekte olan ülkelerin kategorizasyonuna dayanmaktadır ve bu yaklaşıma göre gelişmiş ülkelerde yaşam beklentisi daha uzundur ve menopoz sonrası dönemde daha uzun olacaktır. Bir yandan gelişmiş ülkelerde menopoz yaşının 50-51 arasında olması, gelişmekte olan bir ülke olarak Türkiye'de menopoz yaşının 47 olması ve 45-49 yaş arasında değişmesi nedeniyle bu yaş aralığının zaman içinde değişebileceği ön görülebilir. (Çetin, 2000, s. 28). Diczfalusy (1986) ise menopozun sadece battı toplumları için bir sorun olmadığını vurgulamaktadır. 21. yüzyılın ortalarında gelişmekte olan ülkeler için de bir sorun olabileceğini belirtirtmektedir. Büyük ölçüde, gelişmekte olan ülkeler uygun tıbbi altyapı eksikliğinden dolayı zarar görebilecektir. Bu açıdan bakıldığında menopoz hakkında Türkiye gibi gelişmekte olan bir ülkede menopoz hakkında çalışma yapmak önem arz etmektedir.

Türkiye literatüründe tıbbi makaleler ve tezler incelendiğinde, kadınların artan yaşam beklentisi ve menopoz sonrası yılların uzaması oldukça dikkate alınmaktadır. Ayrıca, mevcut hükümet de menopoz olarak kabul edilir. Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü'nün yaptığı Türkiye Nüfus ve Sağlık Araştırmaları'nda 1978, 1983 ve 1988'de tamamlanan raporlarda menopoza ilişkin bir bilgi bulunmuyordu. 2018 yılına kadar menopoz, "Doğurganlığı Etkileyen Diğer Ara Faktörler" başlığı altında

incelenmiş ve menopoza ilişkin önemli bir bilgi kaynağı olmuştur. Bu araştırmada, menopoz 30 yaş üstü kadınların kontraseptif yöntemleri bırakma ya da kullanmama tercihlerinde önemli rol oynamaktadır. 2018 yılında menopoz, "ara faktör" yerine "Doğurganlık" ana başlığı altında tartışılmış ve menopoz içerik olarak doğurganlığı ele almaya devam etse de, son çalışmalarda kapsamının genişlediği görülmektedir.

Ayrıca 1993-2018 yılları arasında menopoz yaşayan kadınların oranı istatistiksel olarak incelendiğinde, oran 2018 yılına kadar %8-9 civarındaydı. 2018'de %10,3'e yükseldi. Sonuç olarak, Türkiye'de menopoz hem nitelik hem de nicelik olarak önem kazanmıştır.

İkinci olarak menopozun önemi toplumsal hareketlerin hız kazanmasıyla artmıştır. Batı literatürüne baktığımızda, bilim ve tıp otoriteleri tarafından tanımlanan menopoz kavramı 1970'lerde sorgulamaya başlamıştır. Kişisel olan politiktir, radikal feminizmin kompakt bir özeti olarak ortaya atılmış ve radikal feministler kadınların kişisel sorunlarının politik meseleler olduğunu savunmuşlardır. Özel ve kamusal alan arasındaki ayrımı eleştirmişler (Saulnier, 1996, s.32) ve cinsellik, üreme, kürtaj, kadına yönelik şiddet, tecavüz vb. konular siyasi arenaya taşımışlarıdır. Radikal feministler kadınların ezilmesinin tıp, din, bilim, hukuk ve diğer sosyal kurumlar tarafından meşrulaştırıldığını iddia etmişlerdir (Lorber, 2012, s.127). Önemli bir şekilde, 70'lerin sonunda, cinselliğe yapılan vurgu, cinsel çifte standartlar ve kadınların cinsel özgürlük hakkı, cinsellik ve iktidara odaklanmaktan kaymıştır (Richarson, 1993, s.160). Başka bir deyişle, kadın sorunları kamusal sorunlar olarak tartışılmaya başlanmış ve kadın sağlığı ve cinselliği bu konular politik, ekonomik veya tıbbi söylemlerden bağımsız olmadığı için sorgulanır hale gelmiştir. Kadın sağlığı ve cinselliği, güç ilişkileri, özellikle kadın ve erkek arasındaki eşitsizlikler çerçevesinde toplumsal bir inşa olarak kavramsallaştırılmaktadır. Bu bağlamda, menopoz bireysel ve tıbbı bir kavram olmaktan çıkıp toplumsal cinsiyet bağlamında inşa edilmiş bir deneyim olarak karşımıza çıkmaktadır.

LİTERATÜR

Modern tıp, menopozu, yumurtalık fonksiyonunun kalıcı olarak kesilmesi, yani kadının üreme potansiyelinin sona ermesi olarak tanımlar. Bu tanım, menopoz deneyimini evrensel olduğunu ve kadınların yaşlanma sürecinin başlangıcı oldunu ifade eder (Sherman, 2005, s. 44). Dünya Sağlık Örgütü menopozu şu evrelerde sınıflandırır: Menopozdan hemen önceki dönem (menapoza yaklaşmanın endokrinolojik, biyolojik ve klinik özelliklerinin başladığı) ve menopozdan sonraki ilk yıl olan perimenopoz. Premenopoz genellikle belirsiz bir şekilde menopozdan hemen önceki bir veya iki yılı ifade etmek için veya menopozdan önceki üreme döneminin tamamını ifade etmek için kullanılır. Postmenopoz, menopozun indüklenmiş veya spontan olup olmadığına bakılmaksızın, son adet döneminden (FMP) itibaren tanımlanmaktadır (Uluslararası Menopoz Derneği, 2020).

Modern tıp 1950 ve 1960'larda uygulamalarını değiştirdi ve menopoz sonrası kadınlar için uzun süreli tedavi olarak östrojen reçete edildi. Bu yaklaşım, normal ve patolojik tanımlarının, menopoz ve yaşlanma arasındaki sınırların bulanıklaşmasına neden oldu. Her kadın belli bir yaşta menopoza girse de, vücutlarındaki değişiklikler nedeniyle kadınsılığın azalmasıyla suçlandılar. (Watkins, 2007, s. 1). Özellikle 1966'da Robert A. Wilson, menopozun cinsiyetçi tıbbileştirilmesini özetleyen Feminine Forever'ı yayınladı. Wilson, menopozu kadınların gençliğini, kadınlığını ve cinselliğini yanlış yere koymasına neden olan bir eksiklik hastalığı olarak tanımladı. Östrojen replasman tedavisinin kadınların eksiklik hastalığını önlemesine izin verdiğini iddia etti. Böylece kadınlar menopoz dönemlerinde de "tamamen cinsiyetli" kalırlar (Houck, 2003, s.104). Bu bağlamda, McCrea (1983), menopozun tıbbileştirilmesinin hakim olan yaş ayrımcılığını ve cinsiyet ayrımcılığını yarattığını öne sürmüş ve menopozun tıbbi tanımının dört temasına dikkat çekmiştir:

> 1) Kadınların potansiyeli ve işlevi biyolojik olarak mukadderdir,
>
> 2) Kadınların değerini doğurganlık ve çekicilik belirler,
>
> 3) Kadınsı rolün reddedilmesi, fiziksel ve duygusal hasara yol açacaktır,

4) Yaşlanan kadınlar işe yaramaz ve iticidir (s.111).

1970'lerin ortalarından ve 1980'lerin başından itibaren özellikle ekonomik olarak gelişmiş ülkelerde yeni bir sağlık paradigması ortaya çıkmıştır. Eski sağlık modeli, hastalığı iyileştirmeye yönelik halk sağlığı hizmetlerine dayanmasına rağmen, yeni model, hastalığın önlenmesine ve sağlığın geliştirilmesine dayanmaktadır. DSÖ'nün Sağlığın Teşviki ve Geliştirilmesine İlişkin Birinci Uluslararası Konferansı, bireyin kendi sağlığı için sorumluluk alma yetkisinin birincil görevi olduğunu göstermektedir. Kronik hastalıkların üstesinden gelmek, geç modern toplumun kalbinde yer almaktadır (Moore, 2010, s. 101).

Bu dönemde, menopozun tıbbileştirilmesindeki ikinci yükseliş, iki bilimsel gelişme nedeniyle 1980'lerde gerçekleşti. İlk gelişme, endometriyal kanser riskini azaltmak için sentetik progesteron veya progestinin ikinci bir hormon olarak eklenmesidir. İkinci gelişme ise östrojen kullanımın kemik kaybı ve osteoporozun önlenmesinde etkili olmasıdır. Medya, ilaç endüstrisi ve tıp mesleklerinin işbirliği, HRT'nin yeniden popülaritesine katkıda bulunmuştur. 1990'lardaki klinik raporlardan sonra HRT daha popüler hale gelmiştir çünkü bu raporlara göre HRT kalp hastalığı riskini azalttığı iddia edilmiştir. Ancak 2002 yılında Kadın Sağlığı Girişimi raporunu yayınlamış ve beklenmedik sonuçlara dikkat çekerek östrojen-progestin kombinasyonunun kalp hastalığı, felç, kan pıhtılaşması ve meme kanseri riskini artırmasına neden olduğunu belirtmiştir (Watkins, 2007, s.5).

Tıbbi tanımlamaların yanı sıra menopoz bir deneyim olarak hormon düzeylerinden daha fazlasıdır. Yaşlanan kadın bedenlerini gözetleyen ve kontrol eden tıbbi bir bakış vardır ve biyomedikal söylem son derece baskın olmasına rağmen, tüm kadınların paylaştığı evrensel bir menopoz deneyimi değildir. Lock ve Kaufert'e (2001) göre menopoz karmaşık bir biyososyal ve biyokültürel süreçtir. Araştırmaları hem Japon kadınların hem de Japon doktorların, menopozu Batılı kadın kültürüne kıyasla orta yaş kadınının bir işareti olarak tanımlamadıklarını gösteriyor. Kônenki, menopozun dar anlamı yerine, kişinin hayatındaki değişim dönemi anlamına gelir ve Japonca'da sıcak basmasını tanımlayacak bir kelime yoktur. Araştırmanın bir diğer önemli bulgusu ise örneklemin neredeyse dörtte birinin sadece adetin bitmesini bir konenki belirtisi

olarak saymamasıdır. Yani, yaşlanma sürecinin biyolojik özellikler tarafından damgalanmadığı anlamına gelmektedir (s. 502). Amini ve Cormack (2019) da menopozla ilgili Anglo-Amerikan bakış açılarının baskınlığını eleştiriyor. Batılı kadınların deneyimlerini evrenselleştirmek, başta ataerkil Müslüman toplumlar olmak üzere diğer kadınların deneyimlerinin marjinalleştirilmesi anlamına geldiğini belirtir. Onların durumunda, İranlı kadınların menopoz deneyimleri, acı çekme ve pişmanlık üzerine odaklanan kayıp anlatılarının yaygın olduğunu, ancak aynı zamanda menopoz zamanının bir öznellik konumu kazanma olduğunu göstermektedir.

METODOLOJİ

Metodoloji, belirli bilimsel disiplinlerde, teorik araştırmanın genel yapısının nasıl uygulandığının açıklamalarını içeren, araştırmaya felsefi ve analitik bir yaklaşımdır (Harding, 1987, s.3). Feminist metodoloji, cinsiyete duyarlı olan ve bir değişken ekleyen yüzeysel sosyal analiz sunmaz. Aksine feminist metodoloji, kadını merkeze almamızı sağlar (Stacey & Thorne, 1985, s.303). Araştırmada kadını merkeze yerleştirirken deneyimleri analizde daha görünür hale getirmektedir. Kadınların deneyimlerinin görünürlüğü, duygu, duygu ve algı deneyimlerinin ciddiye alınması gerektiği anlamına gelmektedir (Browning, 1993, s. 16). Bu nedenle, bu araştırmada feminist metodoloji benimsenerek saha çalışması tasarlanmıştır.

Alan çalışmasının başında kadınların menopoz deneyimlerine odaklanmayı hedefliyordum. Araştırmam saha çalışması sırasında yeniden şekillendirildi çünkü katılımcılar menopozun kadınların yaşam döngüsü deneyimlerinden izole edilmiş bir deneyim olmadığını vurguladı.. Bu nedenle yaşam seyri yaklaşımı ile kadınların deneyimlerini derinlemesine anlamayı hedefledim. Menopoz ve kadınların yaşam seyri arasındaki dengeyi sağlamak için, kadınların deneyimini merkeze yerleştirmek için nitel araştırma yöntemini kullandım. Ayrıca, çalışmanın ele aldığı kilit sorulardan oluşan derinlemesine, yarı yapılandırılmış bir görüşme yöntemi kullandım. Sonuç olarak, yarı yapılandırılmış görüşmelerde insanları daha açık konuşmaya ikna eden açık uçlu sorular tercih edildi (Arksey ve Knight, 1999, s. 97).

ODTÜ İnsan Araştırmaları Etik Kurulu mülakat sorularını 29 Ocak 2021'de onayladıktan sonra hemen saha çalışmasına başladım ve saha çalışması 1 Mart 2021'de sona erdi. Genel olarak Türkiye'nin farklı illerinde menopozu deneyimlemiş 24 kadınla çalıştım. Mekânsal dağılıma katılımcıların 10'u Ankara, 4'ü İstanbul, 3'ü İzmir, 4'ü Çorum, 1'i Aydın, 1'i Konya, 1'i Londra'dandır. Londra'dan katılan görüşmeci Türkiye'de yaşamış ve İngiltere'ye göç etmiş birisidir. Kendisi menopoz döneminin bir kısmında Türkiye'de bulunmuş ve sağlık hizmetlerinden faydalanmıştır.

Katılımcıların mevcut yaşı 42 ile 77 arasında değişmekte olup, yaş ortalaması 57'dir. Bir diğer önemli husus ise menopoz yaşının 32-57 arasında olması yani kadınların 1994-2020 yılları arasında menopoza girmiş olmalarıdır. Ortalama menopoz yaşı 47'dir. Katılımcılardan 17'sinin iki, 5'inin bir, 2'sinin üç, 1'inin hiç çocuğu olmadığı belirtilmiştir. Bu anlamda iki çocuk sahibi olmak çocuk sayısında en sık görülen tiptir. Medeni durum dağılımı 19 kişinin evli, 5 kişinin bekar olduğu, 3'ünün boşandığı ve 2'sinin eşini kaybettiği şeklindedir. Mülakat sorularında cinsel yönelim ile ilgili herhangi bir soru bulunmamakla birlikte medeni durum ve kadın anlatıları da heteroseksüelliğin baskın biçim olduğunu göstermektedir. Bu nedenle ilişkinin türünü heteroseksüel olarak belirtmiyorum.

15 kişinin üniversite mezunu, birinin önlisans (2 yıllık üniversite mezunu), birinin yüksek lisans ve birinin de doktora olması nedeniyle eğitim seviyesi yüksek bir örnekleme karşımıza çıkmaktadır. İkinci yaygın eğitim düzeyi lise mezunudur ve dağılımı 6 katılımcı lise mezunu ve bir katılımcı lise terk biçimindedir. Katılımcılardan sadece ikisi ilkokul mezunudur. Yüksek eğitim düzeyine bağlı olarak sadece 4 katılımcı mesleğini ev hanımı olarak tanımlamıştır. Diğerleri aktif olarak çalışıyor veya işlerinden emekli olmuşlardır. Bunlardan biri mavi yakalı, diğerleri beyaz yakalı. 20 kişiden 12'sinin kamu görevlisi olması önemli bir noktadır. Sadece 4 katılımcı özel sektörde çalışıyor ve 2 katılımcı serbest meslek sahibidir.

Aylık aile geliri üç bölüme ayrılabilir. Aylık aile gelirinin ilk kısmı 3000-4500 TL arasında değişmektedir; 6 katılımcı bu bölümdedir. İkinci kısımda ise gelir 5000-7000 TL arasında değişiyor; 7 katılımcı var. Son olarak son kısım 10000-30000 TL

arasındadır; Bu bölümde 11 katılımcı var. Bu anlamda, üst-orta düzey, orta ve alt düzey gelirden daha yüksektir.

ANALİZ

Bu araştırma, Türkiye'de kadınların menopoz deneyimlerini yaşlanma, beden ve cinsiyetin kesişimselliği bağlamında anlamayı amaçlamaktadır. Menopoz biyolojik bir sorun olarak görülse de feminist araştırmacılar, menopozun yalnızca tıbbi sorunlarla ilgili olmadığını ve tüm kadınlar tarafından paylaşılan evrensel bir deneyim olmadığını savunuyorlar. Menopoz deneyimlerinin inşasında sosyal ve kültürel yönler hayati öneme sahiptir. Mevcut literatür, kadınların menopoz deneyimlerini anlamak için toplumsal cinsiyet perspektifinin gerekli olduğunu savunmaktadır. Bu araştırmada cinsiyet ve yaşlanmanın nasıl kesiştiğini ve kadınların bedensel değişimlerini nasıl açıkladığını göstermeye çalışıyorum. Buradaki can alıcı nokta, biyomedikal ve sosyokültürel modellerin dinamik yapılar olarak kabul edilmesidir, çünkü sosyal ilişkiler onları inşa eder. Bu ilişkide kadın özne olarak ele alınır ve araştırma kadınların deneyimleri üzerine kuruludur. Dolayısıyla tıp ya da kültür gibi belirleyici bir yapı yoktur. Kadınların bu yapılarla etkileşimleri ve bu etkileşimler aracılığıyla kadınların menopoz deneyimlerinin nasıl yapılandırıldığı önemlidir.

Hiçbir katılımcı menopozu bir hastalık olarak tanımlamamıştır. Tüm katılımcılar menopozun doğal bir süreç olduğu konusunda hemfikirdirler ancak adet döngüsünde düzensizlikler fark ettiklerinde doktora gitmişlerdir. Önemli olan nokta, uzun adet döngüsü, kısa adet döngüsü, lekelenme ve ağır kanama gibi düzensizliklerin tıbbi bir soruna işaret edebileceği veya hamileliğin adet gecikmesine neden olabileceğidir. Daha net bir ifadeyle, kadınlar menopozda oldukları için doktora gitmezler. Aksine düzensizlikleri fark ederler ve doktorlar kadınları menopoz hakkında bilgilendirir. Yani, menopoza girdiklerinin bilgisini doktordan alırlar. Ayrıca, medikal tedaviler ve öneriler kadının yaşına göre değişmektedir. Kadınlar ihtiyaç duyduklarında doktora gittiklerini savunuyorlar. Özellikle menopoz sürecinde kadınların kendilerine hipokondriyak yani hastalık hastası denmesine karşı çıkmaktadırlar. Kadınlar en iyi doktorun kişinin kendisi olduğu konusunda hemfikirdir, bu kadınların doktormuş gibi davranarak kendilerine teşhis koymadıkları anlamına gelmez.

Aksine kadınlar sağlıklı bir yaşam sürerlerse hastalıkları önleyebileceklerine inanırlar. Acil bir durumda doktora gitmeyi tercih ederler ve daha az ilaç almayı hedeflerler. Sağlıklı diyetlerin ve düzenli egzersizlerin hastalıkları önleyici olduğu ve kadınların çok sayıda doktor ziyareti ve uyuşturucu veya hap kullanmak yerine sağlıklı yaşam tarzlarını tercih etmesi sosyal bir olgu olarak ortaya çıkmaktadır. Özellikle, beslenme alışkanlıkları ve diyet türleri eskiye göre farklılık gösterir. Örneğin, kadınlar hamur işi, yağlı yiyecekler ve tatlılar yemeyi bıraktıklarını belirmişlerdir. Kadınların çoğu geleneksel beslenme alışkanlıklarını değiştirdiklerini ve sebze gibi daha sağlıklı besinler tükettiklerini savunmaktadırlar. Sosyoekonomik sınıfa göre gıda türleri ve nitelikleri değişmektedir. Örneğin, sosyoekonomik düzeyi yüksek olan kadınlar bulgur yerine kinoa gibi ithal gıdaları tercih etmektedir. Orta ve alt sosyoekonomik sınıflar, bütçeleri dahilinde sağlıklı beslenmeyi tercih ettiklerini iddia etmektedirler.

Menopozun en sık görülen belirtisi sıcak basmalarıdır çünkü kadınların vücutları alarm verir, ısınmaya ve terlemeye başlar. Sıcak basmaların benzersiz özelliği, diğer insanların kızarma ve aşırı terlemeyi fark edebilmesidir. Menopozdaki kadınlar, başkalarının dikkatini çektikleri ve otomatik olarak menopozlu olarak etiketlendikleri için utanç duyduklarını ifade etmişlerdir. Türkiye'de menopoza giren kadının daha yaşlı, seks hayatından yoksun ve mutsuz olduğu için meraklı, burnunu başkasının işine sokan, mutsuzluklarını ve doyumsuz ruh hallerini baklarına yansıttıkları gibi yaftalamalardan kaçındıkları için menopoz olduklarını dışarıdaki insanlar ile paylaşma konusunda çekincelidirler. Menopoz teyze terimi, menopozdaki kadınlara karşı tutumun bir etiketi olarak kullanılmaktadır. Cinsiyetçi ve yaş ayrımcılığına dayalı söylemlerin, tutumların ve davranışların kesişimi, kadınların deneyimlerini saklamasına neden olmaktadır. Ancak, ateş basması ve kızarma başlayana kadar kimse dışarıdan kimin menopoza girdiğini fark edemez. Kadınlar vücutlarını kontrol edemedikleri zaman kendilerini rahat hissetmezler çünkü dışarıdan bakıldığında da menopozda olduklarına dair işaretleri saklayamazlar. Bir diğer önemli bulgu ise vajinal kuruluktur ve kadınlar, eşlerinin kocalarına karşı görevini yerine getiremediklerini iddia ettikleri için kendilerini suçlu hissederler. Bu nedenle östrojen

kremleri, kayganlaştırıcılar veya daha doğal teknikler içeren vajinal kremler kullanabilirler.

Bazı katılımcılar ise herhangi bir fiziksel semptomu olmadığını ve vücutlarında herhangi bir değişiklik olmadığını savunmaktadır. Menopoz öncesine göre tek fark adetin kesilmesidir. Fiziksel olarak hiçbir şeyin değişmemesi durumu psikolojik değişimler için de geçerlidir. Kadınlar, menopoz dönemlerinde duygusal ruh hallerinin istikrarlı olduğunu iddia etmektedirler. Ancak kadınların bir kısmı menopozun vajinal kuruluk nedeniyle kaygıya neden olduğunu iddia etmektedir. Kadınların çoğu, menopoza girmeden önce kocalarıyla ilişkilerinin bozulmasından korktuklarını ifade etmişlerdir. Fiziksel değişimin psikolojik baskıya veya sorunlara dönüşebileceğini öne sürmüşlerdir. Psikolojik değişim yşayan kadınlar ise dünyadan bezmişlik duygusunu yaşadıklarını belirmişlerdir. Bunun nedeni olarak ise kadınlar geriye dönük olarak hayatlarını sorguladıklarını ve gündelik meselelerden uzaklaştıklarını gösterirler. Ancak kadınlar kendi kendilerini sorgulama sürecinin uzun sürmediğini ve geçici olduğunu belirtirler. Dikkat çekici bir şekilde, kadınlar bu güçlenme sürecinden geçtiklerini iddia ediyorlar.

Bir diğer önemli model menopoz, cinsellik ve üreme arasındaki ilişkidir. Bu araştırmada cinsellik ve üretkenlik analitik olarak farklılaşıyor çünkü menopoz cinselliğin değil üremenin sonudur. Doğurgan olmak, erken yaşta menopoza giren kadınlar için önemli bir sorundur. Bununla birlikte, çoğu kadın, erken anne olduklarını ve doğurganlık kaybının kadınların deneyimlerinde çok önemli bir rolü olmadığını iddia ediyor. Diğer bir deyişle geç annelik Türkiye'de yaygın bir deneyim değildir. Evlilik ve hamilelik için kültürel olarak onaylanmış bir beklenen yaş vardır. Cinsiyet ve yaşlanmanın kesişimi, genç yaşta anne olmanın bir norm haline geldiğini ve kadın biyolojisi çocuk sahibi olmasına izin vermesine rağmen, geç anne olmayı sınırlar. Bu bağlamda kadınlar erken yaşta menopoza girmezlerse üremenin sona ermesi sorun olmaz. Aksine, menopoz lüks bir haline gelir çünkü menopoz, yoğun kanamadan, pedden kan dökülmesinden ve adet sancılardan kurtulmak anlamına gelir.

Bir diğer önemli nokta ise menopozun cinselliğin sonu olarak görülmesidir. Kadınlar, bu bilginin kabul edildiğini ve geçerli olmadığını iddia ederler. Cinselliğin sona

ermesine mit denir ve kadınlar bu efsanenin menopoz öncesi kadınlar üzerinde baskı oluşturduğunu iddia ederler. Burada can alıcı nokta, cinselliğin süreç boyunca ve sonrasında devam etmesidir ki bu kadının cinsel yaşamını değiştirmekle aynı şey değildir. Bazı kadınlar cinselliklerinin menopozdan etkilenmediğini iddia etse de bir başka grup vajinal kuruluk ve libido azalmasının cinsellikte değişikliklere neden olabileceğini iddia etmektedir. Önemli olan nokta, kadınların kendi cinsel istek ya da zevkten bahsetmemesi; kocalarıyla ilişkilerinin nasıl değişeceği konusunda endişelenmeleridir. Kadınların cinselliği kendilerine ait değilmiş gibi kocalarına karşı bir görev olarak görülmektedir. Görevlerini yerine getiremedikleri zaman ailesel bir kriz yaşanabildiğini de eklemişlerdir. Bu anlamda, kadın cinselliği aile bağlamında sınırlandırılmıştır. Kadınlar ayrıca özellikle ileri yaşlarda eşlerinin tutumlarının cinsellikte oldukça etkili olduğunu da ekliyorlar ve cinsel sorunlarını kocalarının olumlu, kibar ve anlaşılır tutum ve davranışlarıyla çözebildiklerini ifade ediyorlar.

Sosyokültürel model, menopozun çevresini genişletir ve menopoz deneyimlerinin arka planını kavramsallaştırmaya çalışır. İlk olarak, mevcut literatür vücut şekli, vücut boyutu, daha genç görünüm ve cinsel açıdan çekici olma konusunda endişelenen kadınlara odaklanmaktadır. Menopoz, yaşlanan bedenler yoluyla kadınlık kaybı olarak tanımlanır. Bu araştırmada kadın olmanın tanımı sadece görünüşleri ifade etmemektedir. Kadınlar, değişen sosyal rollerinin, statülerinin, konumlarının ve etkileşimlerinin menopoz deneyimlerinde oldukça etkili olduğunu öne sürüyorlar. İlk argüman, Türkiye'de kadın olmanın iki nedenden dolayı karmaşık ve zorlu olduğudur. Birinci neden, çalışan kadınların hem ev içinde hem de dışında çalıştıkları için kendilerini ev hanımlarından farklılaştırmalarıdır. Çocuklara bakmaktan ve ev işlerinden sorumlu olarak görülürler; eş zamanlı olarak, tam zamanlı işleri vardır. Katılımcılar daha genç yaşta çalışmaya ve anne olmaya başlamışlardır. Bu koşullar altında kadınlar, kadınlıklarını gözden kaçırdıklarını ve bedenlerine odaklanamadıklarını iddia ederler. İkinci neden ise Türkiye'deki toplumsal cinsiyet eşitsizliği nedeniyle kadınların kendilerini güvensiz hissetmeleridir. Ağırlıklı olarak kadına yönelik şiddet, kadın cinayetleri ve yetkililerin yetersiz cezalandırması öncelikli kaygılardır. Bu noktada, kadınlar hayatlarının güvenliğine karşı hassastırlar.

Çalışmak, kimlik inşasının önemli bir parçası haline geldiğinde, kadınların emekli olması özel bir analiz gerektirmektedir. Kadınlar sosyal politikalar gereği belli bir yaştan sonra işten ayrılmak zorunda kaldıkları için emeklilik kronolojik yaşa göre yapılmaktadır. Menopoz emeklilik dönemi denk gelmekte ve kronolojik ve biyolojik olarak birbirini etkilemektedir. Diğer bir deyişle emekli olmak ve menopoza girmek iç içe geçmiş bir deneyim olarak karşımıza çıkmaktadır. Kadınlar kendilerini emeklilik nedeniyle verimsiz, evde kaldıkları için hareketsiz, menopoz nedeniyle infertil hissedebilmektedirler. Tüm bu olumsuzluklar bir araya geldiğinde farklı geçişler aynı anda yaşandığı için kadınlar bazı sorunlar yaşayabilmektedir. Menopoz sürecinde kadınlar, yaşlanmayı azaltmak ve sosyalleşmek için aktif ve üretken kalmaya çalışıtıklarını belirmişlerdir.

Bir diğer önemli örüntü ise kadınların menopoz yaşı olan anneannelik döneminde yeni bir toplumsal rol kazanmalarıdır. Kadınlar torunlarına bakmanın zorunlu bir şey olmadığını ve gönüllü olarak yaptıklarını belirtmektedirler. Özellikle kadınlar, çocuklarının bebek bakıcılarından yardım alabileceğini iddia etmektedir ve bu durumdan endişe ve üzüntü duymadıklarını eklerler. Ancak çocuklarının yardıma ihtiyacı varsa ve ücretli iş için bütçeleri yoksa kadınlar sorumluluk alabilir. Kadınların çoğu, ekonomik koşulların bakım eylemlerini belirlediğini iddia ediyor. Çocuklara bakmak, kendi kızlarının ya da gelinlerin birincil sorumluluğu olarak görüldüğü için büyükannelik yarı zamanlı bir çalışmadır.

Ayrıca, menopoz döneminin evde kalma ve çocuklara bakma zamanı olmadığı görüşü hemen hemen tüm katılımcılar tarafından ortak olarak paylaşılmaktadır. Önceki ifade geçmiş nesiller için geçerlidir. Ancak kadınlar, kadınların emekli olduktan ve çocuklarını büyüttükten sonra kendilerine zaman ayırmak istediklerini savunmaktadırlar.

Kadınların emekli kadın ve anneanne tanımları farklı yaşlanma süreçlerini ifade etmektedir. Yaşlanma ve menopoz arasındaki ilişkiyi sorduğumda, kadınlar yaşlanmayı fiziksel bir gerileme olarak tanımlıyorlar çünkü yaşlanmak fiziksel aktiviteleri sınırlamak anlamına geliyor. Ancak yaşlanma aniden menopozla başlamaz ve menopoz bir yaşlanma nedeni olarak kabul edilmez. Ancak menopoz, vücuda iyi

bakmanın bir uyarısı olarak dikkate alınır. Kadınlar yaşlanma ile menopoz arasında olgunlaşma olarak daha olumlu bir ilişki kuruyor. Yaşlanmanın inkar edilmesi ve "yaş almak" tabirinin kullanılması, kronolojik yaşla daha çok ilgili olan fiziksel yetenek ve yetenekler yerine daha fazla deneyime sahip olmayı ifade eder. Olgun olmanın tanımı, karar verme sürecinde daha özgüvenli, sakin ve bağımsız hissetmektir. Katılımcılar, kadınların kendi deneyimlerinin artması nedeniyle toplumsal baskıların ve diğer insanların etkilerinin azaldığını söylemektedir. Bu anlamda olgunlaşma, kadınların güçlendirilmesi olarak bağlamsallaştırılır.

Son kavram olarak, kadınların kendi annelerine göre menopoz hakkında çeşitli kaynaklara sahip olduklarını ve menopoz hakkında diğer insanlarla daha rahat konuşabildiklerini göstermesidir. Önceki nesilde kadınlar menopoz hakkında konuşmuyor ve şikayet etmiyor olmaları dile getirilmiştir. Bu araştırmada, menopozun bir önceki nesle kıyasla bugün özgürce konuşabileceği konusunda bir fikir birliği vardır. Ancak mülakatlar derinleşince katılımcılar kadın arkadaşları ve komşularıyla menopozu konuşabileceklerini söylediler. Menopozla ilgili arkadaş sohbetleri, menopozun işyeri gibi kamusal alanda ve aynı zamanda özel alanda konuşulmadığını iddia ettikleri için kadınlar arasında bir paylaşım ortamı olarak görülmektedir. Katılımcılar, kadınsı ve erkeksi konuların konuşulmadığı için kişisel durumlarını çocuklarıyla paylaşamayacaklarını söylemektedirler.

Ayrıca katılımcılar, eşlerinin menopoza ilgisiz ve düşüncesiz olduğunu ileri sürmektedirler. Bu nedenle kadınlar kocaları yerine aynı deneyimi paylaşan diğer kadınlar hakkında konuşmayı tercih ederler. Son argüman, katılımcıların daha muhafazakar bir dönemde büyüdüklerini vurgulamalarıdır. Adet, cinsellik ve hamilelik hakkında konuşmadığı ve belirli koşullarda bu durumların saklandığı ifade edilmiştir. Bundan bağlamda, menopozu gizlemek ya da daha az konuşmak daha doğal görülürken yetiştirilme tarzlarından dolayı daha açık ve daha az muhafazakar olduklarını iddia ederler.

SONUÇ

Özetlemek gerekirse, biyomedikal ve sosyokültürel modeller menopozu farklı tanımlar; ancak kesişme noktaları cinsiyet, yaş ve bedendir. Özellikle, menopoz yaşı kurulan ilişkileri etkiler. En kritik bulgu, üçünün menopoz yaşına göre şekillenen üç farklı tipoloji olmasıdır. İlk tipoloji erken menopozdur. 40 yaş altında ortaya çıkar. Bu nedenle 30'lu yaşlarda menopoza giren kadın olmaya prematüre menopoz denir. Bu tip menopoz doktorlar tarafından patolojik olarak görülür ve hormon seviyelerindeki ani değişiklik nedeniyle hormon replasman tedavisi alınmasını şiddetle tavsiye ederler. En uzun süreli hormon kullanımı bu grupta görülür. Aynı zamanda, bu grup HRT kullanımı nedeniyle en sık ve düzenli doktor ziyaretlerine sahiptir. Kadınlar, doktorları vücutlarının menopoz değişikliklerine hazır olmadığını söylediği için uzun süre kullandıklarını iddia etmektedir. Kadınlar açısından prematüre menopoz beklenmedik ve hazırlıksız bir durumdur. Bu kadınlar, bu deneyimi paylaşacak bir akran grubu olmadığı için kendilerini daha izole hissetmektedirler. Aynı zamanda prematüre menopoz, menopozun ileri yaşlar için bir sorun olduğu konusunda yaygın bir bilgi olduğu için sosyal hayatta erken menopoz bir anomali olarak görülmektedir. 30 yaşından sonra anne olmayı planlayanlar veya geç anne olanlar için üremenin sona ermesi ciddi bir sorun olabilmektedir. Ayrıca, 30'lu yaşlardaki menopoz istenmeyen bir etiket olarak kabul edilir, çünkü kadınlar yaşlanma ile ilgili herhangi bir belirti veya özelliğinin olmadığını iddia ederler; onlar sadece menopozdadır. Başka bir deyişle, prematüre menopozu deneyimlemiş kadınlar, menopozun mevcut tanımlarını ve tedavilerini stereotiplerini yaşa bağlı olması nedeniyle oldukça eleştirmektedir.

İkinci tipoloji, kadınların 40 ila 45 yaşları arasında menopoz yaşadığı erken menopozdur. Teorik olarak erken menopozun üst sınırı 45 olsa da doktorların yaklaşımları 40'ların sonları için aynıdır. Türkiye'de ortalama menopoz yaşı 40’lı yaşların sonuna denk gelmektedir. Büyük olasılıkla, doktorlar da bu yaşı temel almaktadır. Dolayısıyla 40'lı yaşlarda menopoza girmiş bir kadın olmak iki farklı eksene ayrılmaktadır. Birincisi, 40 ve 45 yaşlarında menopoz yaşayan kadınların erken menopoza daha yakın olmasıdır. Küçük fark, üremenin sona ermesinin daha az etkili olmasıdır, çünkü kadınlar menopoza girdiklerinde artık çocuk sahibi olmayı

düşünmediklerini söylerler. Hormon kullanma süresi prematüre gruba göre daha kısa olduğu için doktorların önerileri de farklıdır. Kadınlar, doktorlarının bir adaptasyon dönemi olarak hormonları kullanmayı önerdiğini iddia etmektedirler. Ancak 45 yaşından sonra hormon kullanımı azalır ve kadınlar sentetik hormon kullanmadan menopoza girdikleri görülmektedir.

Bu noktada, hormon seviyelerindeki değişiklik nedeniyle kadınlar daha fazla fiziksel semptom yaşayabilirler. Kadınlar ve doktorları, yaşam tarzlarını değiştirmenin olumsuz fiziksel değişikliklerden kaçınmada oldukça etkili olduğu konusunda hemfikirdir. Bu bağlamda kadınlar doktor ziyaretlerinin menopoza özel olmadığını öne sürmekte ve yıllık kontrol için hastaneye gitmektedir.

Son grup, 50'li yaşlarda ortaya çıkan doğal menopozdur. 50'li yaşlarda menopoza girmiş bir kadın olmak diğer gruplardan farklıdır çünkü bu grupta menopoz yaşlanma ile ilişkilendirilir. Bu nedenle kadınlar bedenleri konusunda daha dikkatli olduklarını savunurlar. Sağlıklı beslenme ve aktif yaşamın korunması, vücudun zayıflamasına karşı kritik öneme sahiptir. Bu yaşta ekonomik ve sosyal statü değişebilir. Dolayısıyla 50'li yaşlarda kadın olmak, emekli olmak ya da anneanne olmak gibi belirli kavramları da beraberinde getirebilir. Bu anlamda yaşlanma süreci biyolojik, kronolojik, sosyal, kültürel ve ekonomik yönleriyle birlikte gelir. Kadınlar emekli olduklarında kendilerini verimsiz hissediyorlar. Ancak verimsizlikleri yalnızca ücretli emekle ilgilidir. Evdeki ücretsiz emekleri, torunlara ve kendilerinin ya da eşlerinin anne ya da babalarına bakmakla büyüyebilir. Çoğu kadın, çalışma hayatından emekliliğe keskin bir geçiş olduğu için aktif kalmanın çok önemli olduğunu iddia ediyor. Bir diğer farklı bulgu ise 53 yaş ve üzeri kadınların yaşadıklarını geç menopoz olarak adlandırdıklarını iddia etmeleridir. Bu grup, menopozun her zaman istenmeyen ve beklenmedik bir durum olmadığını savunmaktadır. Belli bir yaştan sonra adet görmek kadınlar için bir yük haline gelir çünkü adet öncesi sendromu, ağrıları ve hamilelik korkusunu yaşamak istemezler. Prematüre ve erken menopoz bir şoka neden olurken veya olumsuz çağrışımlarla bağdaştırılırken, doğal menopoz daha çok temizlik ve rahatlama ile tanımlanır. Bu gruplarda kadınlar dışarıdan hormon almayı tercih etmezler ve doktorlarının bu tedaviyi önermediğini de eklerler.

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