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It's Not Just Hormones: Understanding Menopause Anxiety Through a Feminist Rhetorical Framework

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Abstract: Throughout this article, we place qualitative survey responses into conversation with how menopause and anxiety are rhetorically positioned by influential healthcare organizations. Our article illuminates how everyday people experience anxiety related to menopause and how their stories reveal something deeper at play than hormones. As our research reveals, anxiety during menopause is not simply because of hormones—it is also a result of the way menopause is rhetorically positioned in social constructs around women and aging. Using feminist rhetorical frameworks alongside participant responses, we unpack the ways that menopause anxiety is tied to ageist and sexist narratives and argue that until healthcare organizations recognize that anxiety is both hormonal and rhetorical, women's midlife health will not improve. We conclude by offering strategies healthcare organizations can use to rhetorically address the stigma around menopause anxiety and, thus, to enhance the ways menopausal people experience this life transition.

Keywords: menopause; anxiety; stigma; healthcare, communications

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Introduction

A quick survey of menopause educational materials from The North American Menopause Society to the Cleveland Clinic to the Department of Health & Human Services reveals "anxiety" as a commonly listed symptom of menopause. While emphasis on the mental health components of the menopausal transition has been a mainstay of menopause discourses for some time, emphasis is ordinarily placed on mood swings and uncontrolled anger and not necessarily anxiety, as shown in popular culture representations such as Kitty's menopause meltdown on *That 70s Show* in which she rages at everyone with little-to-no provocation. Yet the ways anxiety is rhetorically framed in medical communications is just as reductive. Anxiety is often represented in these materials in generic terms (e.g., fear, worry), and individuals are advised to proactively mit-

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igate anxiety by changing their diets, seeking medication, getting more exercise, drinking less alcohol, and reducing stress. Indeed, most messaging on menopause symptoms is overly simplistic. Even Dr. Mary Claire Haver, hailed as a progressive pioneer in medical approaches to menopause, often focuses her messaging on how to address menopause symptoms via ways that mirror mainstream diet culture—e.g., diet, exercise, supplements, and fasting (Haver).

While the assumption that women can easily solve menopause anxiety through diet and exercise is problematic, what's most worrisome is this: healthcare organizations almost exclusively frame anxiety as an individual's *hormonal response* to menopause and rarely as something that we find to be just as, if not more significant—anxiety as a psychological reaction to negative stereotypes about women and aging. In this way, anxiety (like the concept of hormones itself) serves "an enthymematic purpose" that allows "long, complex arguments to be condensed into something simple" (Koerber 181). As Amy Koerber points out, over-simplifying the complexities of female biology and "female problems" (182) like anxiety allows individuals to ignore complex gendered constructs about women, thus perpetuating "deeply embedded judgments" about women and their bodies (Koerber 191).

As two feminist rhetoricians in the throes of perimenopause who experience chronic anxiety, we believe that feminist rhetorical frameworks can help us acknowledge that anxiety thrives in many capacities during menopause and that marking the rhetorical factors that drive such anxiety can help destigmatize it. We see the decoupling of menopause anxiety and stigma as being especially important for healthcare organizations that support women during midlife and beyond. Throughout, we argue that while hormones play a role in perimenopausal and menopause anxiety, the condition is *also* tied to ageist and sexist narratives. Thus, until healthcare organizations recognize that anxiety is both hormonal *and* rhetorical, the conversations around menopause will remain stagnant.

We support this argument by drawing from 180 survey responses[1] on peri/menopause symptoms, support, and social stigma to reveal that symptoms of anxiety are influenced by stigma around women and aging. Throughout, we use feminist rhetorical frameworks to unpack these connections, to illustrate the deeply embedded stigma around menopause, and to offer ways feminist rhetoricians can change the narrative. While our analysis contributes to conversations across multiple sites of disciplinary inquiry such as rhetorics of health and medicine and rhetorics of reproductive justice, we focus on feminist rhetorics as we see the fundamental issue of menopause-driven stigma as originating in sexist, misogynistic, and gendered views about women and aging—topics of long-standing concern to feminist rhetoricians.

Notes on Methods

We designed our survey to understand people's attitudes and opinions about menopause, the types of symptoms they experience, and where (if anywhere) they seek care and support. Recognizing the differ-

1 Refer to Appendix A for a complete list of survey questions.

ent ways that menopause might be experienced as a lived, material reality and wishing to capture the rich, diverse experiences and dispositions menopausal persons possess, we shared our survey across social media channels populated by diverse groups and communities; we sent individual recruitment messages to community-leaders in menopause who represented diverse and inclusive perspectives; we chose a survey because we wanted marginalized participants to feel as anonymous, safe, and comfortable as possible when responding. While our participant pool still skewed largely white, affluent, and educated, it did include many people who experience multiple forms of marginalization, including those with disabilities and chronic conditions; queer individuals; nonbinary individuals; transpersons; persons at or below the poverty level; and Black, Indigenous, and other people of color (BIPOC).

Alongside and in contrast to our data, we rely on medical texts and their descriptions of the relationship between menopause and anxiety to illustrate our central claim that such texts overemphasize hormonal flux and deemphasize stigma, misogyny, and ageism as strong etiological factors when it comes to menopause and anxiety. Throughout, we rely on longer narrative responses to our survey questions as these emitted the most agentive and rhetorical forcefulness; we could "hear" these respondents recalling these experiences, and many were delivered in narrative form. We want to point out, though, that the word "anxiety" appears in the survey results overall 45 times—even when it is given as a one-word response to a question on symptoms, which was often the case. Thus, our data reveals the pervasiveness with which menopausal persons experience anxiety.

Our project also considered spaces where resistance to purely hormonal accounts of menopausal anxiety already exist and how and why such places show the power of marginalized positionalities to articulate this complexity. In 2019, Omisade Burney-Scott, a "Black Southern feminist, storyteller, and reproductive justice advocate" launched a Black Girl's Guide to Surviving Menopause (BGG2SM), a "Black women-led multidisciplinary project in the menopause and aging landscape" dedicated to "creating new dialogical tools necessary to support our narrative and culture shift work" (Burney-Scott). BGG2SM was born out of Black women's knowledge that menopause and aging is uniquely stigmatizing for Black communities. As Burney-Scott boldly puts it: "Patriarchy and misogyny seeks to erase the value of Black women. We live in a youth-crazed, youth-centric, youth-focused society which marginalizes older women" (Burney-Scott). In these marginalized places, there *is* a clear statement on ageism, stigma, and sexism in relation to menopause.

As we designed our survey and sought to learn more about stigma and menopause, we kept in mind Burney-Scott's words—that marginalized persons are particularly impacted by negative rhetorical constructs around women and aging. Moreover, as we analyzed the data across demographics, we observed that the stigma and discrimination associated with menopause was pervasive—all groups primarily used negative words when we asked them what "comes to mind" when they think about peri/menopause. This revealed to us that marginalized and BIPOC communities are forced to navigate *multiple layers of stigma around menopause*—the deeply embedded prejudices and discrimination around race, gender, and ability as well as the continual "lack of information around how non-binary, Black women, and femmes" experience aging (Burney-Scott).

We also tried to be aware of how, as White, middle-class women of privilege, we needed to resist "locking ourselves into the tunnels of our own visions and direct experiences" (Royster, 33).

Cheryl Glenn's notion of rhetorical feminism also guided our analysis as we considered feminism as a theoretical tool that can help us practice feminism in ways that enact change and ignite hope (Glenn 2018). In other words, while we criticize the gaps and erasures rhetorically enacted by healthcare communications that provide over-simplified views of hormones and anxiety, we also acknowledge that there are, indeed, opportunities to reimagine (Royster and Kirsch) such documents in ways that support both the goals of medicine and acknowledge that menopause anxiety stems from more than just hormonal changes.

Readers will notice that our organizational approach is thematically driven, rather than arranged according to a traditional "Introduction, Methods, Results, and Discussion" (IMRAD) format. We blend elements of classic qualitative inquiry with a themes-driven style of research reportage. The first theme we take up is stigma and ageism—particularly as they play out in feminist rhetorical scholarship and related work on menopause. We then examine what the North American Menopause Society deems "the most complete and current discussion" on menopause. Next, we look to more participant stories that illuminate gaps and erasures within discussions about anxiety and menopause. We conclude with feminist rhetorical strategies healthcare professionals can use to acknowledge the cultural reasons that may cause or contribute to menopause anxiety.

Finally, we acknowledge that menopause anxiety is a complex experience and is neither the result of just hormones or rhetorical stigma alone. Indeed, it is impossible to prove that anxiety is rooted in one cause or another. Instead, anxiety is a mélange of hormonal changes, life experiences, psychological and emotional shifts, and relearning one's place in a society that does not value aging. What we wish to emphasize, then, is that anxiety thrives in many capacities during menopause and that marking cultural factors around it can go a long way in destigmatizing anxiety, especially if acknowledged by medical organizations.

Rhetoric, Stigma, and Ageism

Feminists have long pointed out that menopause is a uniquely stigmatized life transition. In the 1990s, Gail Sheehy underscored the unabashed sexism toward aging women in her widely read book, *The Silent Passage*. Numerous authors and poets from Anne Morrow Lindbergh (*Gift from the Sea*) to Lucille Clifton ("To My Last Period") have captured how the older version of a woman's self is perceived as less beautiful, less useful, and less valuable than her younger self was.

Acutely aware of such discrimination, Judy Segal argues that ageism is rhetorically wrought and that it lives in the same plane of existence as do other damaging forces, such as sexism, classism, homophobia, and transphobia—all of which function, through language and other persuasive choices, to inflict inordinate suffering. Menopause discourses, moreover, mirror ageist ones in the push to outsmart aging with the

correct products and procedures—a phenomenon that Segal explains well. What is specific about ageism, says Segal, is that it "takes as its object ourselves—our future selves" as well as, in some cases "our present ones: old people may be, and frequently are, ageist, wanting to dissociate from others of their age; embarrassed, really, to be old" (Segal 168). Ageism, we would add, is uniquely capable of creating and fueling "felt" stigma, or the brand of stigma that has to do with a person's negative opinions and beliefs about what they have internalized about themselves. Segal concludes by suggesting that ageism could be combatted rhetorically if people who are young could begin to see themselves *as continuous with* the people they will someday be if they are fortunate to live long enough—old people (Segal).

In a related piece, Segal uses enthymemes to explain how ageism works: "Major premise: All people who are frail or dependent on others are not valuable Americans. Minor premise: Old people are frail and dependent on others. Conclusion: "Old people are not valuable Americans" (Segal 182). The result of this enthymematic logic is that old people are meant to exist at the margins of American life and culture. She also uses epideictic rhetoric as a tool to show how, particularly in political discourses, ageism is perpetuated and challenged; Biden is criticized for being old and frail, for example, while Trump emphasizes his strength and stamina, likening it to a younger version of himself when he claims to feel as good as he had 20 years ago (Segal).

In a similar vein, Jen Gunter argues we should be wary of arguments that fail to recognize that "the experience of menopause is negatively affected when youth and reproductive status are revered" (n.p.). Gunter cautions that ignoring the cultural and social factors that shape menopause can lead to an overemphasis of menopause as a medical condition, a throwback to 1960s framings of menopause as a disease to be fixed through pharmacological intervention. Gunter stresses that menopause, like pregnancy and puberty, is not a disease but a natural life experience. But what is important to observe here is that, unlike pregnancy or puberty, many women spend half their lives or more either in perimenopause or menopause. The fact that menopause spans such a significant portion of a woman's life is critical because it means that many women will spend most of their lives navigating the cultural stigma around aging women. This makes it all the more important for healthcare organizations to do the important work of recognizing the cultural, biological, and rhetorical layers of menopause.

But even with the abundance of perspectives about stigma and aging, it is somewhat surprising that current medical literature still fails to meaningfully acknowledge it. However, as Segal aptly points out, the discourses on "healthy aging" do more harm than good, and medical discourses on their own do not have the capacity to undo the damage done by ageism and cannot solve this problem (Segal). What we observe is that the worry, the negative feelings, and the shame around menopause get put into the category of anxiety—a catch-all bucket for virtually any uneasy feeling experienced during menopause; most of the time, this bucket is attributed to hormonal changes. While we do agree that medical discourses cannot, on their own, solve the issue of ageism, we do think that if medical texts were to better acknowledge the everyday lived experiences of menopausal persons as they are mired in stigma, anxiety could be alleviated in a more thorough way than

it is when hormonal causes are overemphasized.

Here's an example: The NHS, Scotland's national health information service, states that "Changes in your hormones during menopause can impact your mental health as well as your physical health. You may experience feelings of anxiety, stress or even depression" (NHS). They explain that these symptoms may manifest as a "loss of self-esteem," "loss of confidence," or "low mood and feelings of sadness or depression" (NHS). Moreover, they also claim that "these psychological symptoms are a result of the *changes happening to your body* and can have a big impact on your life" ("Signs and Symptoms of Menopause," emphasis added). Undeniably, hormones can drive such feelings. We are not arguing that they cannot be the cause of anxiety. However, we take issue with the premise that they are the main or even only cause of menopause-related mental health struggles. As our survey respondents reveal, hormones are not the only—and perhaps not even the most significant—contributor to anxiety. Consider, for instance, what these survey respondents say:

> *"I work in an all-male environment 2 females 30 plus males. They actually laugh at any symptoms related to perimenopause."*

> *"I am worried that my brain fog has a detrimental effect on my performance at work and do my best to cover it up, working more slowly and triple checking everything. I freelance and worry that people wouldn't use my services if I told them about the perimenopausal problems I'm experiencing."*

It is not a stretch to imagine that employees who work with colleagues who "actually laugh at any symptoms related to perimenopause" or who fear losing their jobs because "people wouldn't use my services if I told them about the perimenopausal problems" would lead to significant anxiety. Undeniably, triple-checking everything is an anxiety coping mechanism. What's more, how these respondents describe their experiences reveals a prevailing rhetorical trend that mocks and dismisses aging women; they either experience that reality or actively fear it.

Feminists have long pointed out that aging women are held to different standards than men. As women age, they become crones; men become distinguished. The prevalence of adages such as "men age like wine and women age like milk" further illustrate the sexist ways society rhetorically frames aging women. In her work on women's reproductive rhetorical agency, Heather Brook Adams uses the phrase "a rhetorical imprint of gendered anxieties" to describe the "gendered anxieties that emerge alongside women's increasing capacity for sexual autonomy" (Adams). While Adams' focus is on social access to oral contraception, her notion of a "rhetorical imprint" as it relates to "gendered anxieties" offers a way to think about the gendered anxieties that emerge from perimenopause. Our study, for example, shows the gendered anxieties around peri/menopause and aging through participants' stories like this one:

> *"I had my first ever anxiety attack at my daughter's school Christmas fair. It was boiling hot in the room, she had bought some slime, opened it and got it everywhere. I had a hot flush*[2]*,and I remember feeling totally overwhelmed, helpless and hopeless trying to clean her up. I wanted the ground to swallow me up. I wanted to be as far away from there as possible. I wanted to cry, howl even. It took all my resolve to leave in a dignified fashion."*

This respondent's use of phrases like "I wanted to cry, howl even" and "I wanted the ground to swallow me up," underscore the deep social shame that accompanies the menopausal transition. Her anxiety attack, as she tells the story, is inextricably linked to embarrassment. A hot flush is perhaps the most common symptom in menopause (according to *Johns Hopkins Medicine*, over 75% of women experience them), yet the pervasive rhetorical imprint of gender-based stigma makes it impossible for this participant to experience this symptom in a public place without also experiencing extreme anxiety over a relatively mundane occurrence—a child spilling something ("Menopause"). While it is entirely possible that this respondent's anxieties have worsened due to hormonal changes, we find clear evidence in her story that she is also experiencing anxiety related to stigma and fear that she will be "caught" having a menopausal symptom in a public place.

Not surprisingly, too, medical discourses about anxiety and menopause mirror the discursive patterns of other mental health diagnostic criteria with emphasis placed on the impairment of or interference with everyday life. The blog post, "Mood Changes During Perimenopause Are Real. Here's What to Know" from The American College of Obstetricians and Gynecologists (ACOG), describes anxiety, for example, as a "constant worrying that gets in the way of your day-to-day life" (Silver). With deep fears like others noticing a hot flush and fear of losing employment, it is difficult to attribute all of menopausal anxiety to hormones. Even when hormones are clearly a factor, too, it's also evident that stigma is at play, as in this participants' story:

> *Someone chose to pull me up on something I'd posted on Facebook about brexit being a total bag of sh*te and I knew he was about to try and belittle me—I had to literally run out and fall apart in the toilets. Tears, peeling off soaking clothes from the sweat. It made me fear going anywhere. I stopped going places … I'd say perimenopause and even more fluctuating unpredictable hormones have made it so I can't trust in myself. It strips that away and leaves anxiety in its place.*

As their narrative makes plain, this person's entire sense of self is shifting. The fact that some of their suffering is likely hormonally affiliated is undeniable, and she most certainly attributes anxieties to hormones. Yet there is also evidence that public perceptions of their value, intelligence, and worth are also an acute cause of distress. Anxiety around menopause does certainly appear to influence many women's day-to-day lives. But a major contributor to such anxiety—the belief that aging women are only good enough, as one participant put it "for the scrap pile"—goes unmentioned in the ACOG blog post. Indeed, a search of the catalog of ACOG web resources using search terms such as "menopause stigma," "stigma," and "stigma and

2 While many in the U.S. use the term "hot flashes," the term "hot flushes" is used in the U.K. and elsewhere. Both terms mean the same thing. Our survey included women in Canada and the U.K. as well as in the U.S.

aging" reveals no references to how peri/menopausal anxiety is connected to broader rhetorical trends that label menopause women as aging like "milk" rather than "wine." Such omissions are important to note as menopausal persons such as our participant who believe it is "hormones" that have led them to feel like they "can't trust themselves" are not equipped to also acknowledge that this experience of self-mistrust is also driven by cultural stigma.

Current Healthcare Discussions

In 2020, The North American Menopause Society (NAMS) released the 9th edition of The Menopause Guidebook. Described as "the most complete and current discussion of menopause available anywhere," the guidebook covers topics from premature menopause to heart health to sexual function ("Menopause Guidebook, 9th Edition"). Noticeably absent from the seventy-four-page guidebook, however, is content that recognizes the relationship between anxiety and stigma. While anxiety (described by the handbook as "the agitated sense of anticipation, dread, fear, or panic") is referenced multiple times throughout the guidebook, it is either barely or completely unconnected to underlying rhetorical beliefs around aging women (The North American Menopause Society 43).

Perhaps the closest the guidebook comes to acknowledging the relationship between social stigma around peri/menopause and anxiety falls on page seven, with a description of anxiety-like symptoms for individuals experiencing premature menopause:

> Just as important as the physical aspects of premature menopause are the emotional ones. Premature menopause can cause distress to a woman's sense of self. For women who still want to have children, the effects may be particularly damaging. Premature menopause may increase concerns about body image, sexuality, fertility, and the perception of growing old prematurely. (7)

The guidebook's use of words such as "emotional," "sense of self," "damaging," and "increase concerns" point to the recognition that the menopause transition can be fraught with anxiety-inducing feelings. What's interesting, though, is that such anxieties in response to personal and social expectations is only referenced as an individual reaction to life stage transitions and not necessarily as related to social stigma, misogyny, and ageism. In fact, in some ways, the wording reinforces such dispositions; these things are only concerning if they happen to a still-young person. It's notable, then, that this topic only comes up in relation to *premature menopause*—or a time when an individual goes through the transition significantly earlier than expected. Rhetorically, this demarcation of premature menopause as anxiety-causing due to loss of youthful markers and fertility does not go far enough in emphasizing that such stigmas *create the conditions in which such losses will cause anxiety.*

We lament NAMS's lack of progressive content in terms of calling out ageism, misogyny, and sexism as they play out in the menopause experience. However, among organizations from NAMS to ACOG to

the NHS, there are exceptions, and the National Menopause Foundation's rhetorical position on stigma and menopause stands out. On the "About Us" page of their website, they proclaim: "We're creating a positive change (shift) in how people perceive, understand and experience Menopause" and that "We want women to have access to information and networks that ensure that Menopause is a positive and empowering time in every woman's life" (National Menopause Foundation). In other words, the NMF recognizes that menopause is a uniquely gendered experience that creates negative rhetorical imprints "in how people perceive, understand and experience" menopause. Although content and resources (e.g., blogs, podcasts, literature) the NMF offers on menopause stigma are scarce, we see their recognition that menopause is stigmatized as an important first step in rhetorically normalizing— and even celebrating—women and aging. Yet such discourses, particularly in sanctioned sources of information and support for menopausal women, feel rare.

Perhaps more importantly, even for those who experience peri/menopause during "normal" or expected times of life, the rhetorical imprints that propel the idea that women "age like milk" remain. One survey respondent, for instance, described their experience with peri/menopause as something that "temporarily ruined my life. I felt old, washed up, and a shadow of my former self." Words like "ruined" and "shadow" suggest that this participant sees the process of aging as one that fundamentally diminishes their sense of self and value to others. While it is typical for one's sense of self to evolve as we age, menopause creates a uniquely negative view of the natural aging process, as is evidenced in the participant stories that follow.

More Participant Stories

As we have argued throughout, we believe that, based on our own experiences and the experiences of our participants, that experiencing anxiety—even extreme anxiety and panic—during the menopause transition is not only about hormonal changes. We believe that clinically significant anxiety can also emerge in response to the acute stigma, ageism, and misogyny that are an undeniable and visceral part of this life phase. When people are convinced hormonal changes alongside attendant changes to the self and cognitive abilities are to blame for this anxiety, there is not enough rhetorical space to consider how mitigating such toxic factors could alleviate this prominent symptom. In the following participant stories, we see evidence of such suffering:

> *Let's see—recently, I was having a one-on-one meeting with an undergrad student (male), and I started to feel like I was having a low-level panic attack, like I was hot and jumpy and I couldn't breathe. A little nauseated, because that's also how I roll. I took off my mask (because I was still masking at work) and sipped my water, which wasn't cold enough. In my head I was like,"am I going to have to tell this poor kid that I'm having a hot flash and I need to walk around the halls for 2 minutes or I'll die?"*

While the participant reported that the feeling passed and they did not have to share this personal information with the student, this example illustrates that the social stigma associated with menopausal symptoms prevented the participant from being able to say, simply: "Excuse me, I'm having a hot flush that

is making me very anxious and I need to step out," the way it might be possible to do if it were, instead, a coughing fit or a need to use the restroom. It also seems highly likely that the hot flush itself and the fact that it was happening in a workplace setting caused a panic attack.

And while that participant was able to make light of the experience, others had ominous reportage of altered realities with implications for material conditions, as in the respondent who told us simply that they'd suffered from "*severe anxiety,* and that they "*Didn't cope well became very distressed and anxious and ultimately unable to continue working.*"

We noted, in fact, that many participants identified the workplace as an especially fraught place for menopause-related anxiety, as in the participant who said,

> "Anxiety has affected me significantly at work and I had to seek help as I could no longer do my job. I felt exposed and a failure. I'm still working through this."

The felt stigma in this response is extreme. Not only did anxiety interfere with the respondent's ability to do their job—something that could most certainly happen in hormonally-driven anxiety—but the sense of being exposed as a failure and the need to continue to work through that feeling show something else at play: the suffering that comes from stigma.

The sense that everyday life has been altered by the severity of anxiety was something else we saw a lot in the results, as in the person who lamented that they "*Have anxiety now and have had lots of moments hiding away in toilets if out socially.*" The idea that a person would be reduced to hiding in bathroom stalls is unbelievably daunting. It's difficult to think that this extreme reaction could be hormones alone and not at least partially to do with how very awful it is to be, as participants described, treated as if they are transitioning into irrelevance, invisibility, and worthlessness.

And perhaps such insinuations as they circulate in *doxa* in a variety of ways influence the way a person feels about themselves during this fraught transition. They might feel something like this person experiences: a brand of anxiety that is an "*overwhelming sense that I could not cope in situation that I'd coped without even thinking in the past, having tears as anxiety took over, embarrassing myself with 'feelings' fighting against rational side of brain*." In this example, the respondent makes it clear that they are suffering, in part, in response to the feeling of having changed and of having lost a sense of control over emotions and lost a capacity to cope. While it is entirely possible that some changes that have occurred for this person are in response to hormones, it is also possible that they are starting to see themselves as less than capable because their status as an aging woman has rendered them diminished in others' views, and those views have become internalized. Such feelings of embarrassment could even lead to what another respondent reported: *"I had to watch my mood and how I behaved at work. Previous to menopause I was very patient but I lost all patience in menopause*."

In these varied responses, we see clear rhetorical themes of suffering, fear, embarrassment, and dismay. Such things, we argue, could be at least partially addressed if there were more spaces to openly discuss and challenge ageism, sexism, and misogyny as they deeply impact such experiences.

Moving Menopause Rhetorics Forward

At the beginning of this article, we promised to not focus exclusively on gaps and erasures in medical communications. To be sure, recognizing these rhetorical trends is a necessary first step. But Glenn's notion of rhetorical feminism calls for us to do more than critique; she also asks us to foster hope. With that in mind, we offer the below strategies that healthcare organizations who support women's midlife health can use to more fully recognize the relationship between menopause anxiety and social stigma. Through such recognition, these organizations—whether they are formal menopause associations or the on-the-ground obstetrician or midwife—can play a positive role in helping women navigate the layered physical, emotional, and social complexities of menopause.

The recommendations that follow lean into queer, trans, and BIPOC scholars and activists in two ways. First, these recommendations inhabit a reimagining of how we understand, care for, and attend to marginalized, menopausal bodies and to the voices and experiences that are "still largely under considered and uncredited" (Royster 32). Second, in our recommendations we want to both call for, and move beyond, "access" to menopausal knowledge and care. As minoritized, trans and queer scholars have argued, real change is about both gaining access to critical healthcare (Edenfield et al.) as well as creating the ability for minoritized communities "to dream, to act, to build" healthcare spaces that are authentically inclusive and individually responsive (Sánchez, Green, and Flores 3). The recommendations below are a starting point from which to dream, to act, and to build healthcare frameworks that both provide meaningful medical care and destigmatize menopause.

- **Acknowledge that anxiety is more than just hormones.** Anxiety during menopause can be the byproduct of hormonal shifts—as well as worry over others' perceptions of aging. Medical documents can adopt language that addresses both concerns using statements such as "Anxiety around menopause can be more than the result of hormonal changes. It can also be a response to negative views of menopause." As feminist rhetoricians, we can also increase the visibility of this issue by arranging spaces at key conferences, such as *CCCC* and *Feminisms and Rhetorics*, for perimenopausal persons to convene and give and get support related to anxieties.

- **Recognize that Black and marginalized communities experience menopause differently and that this might increase feelings of anxiety.** As a 2023 New York Times article entitled "How Menopause Affects Women of Color" underscores, for women of color, the menopause

transition can be even more complicated. Research has found that the duration, the frequency, the

severity and even the types of symptoms can look different across races. When women of color seek out care, they often encounter physicians who aren't aware of those differences and aren't fully equipped to help them navigate the transition. That can feel like a dismissal of their concerns—a familiar experience for women of color at the doctor. (author PG)

To more explicitly support marginalized individuals during the menopause transition, healthcare documents can include language such as "Anxiety during menopause can be connected to both hormonal changes *and* to racial, social, and cultural beliefs about menopause. This may make it difficult to talk about menopause, navigate the symptoms, and to find information and care." Asking providers to acknowledge that women of color experience menopause differently and that women of color understand for themselves "when something is off" can create space for more productive dialogues and conversations about support and care.

- **Encourage healthcare providers to talk about menopause stigma and its connection to anxiety.** Provider educational materials should include content that helps physicians talk with patients about the stigma associated with gendered conditions like menopause and how such stigma can contribute to anxiety. For instance, materials could include guided statements that a physician could adapt to various clinical settings. For example, a provider might say to a patient: "There is, unfortunately, shame associated with menopause symptoms like hot flushes and emotional anxiety. As we develop a care plan, let's talk about ways to recognize that anxiety can be caused by hormonal changes as well as worry about how others' view menopause." Such guided statements and other educational materials can help physicians talk with patients about social stigma around menopause as well as create opportunities to emphasize that menopausal women are not, as one survey respondent put it, meant "for the scrap pile." In a book we are currently co-authoring with five other feminist rhetoricians, we aim to create a text that will be legible to such care providers and that will do some of this work.

- **Avoid focusing exclusively on anxieties around aesthetic changes.** While many persons experiencing menopause have concerns over issues like weight gain, hair loss, skin dryness, and more, it is important for healthcare providers to help women address these concerns while *also* acknowledging that these issues are rooted in sexist social perceptions of women and aging. Providers, for example, might say to a patient "Let's find ways to address your concerns about the physical signs of aging while also discussing ways we can manage feelings of anxiety connected to how society views aging." In other words, we want to encourage providers to avoid decoupling stigma around women and aging with the aesthetic treatments they provide. One example of such decoupling is the Weill Cornell Medicine toolkit on women's health which in the "Cosmetic Skin Treatment" section tells women that "Advancements in medicine and technology over the years have made it possible for women to safely achieve a more youthful appearance." Nowhere in this section does it acknowledge that society puts absurd pressures on women to maintain

"a more youthful appearance." As feminist rhetoricians, we are well-positioned to do the work of pointing out the underlying sexism in the correlation between menopause anxieties and the loss of youthful "beauty."

- **Encourage individuals experiencing menopause to connect with others.** Healthcare documents and guidebooks might include links or QR codes to non-profit organizations such as "Let's Talk Menopause" where users can discover the stories of others experiencing the menopause transition ("Let's Talk Menopause"). As one of our survey respondents revealed, sharing menopause "*anxiety issues with [other] women*" can be a powerful way to feel heard and to find strategies to cope with the changes around menopause. As mentioned above, feminist rhetoricians undergoing the menopause transition could be great sources of support for each other, and such connections might be made at professional meetings.

Future Directions: Digital Toolkits & Menopause in the Workplace

While these recommendations are a good starting point for considering how feminist rhetoricians can intervene in menopause healthcare spaces, there is more to be done. Moving forward, we hope to develop a digital toolkit that further unpacks the above recommendations. The toolkit will provide concrete, actionable steps that midlife healthcare providers, practitioners, and activists can use to develop inclusive communications that acknowledge the relationship between anxiety, hormones, and stigma.

In developing the toolkit, we plan to look to models such as Weill Cornell Medicine's "Women's Health Toolkit" and The Department of Health and Human Services Office on Women's Health (OASH) toolkit on mental health, sexual health, reproductive health, and heart health for women. Unlike these toolkits, whose focus is on providing healthcare information to lay readers, our project will speak to an audience of healthcare professionals, urging them to develop educational materials and in-office practices that acknowledge the cultural stigmas associated with menopause. Our toolkit will also urge practitioners to better acknowledge the multiple layers of stigma that trans, queer, disability, and BIPOC individuals experience and how such lived experiences can further fuel menopause stress and anxiety.

Another area we would like to explore and—indeed, have already begun to do so—is menopause in the workplace. To date, we have collected dozens of menopause workplace policies from companies around the globe and, alongside several other collaborators, are analyzing what these policies reveal about workplace support for menopause. In many ways, our research is motivated by our collective experiences with menopause in the workplace and by the despairing comments about working during menopause that many of our survey respondents shared. One respondent, for instance, shared that *"Anxiety has affected me significantly at work and I had to seek help as I could no longer do my job. I felt exposed and a failure. I'm still working through this."* As researchers and peri/menopausal women, we want to learn more about why some menopausal women feel like "a failure" in the workplace and to understand how we might find ways to support, celebrate, and

empower, women as they simultaneously work and age. Through research on menopause and anxiety, the development of toolkits for healthcare professionals, and current research on menopause in the workplace, we plan to continue to address this gap in the field and to encourage more conversations about a life transition that over half the global will experience.

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Appendix A: Menopause Survey

Perimenopause means "around menopause" and refers to the years during which your body makes the transition to formal menopause. Perimenopause can start as early as thirty years old or, in some cases, even younger. Menopause refers to the full end of the menstrual cycle.

This survey will ask you questions about your experiences and feelings associated with perimenopause and menopause.

1. When you hear the words "perimenopause" and/or "menopause, "what words come to mind?

2. Which of the following resources have you consulted on perimenopause and/or menopause? Please check all that apply.

- Healthcare providers
- Healthcare apps
- Newspaper articles
- Websites
- Blogs
- Books
- Magazine articles
- Mother
- Family members
- Friends
- Coworkers
- Other

3. Which of these symptoms of perimenopause and/or menopause have you experienced? Please check all that apply.

- Irregular periods
- Vaginal dryness
- Hot flashes/flushes
- Chills
- Night sweats
- Sleep problems
- Mood changes

- Weight gain and slowed metabolism
- Thinning hair
- Dry skin
- Dry eyes
- Sexual difficulties
- Loss of breast fullness
- Migraine
- Other

4. When you've experienced menopausal symptoms, from which of the following people have you asked for accommodations or support? Please check all that apply.

- Healthcare provider
- Supervisor/boss
- Friends
- Family
- Coworkers
- Intimate Partner(s)
- Children
- Elder or Mentor
- No one

5. When you've experienced menopausal symptoms, from which of the following people have you avoided seeking accommodations or support? Please check all that apply.

- Care provider/doctor
- Supervisor/boss
- Friends
- Family
- Intimate Partner(s)
- Children
- Elder or Mentor
- No one
- Other

6. We would like to know more about your above responses. Why did you seek (or avoid) asking for accommodations or support for your symptoms?

7. When you recognized that you were in your perimenopausal transition, how did you feel about it?

8. Describe a time when you experienced a symptom of perimenopause or menopause in a public or workplace setting. How did you cope?

9. In general, how do you think people or society perceive menopause?

10. What is your age?

- Under 21
- 21-34
- 35-44
- 45-54
- 55-64
- 65+

11. 11. What is your gender?

- Female
- Nonbinary
- Transman
- Transwoman
- Male
- Prefer Not to Say
- Other

12. Do you identify with any of the following groups or communities? Please check all that apply.

- Immigrant
- LGBTQIA+
- Transgender
- Indigenous
- Refugee
- BIPOC
- Disabled
- Other

13. Choose one or more races that you consider yourself to be:

    - Asian Native Hawaiian or Pacific Islander
    - American Indian or Alaska Native
    - White
    - Black or African American
    - Other

14. Are you of Hispanic or Latinx origin?

    - Yes
    - No

15. What is your annual household income?

    - Less than $10,000
    - $10,000 to $19,999
    - $20,000 to $29,999
    - $30,000 to $39,999
    - $40,000 to $49,999
    - $50,000 to $59,999
    - $60,000 to $69,999
    - $70,000 to $79,999
    - $80,000 to $89,999
    - $90,000 to $99,999
    - $100,000 to $149,999
    - $150,000 or more

16. What is the highest level of school you have completed or the highest degree you have received?

    - Less than high school degree
    - High school graduate (high school diploma or equivalent including GED)
    - Some college but no degree
    - Associate degree in college (2-year)
    - Bachelor's degree in college (4-year)
    - Master's degree
    - Doctoral degree