



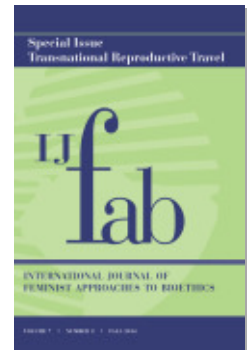
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The time of the change: Menopause's medicalization and the gender politics of aging

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THE TIME OF THE CHANGE:

MENOPAUSE'S MEDICALIZATION AND THE GENDER POLITICS OF AGING

LUCY VAN DE WIEL

Abstract

This article discusses the moment in which normative ideas about aging and reproductive embodiment became conceptually linked in the mid-nineteenth-century medicalization of menopause. The reading centers on the first English book-length publication on menopause, written by E. J. Tilt in 1857, and Foucault's concept of the medical gaze. I analyze mechanisms of observing, conceptualizing, and treating the body in relation to time and discuss their function in affirming and reworking social norms of age and gender. In doing so, I highlight the political work implicit in contesting conceptualizations of female reproductive bodies, their age-specific pathologies, and directives of (self-)surveillance employed in discourses surrounding women's reproductive health.

Introduction

As a nexus of fertility's finitude and female midlife, menopause is a physical and cultural phenomenon through which the relation between the

medicalization of the female reproductive cycle and normative attitudes toward aging become expressed. Age, like other systems of separation, can function as an “instrument of regulatory regimes” and shows similarities to gender in its body-bound, surface-focused, and morally coded position in the sociomedical sphere (Butler 1990, 121). However, although age is an influential social category, its reliance on historical and epistemic constructions of the body has not been politicized to a degree comparable to other categories like gender, race, and sexuality. As Kathleen Woodward argues in “Against Wisdom,” we have no word analogous to *feminist* to recognize the rejection of ageism, or to designate the challengers thereof (2002, 209). Following Kay Heath’s call (2009) for “age-sensitive readings that recognize the constructed nature of this aspect of identity,” I draw attention to the moment in which aging and the reproductive function became conceptually linked in the mid-nineteenth-century medicalization of menopause (202).¹ Positioning this as a key moment in the history of the gender politics of aging, I will analyze how discursive constructions of female anatomy and pathology developed in menopause’s medicalization are indicative of normative frameworks organized by age.

I focus on the earliest entrance of menopause in British gynecology, marked by the first English book-length publication on menopause by E. J. Tilt in 1857 and its subsequent editions up until 1882. As one of the instigators of menopause’s medicalization, Tilt is a pivotal figure in the history of gynecology whose work is of significance to feminist scholarship on aging, body politics, and (non-)reproduction. His pioneer studies are relevant because they make the legitimizing discourses explicit that position menopause as a recognizable pathology in need of medical management, a clinical specialty, and “a subject of legitimate knowledge” in gynecological research (Foucault 1973, 137). They also actively engage a variety of existing conceptualizations of the menopausal body prior to the development of a—if not monolithically so—certainly more unified specialist consensus. In Tilt’s *The Change of Life in Health and Disease* (1857), the female body proved to be a site of contestation as concurring models of menopause situated it in the “bad” blood, the womb, the ovaries, and its extractions. In offering a medical explanation for menopause and its symptoms, Tilt uses various medical constructions of the body and reproductive aging. Critical feminist perspectives have pointed out how gender inequalities are perpetuated through medical constructions of the female body and its reproductive capacities. Shildrick and Price (1999), for example, argue that these constructions “are founded in linking the feminine to a body that is curiously and uniquely

unreliable” and, therefore, “demands attention and regulation” (3). They point to a double movement in which, on the one hand, sexual difference affects the degree to which bodies are medicalized and, on the other, gender stereotypes are reiterated and naturalized in the treatment and conceptualization of these bodies. I will argue that the dimension of age normativity is similarly written into the specific medical constructs of the menopausal body and that its early medicalization process makes this explicit.

Foucault’s concept of the medical gaze as developed in *Birth of the Clinic* (1973) is a tool for understanding the complexity of medicalization. A Foucaultian reading avoids simple oppositions between oppressive medicine men and victimized patients, but looks at knowledge practices and the discursive power distributed through them. For Foucault, power is not localized “in anybody’s hands,” but, rather, individuals are “the elements of its articulation” and are “always in the position of simultaneously undergoing and exercising this power” (Foucault 1980, 98). Discursive power is actualized in the knowledge constructions of bodily truth—and the mechanisms that produce them—that are circulated in medical language and practices employed by medics and patients alike (Radtke and Stam 1994, 4). While the Victorian gynecological tradition is clearly oppressive and sexist by our standards, the point is not to identify a historical culprit for continued inequality, but to examine the normative force that knowledge production of the body holds. Moreover, my reading of Foucault’s *Birth of the Clinic* gives an account of the specific epistemological shifts that provided the context for menopause’s medicalization. These shifts enabled an understanding of menopause as both a medical concern and a marker of gendered life-course progression. The medicalization of menopause was concurrent with a medicalization of female midlife, in which the “change of life” became positioned as a significant moral and social crossroads for women. I will argue that an important ramification of these medicalization processes is that the epistemological assumptions of technologically driven medicine furtively reinforce a specific moral and social status quo.

Tilt’s work can be read as an expression of the medical gaze and its new modes of knowledge production, while his reading of the menopausal body also points to the continued relevance of older medical epistemes. Combining these prisms, Tilt’s portrayal of the menopausal body betrays specific understandings of what it meant to grow older and of how different life courses were to be lived. The approach of a history of ideas through the body is in keeping with Foucault’s mission “to expose a body totally imprinted by history and the process of history’s destruction of the body,” which positions medicine as a domain that

employs a host of “discursive operations that construct the useful, manipulable body” (Foucault 1977, 148; quoted in Shildrick and Price 1999, 8). With this approach, menopause’s medicalization emerges as an important case study in furthering critical understanding of the intersection between biomedical developments and broader sociocultural structures.

In Foucault’s discussion of the medical gaze, I identify four dimensions that become articulated through the observation and treatment of the body in Tilt’s medicalization of menopause. The first three dimensions of Foucault’s medical gaze correspond to my interest in normalized constructions of anatomy (spatial), its relation to aging (temporal), and the normative frameworks through which they become meaningful (moral). The three, combined, highlight the medical gaze’s fourth dimension: the promotion of (self-)surveillance by anticipating physical futurity.

Through my reading of Foucault’s medical gaze as structurally interconnecting anatomy, age, and morality in processes of medicalization, I will argue that almost all anatomo-clinical gynecological writing on menopause already has in it a claim about aging. The four dimensions of the medical gaze produce specific constructions of reproductive anatomy through which dominant historically specific ideas about aging are naturalized in medical discourses. I will examine plethoric and utero-ovarian constructions of menopause in Tilt’s treatises and analyze their relevance for imagining aging by distinguishing three mechanisms: imagining the life span with epochal transitions, coupling the pathologization of reproductive aging with the inscription of social norms onto the body’s temporal schemes, and anticipating futurity in the body as moral strategy. This analysis thus historicizes the intertwining of gender and age norms in Western cultural conceptions of menopause, some of which continue to hold cultural currency today.

Digital parts

The digital age is a phenomenon we associate with computers, databanks, and mobile phones developed over the last thirty years, but some 150 years prior to today, the first English physician to write medical tracts devoted entirely to menopause voiced his concern about a different “digital” age. In the preface to the third edition of *The Change of Life in Health and Disease* (1870), Edward John Tilt writes about the use of the speculum to observe the womb:

Although a digital examination be invaluable to ascertain the consistency, the size and the shape of the womb, it is often perfectly useless and unreliable

for the diagnosis of ulceration. . . . Indeed, it cannot be too often repeated to those who treat the diseases of women, that if the ocular examination of diseases of the womb were to fall into disuse, all further progress of uterine pathology would be arrested; nay more, it would soon retrograde to what it was before [Joseph] Récamier took it up. (ix)

As a pioneer in the study of menopause within the relatively new specialty of gynecology, Tilt employs various justificatory narratives to validate his observations and treatment of the female change of life. Educated at the Parisian hospitals on which Foucault would base his analysis of the anatomo-clinical turn, Tilt positions the French disciplinary development of gynecology and its early study of *la menespausie* at the center of his argument.² Rather than only advocating the use of a diagnostic tool, he positions the speculum as an instrument of progression in the absence of which medical time would “retrograde.” In fact, he attributes the very development of a medical specialty focusing on women’s reproductive bodies to the speculum’s introduction: “Gynaecology, or the accurate study of diseases of women is the youngest branch of medical literature, for it began in 1816, with Joseph Récamier (1774–1852) and the better means of diagnosis that he introduced” (Tilt 1882, vii). By writing his discipline’s history as predicated on medical technology, Tilt ascribes formative importance to the introduction of the speculum’s ocular, or visual, perspective in observing and interpreting the female body.³

Tilt’s attention to the speculum as an instrument that brings the interior body into the physician’s view can be read as an extension of the new “medical gaze” Foucault makes into his object in *The Birth of the Clinic*. Foucault positions the gaze in relation to an epistemic shift in Western medicine from a pre-nineteenth-century theoretical and disease-focused “classificatory” model to an “anatomo-clinical” medicine focused on observing the diseased and dissecting the deceased body (1973, 2). He identifies a shift in the way in which disease was perceived in relation to the body. According to Foucault, there was a change in the “spatialization and verbalization of the pathological” away from an earlier classification of diseases as separate phenomena and toward an approach that specifically focuses on the body as the “space of origin and of distribution of human disease” in the anatomo-clinical turn (xii, 1). By means of the medical gaze, the pathological becomes recognizable through the visible and conceptual mapping of the body according to norms of health, clinical observation practices, and the morbid vantage point of the autopsy.

What makes this anatomo-clinical turn an epistemic one is its effect on practices of knowledge production of the body and related conceptualizations

of health and disease. This shift comes to bear not only on means of diagnosis,

but on the type of objects to be known, on the grid that makes it appear, isolates it, and carves up the elements relevant to a possible epistemic knowledge (*savoir*), on the position that the subject must occupy in order to map them, on the instrumental mediations that enables it to grasp them . . . and on the forms of conceptualization that it must practice and that qualify it as a subject of legitimate knowledge. (137)

This epistemic work of the medical gaze can be read in the medicalization of menopause in the decades following the development that Foucault describes. Not simply describing the female body, medical tracts discursively construct menopause and its corporeal manifestation as a subject of legitimate knowledge that can be mapped and understood by the expert gaze of the gynecologist. In *The Change of Life*, I read several contesting conceptualizations of this body, each isolating different body parts as explanatory locus of the menopause and each implicating specific, valued ideas about aging. In this analysis, I distinguish four dimensions of Foucault's medical gaze that operate simultaneously in these processes of knowledge production: spatiality, temporality, morality, and futurity.

First, the spatial dimension of the medical gaze entails new ways of seeing the space of the body in relation to notions of normality and pathology (Foucault 1973, 164–65). The transition that Tilt points out with the speculum is not only a technologically motivated change that makes previously hidden inflammations visible to the physician's perception. It also indicates an instrumental mediation of new knowledge practices through which the examined body is observed in relation to a "generalised state of health" (Lupton 2003, 91):

Up to the end of the eighteenth century medicine related much more to health than to normality; it did not begin by analysing a "regular" functioning of the organism and go on to seek where it had deviated, what it was disturbed by, and how it could be brought back into normal working order. . . . Nineteenth-century medicine . . . formed its concepts and prescribed its interventions in relation to a standard of functioning and organic structure, and physiological knowledge. . . . (Foucault 1973, 35)

The medical gaze's spatial dimension thus refers to the co-constitutive viewing of the patient's body in accordance with a normalized "anatomical atlas," through which the healthy state and the laws of pathology are spatialized (3). Tilt's presentation of the speculum makes this work of the medical gaze explicit by stating

that Récamier's group of gynecologists used the instrument "to bring the sexual organs of women within the range of the general laws of pathology" (Tilt 1882, vii). The establishment of gynecology as a field of inquiry as part of this turn provided the discursive framework within which menopause emerged as a medical concern, as an effect of the distinctions drawn between "the change of life in health and disease," as Tilt's title has it (1857). As "the new medical perception finally attributed to itself the task of mapping the figures of localization," the female midlife body was a site of contestation in which Tilt's nineteenth-century gynecology assigned the "seat" of menopause to the "bad" blood, the womb, the ovaries, and its extractions (Foucault 1973, 140).

To understand the significance of localizing menopause in specific body parts, I highlight the second, temporal dimension of the medical gaze. The relevance of time is primarily a result of the anatomico-clinical "technique of the corpse" in which the dead were dissected to reveal what remained enveloped in darkness in the living (Sheridan 1980, 39–41; Foucault 1973, 141). In this context, Foucault speaks of the depth of the medical gaze, both as it traverses into the body, revealing interior surfaces, and as it resignifies death from the absolute endpoint of life to a perspective from which the living and diseased body could be better understood. The speculum is a logical extension of the late-eighteenth-century anatomico-clinical autopsy, transporting this practice from the dead corpse to the living interior to understand its particular pathological structure.

The centrality of the dead body as site of revelation for life's workings reconceptualized aging as a key phenomenon in medical thought. Not only were the dead inspected retrospectively, but in the living the processes of aging were understood as progress toward death: "Degeneration lies at the very principle of life, the necessity of death that is indissociably bound up with life" (Foucault 1973, 158). This focus on degeneration increased medical interest in aging throughout the life span.⁴ As the anatomico-clinical study of "diseases of women" determined the normality and pathology of female reproductive organs, the nature of the medical gaze also added a temporal dimension to these observations, whether through viewing them in relation to aging or through noting the rhythmic nature of monthly or epochal transitions.⁵

As the medical gaze standardizes corporeal time–space, it also operates through a third, moral dimension that relates knowledge production of the patient's body to an understanding of the social. Foucault remarks that "disease is caught in a double system of observation: there is a gaze that does not distinguish it from, but re-absorbs it into, all the other social ills to be eliminated; and

a gaze that isolates it, with a view to circumscribing its natural truth” (43). The integration of social ills into observed pathology gives the medical gaze a moral dimension that interprets the body by associating disease and health with particular lifestyle choices. As will become clear in the case of menopause’s medicalization, the moral dimension of the medical gaze associates pathology with social deviance, while normative behavior favors healing. Medical discourse and its particular conceptualization of bodies and their pathologies thus become an important source for diagnosing existing cultural ideals.⁶

The final dimension of the medical gaze, its futurity, follows from the combined moral and spatio-temporal nature of observing the patient’s body. By invoking uncertain future states of health and disease, present medical observation and treatment can gain disciplinary force. Foucault hints at this process when he draws a parallel between anatomico-clinical medicine and the church: “to the army of priests watching over the salvation of souls would correspond that of the doctors who concern themselves with the health of bodies” (32–33). In Tilt’s work, the salvation of gynecology was not located in the afterlife, but in future menopausal and postmenopausal health.

An alternative to digital inspection, Tilt’s advocacy of the new “ocular examination” symbolizes a medical gaze that points beyond practices of increased corporeal visibility to novel ways of seeing that are indicative of a new organization of normality and pathology in the body (Tilt 1870, ix; Foucault 1973, 164–65). Indebted to its origins in dissection, the medical gaze’s work has a temporal dimension that overlays the corporeal spatiality of the “anatomical atlas” through which it reads into the body a network of mappings derived from its projected future in autopsy (Foucault 1973, 3). However, in Tilt’s text the medical gaze does not have a uniform mapping of the menopausal pathology in the female body, but, rather, simultaneously employs various anatomical atlases through which the change of life could be explained. Focusing specifically on Tilt’s blood theory and organic approach to menopause, I will discuss the contesting localizations of menopause in different body parts and the ideas about aging that are expressed through it.

Balancing blood: Plethoric menopause

Tilt’s plethoric menopause holds a tension between an older humoral understanding of health as a balanced flow of fluids in, out, and through the body, and a later approach that Foucault describes with the anatomico-clinical turn, in which the body is “composed of discreet organs with specific functions and secretions, rather

than as a continuous system of flows” (Freidenfelds 2009, 25).⁷ In its plethoric conceptualization, menopause is understood as a temporary condition in which the absence of menstruation causes congestions of surplus blood, resulting in symptoms such as hot flashes and digestive problems. Whereas in earlier constructions of the sexed body, “menstrual bleeding could occur in a multitude of ways and was not necessarily restricted to non-pregnant, non-lactating women, but could also be experienced by men, by expectant mothers, and through various alternative routes,” by the time of Tilt’s writing, menstruation, and its cessation in menopause, was understood as a specific secretion of the uterus and later came to be understood as linked to ovulation and female fertility (McClive 2005, 86). Rather than a holistic economy of fluids, Tilt’s menopausal plethora was more localized in specific reproductive body parts and, consequently, was clearly gendered.

The menopausal plethora was not an isolated gynecological problem, but a physical expression of the transition from one life course to the next. As the term *change of life* suggests, Tilt positions menopause as a pivotal point in relation to a broader understanding of the life span as divided into various epochs. Especially in women, adult aging was not only understood as decline tending toward the vantage point of death that Foucault highlights, but also entailed transition periods in which the body reconstituted itself to a new stage of life:

Instead of flowing on in smooth tranquility from the cradle to the grave, the stream of life is marked by rapids, which have been called critical, metamorphic, or developmental epochs. (Tilt 1882, 3)

Tilt’s language, its association of health with flow and tranquility, hints at the plethoric understanding of menopause, in which problems arose from internal imbalance and turmoil. The postmenopausal woman would eventually regain a new balance, but in the menopausal epoch plethora could be induced if her body would “suffer the blood to stagnate in congested tissues” (Tilt 1857, 80).

The positioning of changes in the reproductive body as organizing principle for women’s life-course transitions hints at the way in which the passage of time was gendered in the nineteenth century. At a point in history when official time was standardized in England (1880) and technological developments like the railway system called for strict scheduling, women were associated with timelessness as inhabitants of a romanticized domestic space (Heath 2009, 15). Maternal love and domestic bliss were idealized as “sensations that moved according to their own beat. The emerging discourse of domesticity, especially, inculcated and validated a set of feelings—love, security, harmony . . . motherly instincts—in

part by figuring them as timeless” in opposition to the regulation of time encroaching on people’s lives through routinized processes of industrialization (Freeman 2010, 5). The clock of women’s time materialized in her reproductive organs, which positioned her within set life courses and in relation to the available roles of “potential mothers, actual mothers or retired mothers” (Jalland and Hooper 1986, 5, quoted in Heath 2009, 15).

In the absence of a similar periodical significance ascribed to the male reproductive function, the progression through life courses itself became differentiated along gender lines. According to Tilt (1882), men did not experience as frequent periodical crises, nor did their sexual organs change with equal influence on the rest of their constitution, while changes in women’s generative organs entailed both a reconfiguration of general health and social expectations of life-course management:

Puberty is common to both [sexes], but the impulse then given to the constitution of man by the sexual apparatus is, in general, fully effective and all-sufficient to ensure its permanent activity until extreme old age; whereas in woman, this crisis is very liable to be delayed or perverted, and even when puberty has been effectually established, the health of woman is dependent on those oscillations of vital power which render menstruation healthy or morbid. Matrimony, pregnancy, parturition, lactation, are like critical periods, curing some complaints, giving greater activity to others. (3–4)

Thus, in establishing male normalcy as opposed to female pathology, men’s effective development was not in need of medical intervention, whereas women were expected to be in health crises at various transitions in life. These transitions were, remarkably, not only of a physiological nature, but also included social events. It is telling that matrimony was categorized alongside biological changes in the body such as pregnancy and lactation. Whether matrimony was used as a euphemism for sexual activity and potential conception or was itself considered to be a biological transition, this juxtaposition illustrates how the sociocultural life courses were understood to be quite literally discernible in the female body. This construction of women’s bodily aging is, therefore, an instance of what Freeman (2010) calls *chrononormativity*: “a mode of implantation, a technique by which institutional forces come to seem like somatic facts. Schedules, calendars, time zones, and even wristwatches inculcate . . . ‘hidden rhythms’ [:]forms of temporal experience that seem natural to those whom they privilege” (3). Life courses are such hidden rhythms, which, once they begin to depart from what appears natural, cause serious medicalized conflicts in age management.

The temporality of the menopausal transition itself similarly had a rhythmic character associated with femininity. Within the plethoric model, Tilt and his patients anticipated a continued monthly intensification of symptoms during which the previously released menstrual blood congested the body. Menopause was thus characterized by a recurring state of anti-menses rather than the absence of menstruation altogether. Menstrual symptoms associated with the abdominal area (uterine cramps and digestive problems like diarrhea and constipation) had their parallel digestive discomforts in the monthly state of plethoric anti-menses. Discussing them at greater length and before the now quintessential menopausal symptom of hot flashes, Tilt reports lumbo-abdominal pains and hypogastric symptoms in over half of his patients (1857, 161). In keeping with the plethoric logic, lumbo-abdominal pains are the most frequently occurring “compensating actions” that recur on a monthly basis as menstruation had before (Tilt 1857, 54).

A testimony to the temporal standardization of the medical gaze, which normalizes the continued cycle, Tilt observed a variety of monthly symptoms in the majority of his (post-)menopausal patients (1851a, 49). This is no surprise to him, as

for thirty-two years, it had been habitual for woman to lose about 3oz. blood every month, so it would have been indeed singular if there did not exist some well-continued compensating discharges acting as waste gates to protect the system, until health could be permanently re-established by striking new balances in the allotment of blood to the various parts. (Tilt 1857, 54)

In order to compensate for this plethoric superfluity in the menopausal woman, the body was purged in other ways. Hot flashes, nowadays a sign of hormonal changes, were then considered proof of a purging body. While bleedings were falling out of grace and were increasingly deemed ineffective in other areas of medicine, Tilt and his colleagues continued to recommend bloodletting to compensate for the absent menstruation (Ulvik 1999). However, under the influence of the anatomico-clinical turn, the plethoric approach became more focused on specific organs, as exemplified by Tilt’s reasoning for localized bleeding (1857): “by diminishing the quantity of blood, we slacken the energy with which it flows to some particular organ, or its momentum, and thereby diminish the liability to congestion” (84–85).⁸

Although understood as compensatory purgative for the plethoric state, hot flashes could also occur after the change, in which case they assumed a moral dimension in keeping with a renewed imperative to postmenopausal

prudence: “The recurrence of flushes so late in life is not to be wondered at, for woman has been made a blushing creature, and who has not seen women of 60 or 70 blush at the thought of a possible offence to modesty?” (57–58). Modesty was to be reflected in her clothing: “at the cessation of menstruation the vicarious functions of the skin are so important as to require its being covered as much as possible” (104–05). Assuming it common knowledge (which, indeed, social expectations inevitably are), Tilt wondered whether it was “necessary to mention that [menopausal] symptoms will be increased, by the frequenting of Balls, Routs, Operas etc, which, in addition to the numerous stimuli encountered, hot and impure air must be breathed?” (Tilt 1851a, 104). In their advice, doctors forbade activities that were generally thought unbecoming of (post-) menopausal women, whilst upholding a nurturing, calm, asexual ideal.

Following Elizabeth Grosz’s argument that “it is the social inscription of sexed bodies, not the imposition of an acculturized, sexually neutral gender that is significant for feminist purposes,” the significance of lodging age-specific ideals in constructions of the menopausal body is that they were not simply seen as cultural preferences, but thought to be unquestionably ingrained in women’s nature—to the extent that engagement in overexciting activities not befitting her sex and age would give her a more difficult menopausal transition (Grosz 1990, 72–73, quoted in Lupton 2003, 25). These ideals were not only motivated by the logic of the plethora, but were also replicated in the utero-ovarian approach to menopause.

Uterus and ovary: The morality of atrophy

In the blood theory of menopause, the localizing tendency of the anatomoclinical turn was manifested by the resignification of menstrual blood as uterine and quintessentially female, while the treatment of plethora following its cessation changed from general bloodletting to bleeding in the genital area. Yet, Tilt’s work also includes an approach to the female body that directly positions the uterus, and later the ovaries, as the defining core of women’s nature. Accordingly, he understands menopause through the observation of changes in these organs: “The uterus has been regarded as the fundamental portion of the female generative system, a distinction which in reality belongs to the ovaries” (Tilt 1851b, xxiii). This localized understanding is characteristic of the anatomoclinical turn, in which “the seat is the point from which the pathological organization radiates. Not the final cause, but the original site” (Foucault 1973, 140).

In Tilt's discussion of menopausal atrophy as a utero-ovarian seat of menopause, the gendered anatomical standard of normalized decline was temporally bound to a physical and social life course. Tilt described menopause as atrophy of the ovaries, resulting in organs "resembling a peach-stone" and sometimes "not larger than a horse-bean," and determining "corresponding changes in the fallopian tubes, which contract and are sometimes obliterated; it also causes the womb to become atrophied[,] . . . the vagina often becoming narrower and shorter" (1857, 11). Employing terms and metaphors of failure and degeneration that Emily Martin (2001) argues still characterize medical descriptions of menopause in the twenty-first century, the "spatialisation and verbalization" of Tilt's medical gaze created a gendered anatomical standard of normalized decline to characterize midlife (Foucault 1973, xii). For Tilt, changes in standardized reproductive organs' size were prescriptive markers through which age-specific social norms were affirmed, either by a reference to a parallel epochal transition in puberty or by naturalizing a change into the asexual and charitable post-menopausal life course.

Tilt positioned observations of the internal physiology of menopause as the mirror image of early sexual maturation: "Puberty and the c. of life are caused by anatomical changes, the one by ovarian *evolution*, the other by ovarian *involution*" (Tilt 1857, 11; original emphasis). The parallels Tilt drew between the distinct epochs of puberty and menopause were not limited to observable physiology, but had implications for his judgment of women's agency:

The disturbance of regular ovarian action, during the first part of the change of life, sometimes tells unfavourably on woman considered as a *moral* agent. Her mode of dealing with the every-day occurrences of life may betray a want of principle, contrasting in a striking manner with her previous rectitude of conduct, and a return to that untruthfulness which may have characterized puberty. (Tilt 1882, 116)

Echoing Foucault's assertion that social ills were integrated with physical pathology in the anatomico-clinical turn, Tilt then lists cases of women being ill-tempered, angry, leaving their families, becoming tyrannical if they do stay at home, turning introspective, stealing, murdering their children, and becoming suicidal (*ibid.*). It is striking that these are all relational problems: they betray an understanding of women's moral agency primarily in relation to her family. Affirming motherhood roles, for Tilt her primary failure is a failure to care. This failure was understood in relation to an epochal parallel phase of puberty, one that normally preceded the

time of maternal caring; her return to this period suggests a reading of menopause as not only a physical, but also a temporary moral involution.

As the realization of the reproductive ideal became thwarted once women passed childbearing age, menopause became a transition into a new gender-specific normative life course. Tilt (1857) celebrates a postmenopausal ideal of an asexual woman whose nurturing qualities transcend from husband and family to broader society and prescribes how women's maternal nature could be properly maintained later in life: "Time dulls the eye, robs the cheek of its bloom, delves furrows in the forehead, but cannot quell the seraphic fire burning in the heart of women, prompting them to deeds of charity, and to heal the deep wounds which afflict society" (128).⁹ However, rather than focusing on promoting charity, Tilt's postmenopausal life course appears primarily predicated on the physiologically motivated departure from heterocompulsory sexual functionality.¹⁰

Menopausal atrophy was considered to be a sign from nature that marriage and sex ("connexion") were no longer appropriate (Tilt 1870, 111):

In the latter part of this period these organs have a tendency to become atrophied. Can there be a clearer indication that until after the menopause, their hitherto appropriate stimulus interferes with a natural process? Hence it is unreasonable to marry during this unsettled period. . . . Even in those who have been long married, connexion at the change of life is a cause of uterine disorders. . . . I deem it imprudent for women to marry at this epoch without having obtained the sanction of a medical adviser. (111–12)

The affirmation of the cultural taboo of non-reproductive sex is read into women's anatomy as physical changes become interpreted in a way that reinforces dominant ideas on sexual activity at this age. Tilt's explicit statement that women need their doctor's permission to marry—with the intention of consummating the union—exemplifies the medical timetable as disciplinary tool for the control of activity that Foucault identifies in *Discipline and Punish* (Foucault 1977, 149). In this early rendition of "the medical clock as a tool of medical power," the physician prescribes morals as medicine based on standards of reproductive rather than chronological time (Bordo 1999, 72). Through its situatedness in the medical field, Tilt's reading of menopausal atrophy establishes not only the naturalness, but also the healthfulness of dominant norms. In the next section, I suggest that the association between health and age-normativity, established in the process of medicalization, was strengthened by the employment of futurity.

Anticipating bodily futurity

In Foucaultian logic, the endeavor of gynecology is propelled by its own death drive, the direction of which necessitates a negotiation of age, or time in the body. The vantage point of death becomes a constitutive force “endowed with that great power of elucidation that dominates and reveals both the space of the organism and the time of the disease” (Foucault 1973, 144). I mentioned above the understanding of degeneration as progress toward death and linked it to medical interest in aging. As the anatomo-clinical gaze has as its project to “constitute a projective pathological anatomy,” the time of degeneration or disease is not limited to its manifestation in symptoms, but also comprises their *potential* future manifestation as integral to the spatial organization of the organism (Foucault 1973, 162). Here I explore how the medical gaze’s moral work of linking physiological developments to cultural life courses relates to this employment of futurity. I will argue that it is a means to extend the medical gaze’s normative force by implanting menopausal vigilance in other life phases.

As the renaming of midlife from what had previously been known as “prime of life” to “decline of life” suggests, literary historian Kay Heath (2009) argues that nineteenth-century concerns about age are characterized by an apprehension of the earliest signs of aging and a growing consciousness of possible perils in later life courses (22).¹¹ Tilt’s reading of menopause as a “critical” phase layers the cessation of menstruation with both midlife anxiety and the awareness of futurity in the body. The medical gaze works to “project upon the living body a whole network of anatomo-pathological mappings: to draw the dotted outline of the future autopsy” (Foucault 1973, 162). This implies that the medical gaze’s death drive views the patient’s body not only in its present manifestation, but also in relation to its prospective bodily futurity in death: “Death, which, in the anatomical gaze, spoke retroactively the truth of disease, makes possible its real form by anticipation” (158). Beyond a mere forecast, this makes futurity an integral part of the body’s anatomy, whose significance becomes intensified during critical transition periods like midlife and menopause.

Tilt (1882) and his contemporaries regard menopause as a problematic period that “begins at cessation and concludes with the permanent restoration of health” (1).¹² Whereas Foucault’s medical gaze positions death as future vantage point, in Tilt’s text menopause becomes the turning point for a future retrospective. I return to Tilt’s above-mentioned statement:

The stream of life is marked by rapids, which have been called critical, metamorphic, or developmental epochs, and during which an unusual predominance is acquired by one or by several of the organs which together form the human frame. (3)

Rather than death proper, the epochal view of women's lives identified several future reconstitutive transitions—little deaths in the less joyful sense of the word—toward which the present manifestation of the body tended. Symptomatic of a metonymic view of women as defined by their reproductive organs, the progression of the female life span was interpreted primarily in relation to changes in these body parts, which had “unusual predominance” as the original seat of “the diseases of epochs justly deemed critical” (Laqueur 1990, 22; Tilt 1882, xi). In these body parts, the medical gaze located death not only in the grave (or on the autopsy table), but at the end of reproductive and sexual life.

In keeping with this epochal approach to the life span, menopause both “describe[s] the closing scenes of the life of woman” (Tilt 1992, xi) and, after its transition,

there arise a series of beautifully adjusted critical movements, the object of which is to endow a healthy woman with a greater degree of strength than she had previously enjoyed. . . . The immense importance of this change on the subsequent lifetime of women cannot be too highly rated. (4)

Not only do the trials of menopause improve her health, but “it may even promise them a length of life and a strength of constitution superior in general to that of the opposite sex similarly advanced in years,” thus explaining women's greater longevity (Tilt 1851b, 106). With future health and longevity dependent on it, menopause became laden with considerable significance, which led to its moralization and further medicalization. Any disruptions during this period could have long-term effects that could only be prevented by careful medical management.

Tilt and his contemporaries argued both that good behavior in early life prevented a difficult change of life and that the proper management of the menopause was key to future health beyond the transition. Writers of the nineteenth-century purity movement were in the habit of explaining the severity of menopausal discomforts by “indiscretions” committed in younger years (Foxcroft 2009, 186).¹³ Within this logic, disease becomes social punishment, nature's moral justice. Similarly, the promised reward of longevity and future health for following the physician's morally charged advice transforms menopause into a tool for promoting social norms in life courses preceding the change.

Tilt's contemporary Robert Barnes (1873) advised women to be vigilant throughout the menopausal period:

during the whole of this period, the woman should carefully watch her own condition—bearing in mind, that various organic diseases are then most likely to commence, that the latent seeds of hereditary evil are the most likely to become developed, and altogether, that she is passing along a way beset with dangers; but that prudence and watchfulness will assuredly guide her safely through the road. (119)

Although it was accepted knowledge that men suffered more from decay in their climacteric period, women were the ones on the path of danger; they would have to watch their behavior and bodies to survive the transition. The tone used for men's aging in the same text is significantly less prescriptive and fearful. Men are encouraged to think about their own health, discuss it with their doctors, and inform them of the family history of diseases. In the face of increased likelihood of "decay," men do not have to remain weary or guard their everyday behavior; rather, Barnes advises "an individual to examine somewhat into his own condition," asking questions such as "have I hereditary tendency to disease?" (111). The neutral "individual" positions the male patient as universal norm, while the shift in perspective to the first person and the posing of a question rather than the certainty of a road "beset with dangers" position men as less liable to disease and less in need of a physician's counsel at this time.

Thus, the combination of the disparity between the perceived dangers of male and female aging and the lasting influence of menopause on future health resulted in a gendered double standard of aging in nineteenth-century gynecology. Given the importance and danger ascribed to menopause, there was much more at stake for women. After instilling a sense of peril and responsibility in his patients, Tilt argues,

a physician has no right, by his opinion to put to sleep the anxieties of his patient. . . . [Whenever] a female, at this period, which is universally admitted to be a critical and dangerous time for her, comes to complain of symptoms referable to some morbid condition of the reproductive tissues, it is clearly our duty to give a considerate attention to her case and not to dismiss her. (1857, 8)

Here the tension becomes apparent between offering medical help and affirming the need for treatment. The concurrent processes of normalization and pathologization that Foucault identified in *The Birth of the Clinic* are played out

when menopause is described as a natural and necessary transition, while an impetus for expert management is created through the normalization of the perils associated with it. Victorian gynecologists not only provided cures, but also constructed the interpretative framework within which the need for treatment is generated and symptoms are validated. Tilt and those in his footsteps thus prescribed a chrononormative organization of life courses in which the critical nature of the menopausal transition, and the medical advice associated with it, affect women before and after the change. Life courses thus did not only exist in discreet sequence, but became defined in relation to one another through the anticipation of bodily futurity.

In keeping with the earlier parallel drawn between medicine and religion, Foucault suggests that “salvation in the next life has been commuted to a salvation in this life (health, wellbeing, security, etc.)” (Foucault, quoted in Dreyfus and Rabinow 1982, 213–15). Future health was the salvation offered by gynecology, as Tilt’s critical presentation of menopause affirmed the need for the young specialty and its involvement in “the change.” In the same move, however, it located the responsibility for the patient’s health in her own everyday behavior. The age-appropriate normative work in Tilt’s understanding of menopause provides an excellent example of the move from the medicalization of a life event to the adoption of a moral code to fit it. The mechanism at work in the case of menopause and the Victorian ideals of True Womanhood were an early rendition of medical risk management and functioned as a moral tool to influence the behavior of younger generations in anticipation of their later years.

In conclusion, Tilt’s medicalization of menopause entailed the establishment of the physicality of reproductive aging as organizing principle for social life-course management and norms of age-appropriate behavior. This connection was validated and advocated by plethoric and organic approaches to a spatio-temporal interpretation of the female body. Tilt’s writing reflects an attitude to menopause as a transition from one life course to the next; health is expressed through an easy transition and appropriate settlement into a new, non-reproductive role. Reading the body in anticipation of the next epochal life transition, the medical gaze employs bodily futurity as a moral tool both to create the need for medical management and to encourage the patient’s self-surveillance throughout the life span.

Conclusion

It is no longer that of a living eye, but the gaze of an eye that has seen death—a great white eye that unties the knot of life. (Foucault 1973, 114)

This is the eye that stretches the flesh and gauges the size, that releases the blood and covers the skin, whose language interweaves anatomy and aging in the cessation of menstruation in female midlife. The balance and blood of the plethoric state, the size and excretions of uterus and ovary: each has been an anatomical locus and medical gaze's focus of menopause and midlife transitioning. They are a testament to the variety of ways in which the menopause's entrance into discourse intertwined and redefined female midlife and reproductive embodiment as medical problems.

A Foucaultian approach draws attention to the production of discourses that legitimize an understanding of the female reproductive body and life-course progression that is indebted to dominant normative structures. Following Foucault, I approached the work of medicalization with the concept of the medical gaze, in which I distinguished four dimensions: spatiality, temporality, morality, and, combining the latter two, the promotion of (self-)surveillance by anticipating physical futurity. These four dimensions structurally interwove the spatiality and temporality of the aging body through a historically specific prism of gender- and age-normative frameworks.

I have read Tilt's medicalization of menopause in early gynecology as a discursive operation in which understandings of female reproductive physiology and sociocultural ideas of aging become articulated through one another. The construction of menopause as an expectable yet potentially dangerous stage of aging signals an epochal organization of the female life course predicated on women's reproductive organs. Once grouped together and conceptualized as signs of menopause, the concurrent normalization and pathologization of physical changes in women's reproductive bodies naturalized norms of maternity, modesty, and sexuality associated with female midlife. The emphasis on menopause's dangers affirmed the need for expert management and self-scrutiny according to these norms both at the time of the change and in anticipation thereof.

By highlighting a set of three mechanisms in which ideas of aging and reproductive anatomy were articulated through one another, this analysis of Tilt's medicalization of menopause provides points of reference for further research on the constructedness of aging and its gender politics in contemporary processes of biomedicalization. The first mechanism emerges from the

interpretation of changes in the menopausal body as organizing principle for the epochal transitions in the life span. It historicizes the way in which cultural life-course management continues to be predicated on changes in women's reproductive organs. The normative force of the tight knot constructed between the biological "truths" of the female reproductive function and life-course progression can similarly be observed in the controversial nature ascribed to contemporary transgressions of this temporal logic, including late and postmenopausal motherhood, voluntary childlessness at earlier ages, manipulation of reproductive aging with IVF or egg freezing, and the affective charge of narratives of the biological clock.

The second mechanism follows from my reading of menopause's entrance into medical discourse as a process in which age normativity became lodged in an appeal to contesting models of reproductive anatomy. Future critical analyses of the particular impact of age normativity on women, whether in norms of beauty, reproductive timing, or sexual expression, can be informed by a gender-specific history of naturalizing restrictive age-appropriate ideas in relation to the medicalization of the reproductive life span. Thirdly, Tilt's construction of menopause as an expected yet dangerous transition in the female life span employed the anticipation of futurity as a disciplinary tool to enforce these gendered norms of aging. The use of futurity in promoting the need for medical management and self-surveillance both preceding and following the time of the change highlights the political work implicit in these conceptualizations of menopause. On the one hand, they normalize the understanding of gendered aging processes as medical concern; on the other hand, they have implications for the individual agency that can be exerted over aging. As successful aging begets a medical character, normative claims made by professional authorities form the basis for self-surveillance. Attention to the history of promoting normative values to safeguard future health is likewise useful for research into the disciplinary and subversive potential of contemporary surgical, hormonal, and discursive anticipations of age-related infertility, female midlife, and old age that render women's bodies into sites of futurity.

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Notes

1. While the politics of aging typically focuses on inequalities between different age groups, what propels this study is primarily an engagement with the very division that positions the old, or the young, as “other,” in favor of the acknowledgment that every age belongs to all of us: every age is either associated with our past selves or, if death does not interfere, our future ones.

2. Tilt started his medical studies at St George’s in London, but before finishing his degree he moved to Paris to obtain his MD and gain work experience at Parisian hospitals as Récamier’s student. Tilt was also influenced by Gardanne, one of Récamier’s Parisian followers, who coined the term *menopause* in his *Avis aux femmes entrant dans l’age critique* (1816). When Tilt returned to England halfway through the century, his interests reflected the French gynecological tradition, which was more visually based and had a long-standing interest in menstrual health and menopause, evidenced by more than thirty doctoral theses on the female change of life defended at the University of Paris in the period between 1802 and 1830 (Wilbush 1980, 264). In *The Change of Life*, Tilt references the work of Gardanne and Récamier as main influences for the development of the gynecological specialty in menopause.

3. Positioned in an English “war against the speculum,” Tilt became an advocate for the use of the instrument and criticized those who avoided it out of considerations of prudence. For a treatise on the “war on the speculum,” see *The Speculum: Its Moral Tendencies*, by a Fellow of the Royal College of Surgeons (1857); for a more recent historical analysis thereof, see *The Science of Woman: Gynaecology and Gender in England 1800–1929*, by Ornella Moscucci (1993).

4. Situated in the epistemic anatomo-clinical shift at the Parisian hospitals that Foucault describes in *The Birth of the Clinic* (1973), the medical gaze was formative for the development of geriatrics as a medical specialty concerned with aging as physiological decline. Knowledge production in geriatrics was organized around the observation of the elderly in Parisian hospitals: “in its [geriatric’s] evolution into a medical and scientific specialty, the large assemblies of elderly patients at Bicêtre and the Salpêtrière could and did play a great role” (Ackerknecht 1967, 174). Gynecology employed a different type of medical gaze, one that focused on the living body’s interior surfaces through the gaze of the speculum.

Although the studies of both aging—particularly increasing longevity—and human reproduction have long traditions in Western medicine, only in the context of new specializations like geriatrics and gynecology in the anatomo-clinical medicine of the nineteenth century did their combination generate the coining of menopause as a distinct pathology to which medics could devote their careers.

5. Most Victorian writers locate the expected age of menopause somewhere in the forties. Leith Napier (1897) is most specific in establishing an average age of the last menstruation at forty-seven and eight months (85). Other writers would locate “the period of this great change” somewhere in between forty and fifty years (Barnes 1873, 263; Churchill 1864, 218; Graham 1861, 94; McMurtrie 1871, 218). Tilt references exceptional cases of early and late menopause, but also uses forty-five years as the average age (1870, 49). Atkinson

takes another approach and claims that a woman menstruates about thirty-five years and thus reaches her menopause dependent on the age of her menarche (1880, 24).

6. The significance of the medical gaze's interpretative work follows from Foucault's observation that "it was no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and intervention" (1973, 89). Not only are medical discourses "a powerful influence—some would say *the* most powerful influence—on constructions of the female body, and on what it is to be a woman," but, through diagnosis and treatments, interpretations of the body become inscribed into its materiality (Shildrick and Price 1999, 145).

7. Although I focus on its economy of fluids, Tilt's system of flow and balance has other dimensions. One recurring element is thermal dynamics, which, like the blood plethora, is indebted to the humoral paradigm. The presence of heat or cold in the body plays an important role in Tilt's description of menopausal bodies. He lists cases of women in whom menopause was brought on by the suppression of menstruation by extreme cold or the heat of fever. Several authors, including Tilt, describe the importance of climate in the age of onset of menstruation and see it as key to longevity. Tilt remarks on the thermal nature of menopausal hot flashes: "it must have struck many that at the change of life most women have the power of generating a more than usual amount of heat; they often want less clothing, and even in winter, leave their doors and windows wide open" (1882, 58). In turn, treatments involved thermal dimensions such as baths, while overly hot environments where "hot and impure air must be breathed" were to be avoided (113).

8. Tilt's colleague Van Oven advised to apply leeches to the cervix should symptoms occur at monthly intervals (Van Oven 1853, 6, 13, 16, 31–33, 38, 103–04).

9. For the relation between the construction of the female body and ideal womanhood, or "the connection between medico-scientific theories and prescribed social limitations on women" (Levine-Clark 2004, 22), see Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830–1980* (1985); Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (1978); Mary Poovey, "Scenes of an Indelicate Character: The Medical Treatment of Victorian Women" (1988).

10. This sentiment was mirrored in popular writing on the appearance of women: adventuress Lola Montez wrote in *The Art of Beauty* (1858) that coloring ought not to be used by "ladies who have passed the age of life when roses are natural to the cheek. A rouged old woman is a horrible sight—a distortion of nature's harmony" (49). Female journalist Eliza Lynn Linton, furthermore, criticized women in a series of articles in the *Saturday Review* (1868) for "acting and dressing inappropriately and for not attempting to find an interest outside herself" (quoted in Perkin 1993, 147). Interestingly, these criticisms suggest that "many middle-aged women seem not to have been willing to stay put in the asexual, self-effacing, all-nurturing role that society had mandated for them" (*ibid.*).

11. Pre-nineteenth-century Western medicine had considered age in terms of "steps of life," in which middle age was the prime of life. Texts on age focused primarily on reaching old age and achieving longevity. The nineteenth century, Kay Heath argues, saw the rise of midlife anxiety as the middle years transformed from the prime to the decline of life. For menopause, this is particularly relevant as the change of life began to signal the

decline of life. Moreover, the interdependent nature of the life courses integrated midlife anxiety into earlier life courses and propelled its effects into the postmenopausal future.

12. Menopause was seen as the mirror phase of puberty, and the onset of menstruation was fraught with the same dangers as its cessation. The sense of urgency was similarly characterized by the influence the period would have on future life courses. William Potter writes in *The New York Medical Journal* (1891): “during them she lays the foundation for future weal or woe” (Potter, quoted in Vertinsky 1994, 49). In what Vertinsky has called “menstrual disability,” physicians warned against excessive mental or physical activity during puberty and menstrual periods in particular. Whereas pubertal medical management and its primary prescription of rest were motivated by promoting development into a reproductively efficient woman, adult life required a morally informed healthy lifestyle to avoid a difficult menopause. In turn, the change of life needed to be medically managed to ensure longevity and health in later life.

13. One example is the American surgeon John Kellogg, who, in his *Ladies Guide in Health and Disease: Girlhood, Maidenhood, Wifehood, Motherhood* (1883), argued that disregard for nature’s laws could result in a menopausal experience that was a “veritable Pandora’s box of ills, and may well look forward to it with apprehension and fore-boding” (372). Thus, not only during the menopause itself, but also in the life preceding it, acting in keeping with gender roles was a prerequisite for good menopausal health: “Many things that have been laid to our ancestors remotely distant are really the result of wrong-doing and living in the first decade and a half of our lives” (Kellogg, quoted in Foxcroft 2009, 187).

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