Language, Power and Social Process 16

Editors

Monica Heller
Richard J. Watts

Mouton de Gruyter
Berlin · New York

Diagnosis as Cultural Practice

edited by

Judith Felson Duchan
Dana Kovarsky

Mouton de Gruyter
Berlin · New York

2005

Greenburg, A. Gerson, Jennifer Doyle, and D. K. McClure
1994 Letters of recommendation for surgical residencies: What they say and what they mean. *Journal of Surgical Research* 56(2), 192–198.
Hatcher, Larry L.
1983 Letters of recommendation: Validity and contribution to variance in judgments about applicants. Unpublished dissertation, Bowling Green State University, Ohio.
Jolly, Paul and Dorothea Hudley (eds.)
1996 *Association of American Medical Colleges Data Book: Statistical Information Related to Medical Education*. Washington DC: AAMC (Association of American Medical Colleges).
LaCroix, Patricia P.
1985 Sex in recs. *The Journal of College Admission* Fall, 24–26.
Morrisett, Lloyd, N.
1935 *Letters of Recommendation: A Study of Letters of Recommendation as an Instrument in the Selection of Secondary School Teachers*. New York: Teachers College, Columbia University.
O'Halloran, B. A., Elizabeth Altmaier, Wilbur Smith, and Edmund Franken
1993 Evaluation of resident applicants by letters of recommendation: A comparison of traditional and behavior-based-formats. *Investigative Radiology* 28, 274–277.
Raber, Gloria and Ann Beers
1985 Source of letters of recommendation and subsequent teaching performance of first-year teachers. Unpublished dissertation, University of Georgia.
Ross, C. A. and P. Leichner
1984 Criteria for selecting residents: A reassessment. *Journal of Psychiatry* 29(8), 681–686.
Trix, Frances
1998 Beyond he and she M.D.: Pronouns, gender, and maintenance of hierarchy in letters of recommendation for medical school faculty. Paper presented to the International Pragmatics Association, Reims, France.
Watson, Carol
1987 Sex-linked differences in letters of recommendation. *Women and Language* X, 2, Spring, 26–28.

Software

Conc: a Concordance Generator, version 1.70 beta (developed by John Thomson)
1992 Dallas, Texas: Summer Institute of Linguistics.
QSR (qualitative data analysis) Nud*ist (non-numerical unstructured data for indexing, searching and theorizing) 4
1997 Sage: Thousand Oaks, CA.

Chapter 13
Speaking about menopause: Possibilities for a cultural discourse analysis

Cindy Suopis and Donal Carbaugh

Cindy Suopis and Donal Carbaugh follow the lead of Francis Trix in examining non-medical discourse talk about diagnosis. In this case the discourse relates to lay talk about menopause. These authors first describe some features of diagnostic discourse found in their data and then they consider the cultural premises and values associated with the use of those features. They find that women treat menopause both as a developmental stage in life (they are "in menopause") and as an illness that has symptoms that require treating. They conclude with a cogent discussion of the problems associated with medicalizing life stages where people treat naturally occurring events as unnatural problems in need of remedies.

This chapter responds to three basic questions: Through what communicative forms do women diagnose themselves as menopausal? Within these, how do they assess treatments for menopause? And what cultural premises are presumed and created in this talk about menopause? In our response to these questions, we are exploring one principal communicative phenomenon, women's ways of speaking about menopause, which itself is composed of a communication event including two prominent acts of "lay diagnosis" and treatment talk. It is important that we emphasize at the outset that the questions we are raising here are not questions we posed for interviews and thus were not asked by us of women. The discursive phenomena we report about here were produced as a routine yet contingent part of these women's lives, a local achievement of a way of speaking about menopause. Through our study, then, we seek to highlight the communicative forms and acts of this talk and some of its cultural features.

In his influential studies of medical interviews, Elliott Mishler (1984: 104) has distinguished a "voice of the lifeworld" from a "voice of medicine." In his words:

> the voice of the lifeworld refers to the patient's contextually grounded experiences of events and problems in her life. These are reports and descriptions of the world of everyday life expressed from the perspective of a natural "attitude." The timing of events and their significance are dependent on the patient's biographical situation and position in the social world. In contrast, the voice of medicine reflects a "technical" interest and expresses a "scientific attitude." The meaning

of events is provided through abstract rules that serve to decontextualize events, to remove them from particular personal and social contexts.

We find Mishler's distinction helpful for it helps us draw attention to our main focus, the "voice of the lifeworld," at least as an initial way of orienting to the discourse produced by women who are discussing menopause. What we seek to understand is just how women speak about this stage of life in their own, non-medical, scenes. Yet also, what we find in this talk is a kind of medical voice, a way of speaking about physical conditions, symptoms, and treatments. While this talk is not being produced, for the most part, by medical specialists, it does import into its terms and propositions a medical vocabulary and thus at times weaves into the voice a lifeworld, "medical concerns." It is this voice, crafted outside medical contexts yet manufactured in part as a result of them, that we find our main focal concern.

Our study follows in the wake of a recent scholarly discussion concerning "lay diagnosis" (e.g., Beach 2001; Drew 2001; Sarangi 2001; ten Have 2001). Parts of this discussion have emphasized the importance of investigating lay medical theories and lay belief systems about physicality and its treatment (see Sarangi 2001: 5), self-assessments and self-diagnosis (Frankel 2001), the "phase structure of medical consultations" (see Robinson 2001, as well as ten Have 2001: 254), including the larger sequential, event structures relating prior diagnostic talk at home to that of medical consultations (e.g., Beach 1996, 2001). Our hope is to contribute to studies such as these as we focus upon a kind of "lay diagnosis of menopause," beliefs about it and its treatment, and a larger sequence of communication in which these communicative acts find their place.

The perspective we adopt in what follows is a cultural and pragmatic approach to conversation and discourse (Carbaugh 1996; Carbaugh, Gibson, and Milburn 1997; Philipsen 1997; Suopis 2002). In particular, we seek to understand, for example, the ways cultural sequences provide a symbolic context for specific communicative acts, like self-assessment, or self-diagnosis. We seek further, in our analyses, to understand how communicative acts such as these create and presume cultural premises about menopause and the identity of a woman at this life stage, that is, "being a woman" at menopause, thus hearing in these very communicative acts, culture at work.

The primary data for this study were collected as part of a larger project on how women talk about and generate support during menopause (Suopis 2002). Two field sites, public informational meetings about menopause, and an online chat group, supplied the primary data for this study. We discovered, by perusing these data through the above perspective, a kind of self-assessment talk. Our analyses endeavor to show the larger sequential context of that talk, ingredients in self-diagnostic talk including assessments of possible treatments for menopause, and some of its prominent cultural premises about being a female at this life stage.

1. Diagnosing menopause as a stage of life: Like puberty yet unlike illness and pregnancy

One kind of diagnostic discourse can be understood through the following form:[1]

- X (a disease, illness or condition) is something P (a person or organism) gets at point Z.
- X is caused by agent C.
- X is known because of symptoms (1,2,3,n).
- P exhibits symptoms (1,2,3,n).
- Therefore, P HAS X.
- Given that P has X, treatment T is given.

Through this form, a disease or illness carries with it specific and particular beliefs about existence, about the body, the natural world, and ways organisms are linked to minds and spirits. Presumptions about how the body normally works and relates to its physical and non-material surroundings are active in such a form. Further, these conceptions of the disease are also linked to values, to what is deemed good and pleasing, or bad, abnormal, and not pleasing. In particular, conceptions of diseases presume not only what exists, but what is deemed normal and good, including ways of treating that disease in order to return the body to its normal and good condition. In this sense, a conception of a disease rests upon particular beliefs and values, these being expressions of a presumably shared understanding.

The "voice of medicine" Mishler describes rests upon a common sense premise, generally, that diseases are localized in persons such that: P HAS X, and that you know X because of symptoms (1,2,3,n). As a result, if person P exhibits symptoms (1,2,3,n), P is said to HAVE disease X. Typically, we believe we know what can cause X, an agent, or agents, of C. We present this raw bone logic here as a way of introducing a common form of logic which is presumed for a lay diagnosis, and to make the point that lay diagnosis rests upon some shared premises of belief and value which are active through this form, or one like it.

One case study which superbly demonstrates cultural differences in diagnostic discourse is Anne Fadiman's (1997) popular book, *The Spirit Catches You and Then You Fall Down*. In this book, a disease, X, which is known to western medicine as epilepsy, is believed to be caused by a neurological or brain disorder (or the cause is unknown), is noticeable because of symptomatic seizures which a person exhibits, and is treated through various chemical means. For Hmong people, however, X is known as "qaug dab keg" ("the spirit catches you and you fall down"), is caused by having one's soul stolen ("dab"), is noticeable through a person's symptoms of shivering and pain but moreover through their "intuitive

sympathy" (p. 21), and is treated through, among other ways, "neeb," or a ceremony of sacrifice. For Hmong, "qaug dab keg" is also attached to a social position which is conceived less as an illness and more on the order of a "calling" or "vocation" in which one may have special access to things unseen. As such, the condition (X) is not simply a physical affliction but rather a social vocation which can have considerable cultural value (e.g., equipping one for the role of a doctor or shaman).

Our brief cross-cultural comparison is offered here simply as a way of demonstrating how deeply diagnostic discourses invoke and create cultural premises. Note how these create conceptions of X, its possible causes, symptoms, and treatments. As a result, discourses about X bring forth a complex belief system about identities or social positions (e.g., as one with X, as one who treats X), about actions (e.g., regarding treatments, what one can do as a P with X), about feelings (e.g., whether one is sad, pleased, or both with X), and nature (e.g., what exists for X to be as it is, from souls to syringes). And so with menopause.

The women in our study talk about menopause as something they are **in**. A woman does not ***have*** menopause. The condition is expressed as: "I am ***in*** menopause" or "I **am** menopausal." Consider the following utterances:

(1) Gerry: I'm Gerry and I'm in menopause ...
(2) Phyllis: I'm Phyllis. I am 49 and three quarters and I guess you could say I am in perimenopause ...
(3) Pam: Hi, I'm Pam. I'm 44 and I am perimenopausal ...
(4) Sally: I'm Sally. I'm 57. I've been menopausal for about I think a year and a half ...

Speaking about menopause in this way, then, draws attention to it as something, a physical condition one is *in*, a stage of life, in some ways unlike a disease one *has*. In this sense, menopause is distinguished from a disease. It is deemed more similar to *being* pregnant, yet it is also different; it is similar in the sense that it is a period of life one is in, and it lasts for a finite period of time; it is different in that menopause marks the end, rather than the realization of one's reproductive abilities. Further, while menopause is expressed as a stage one is *in*, pregnancy is something that you *are* (e.g., you *are* pregnant, you don't *have* pregnancy, you *have* a baby). Like *being in* puberty (e.g., you are *in* puberty or you are *coming out of* puberty, you don't *have* puberty), menopause is a stage of life one moves in and out of, this being coded into the women's talk. Thus, menopause is unlike a disease, like yet unlike being pregnant, and most like puberty.

Menopause is also talked of like an illness, with causes, and symptoms which can be treated, as we will see below. Yet the phrasing used is different from a medical diagnosis that says: You *have* cancer. You *have* heart disease. You *have* diabetes. In sum, then, menopause stands at the juncture of two discourses: through

a life stage discourse it marks a stage of life, the end of one's reproductive years; through a medical discourse, it is deemed a symptomatic and treatable condition which is like yet unlike an illness. We can clarify the difference between menopausal and disease based discourses by reformulating the above form to suit the shape and meanings of menopausal talk:

- Y (menopause) is something P (a person or organism) goes through at point Z.
- Y is caused by agent C (C meaning a depletion of estrogen).
- Y is known because of symptoms (1,2,3,n).
- P exhibits symptoms (1,2,3,n).
- P is *in* Y.
- Given that P is going through Y, treatment T (a,b,c ...) is possible.

2. Menopause as a life stage malady: A sequencing of communicative acts

In a review of literature on lay diagnosis, Paul ten Have remarks that most research has focused upon medical consultations themselves, and given relatively less attention both to lay diagnosis as an "essential precondition" for "first visits," and to post-visit discussions (ten Have 2001: 252). One exception is Wayne Beach's research, which focuses on pre-clinical talk (1996) and upon post-clinical concerns (2001).

These remarks and studies prompt us to report an overall event sequence of talk concerning menopause. Within our corpus of data, we can distinguish at least four phases or stages of talk in this sequence. We summarize the stages or phases as a decision-making process which is the outcome of a complex sequencing of communicative acts:

(1) A preliminary diagnosis or curiosity
(2) A medical consultation, formal or informal
(3) Peer support and review of the doctor's views about symptoms and treatments
(4) A decision about what to do

The sequence can be initiated in one of two general ways. One involves a woman's noticing a physical, psychological, or social trait in herself which she considers possibly symptomatic of menopause. We will analyze how this is discursively constructed below. The second way the sequence can be initiated is by

curiosity, as when a woman simply wonders about menopause and what to expect from it.

A second stage in the sequence occurs when the noticing of symptoms attributed to menopause is deemed considerable enough, or the curiosity about menopause is deemed sufficient enough, from the woman's view, to warrant a medical consultation. At times this decision was made as the result of discussions with peers. In most cases, in our corpus, this decision to seek medical information was made, apparently, privately without engaging in any discussions.

The result of the decision to become more informed about menopause was to engage in one or more of a set of communicative activities. These included scheduling an appointment with a doctor, attending a public informational session on menopause, and/or logging onto an online chat room where menopause is discussed such as Dr. Koop, MD, Power Surge, alt.menopause, or Ivillage. In these activities, the woman heard and discussed the nature of menopause, possible treatments, and the advantages and disadvantages of the treatments.

A third phase in this larger sequence constitutes the bulk of our data, women talking together about menopause. We note here that the diagnoses proffered by medical professionals, and the advice given concerning treatments, were subjected through this talk to the discussion of the woman's peers. The chain of information has thus, up to this point, in its fullest version, moved from the woman's initial self-diagnosis, to medical consultations, to a peer review. It is this peer review of symptoms and treatments that is the most elaborate form of talk in our corpus, and which we turn to below. We note here, initially, how this phase of talk assumes an authoritative air in our corpus. As doctors' and experts' recommendations are presented in and subjected to this discourse and to subsequent reactions and commentaries from other women, the symptoms and treatments of menopause themselves become shaped and molded to the circumstances of the woman's life. While the qualities and extent of this talk may be unique to menopause, the phase itself may be active more generally for other "physical conditions."

A final stage, the outcome of the above sequence, is the woman's decision about what to do about menopause.

3. Personal impact statements: Speaking about the speaker and symptoms

Let's listen to several women who have come together to talk about menopause.

(5) Segment 1:

Phyllis: I'm Phyllis. I am 49 and three quarters and I guess you could say I am in perimenopause. I am having some hot flashes that are worse at different times at night and when they are I find that I am extremely tired and do not feel like myself.

(6) Segment 2:

Pam: Hi, I'm Pam. I'm 44 and I am perimenopausal. *Struggling in some ways, in other ways, not.*

Sally: I'm Sally. I'm 57. I've been menopausal for about I think a year and a half. I am not on HRT but I have started black cohosh and it does work on the vaginal dryness – it corrected that and I know its working cuz my breasts were very tender and I've been sleeping but I don't know if it's because I'm tired from the trip or whatever. I didn't sleep over there because I just had a hard time sleeping, but in general I do think I'm sleeping better. And the hot flashes I have noticed, they're not so much.

Kim: I'm 49 and taking HRT and have done some shuffling around on it and finding the right place to be and decided to go on it because I had a lot of hot flashes at night, not sleeping well, and those emotional moody things, and disease in the family so there was a lot of reason why I chose to do this and it will remain to be seen with the new research coming out whether I will remain on it or I won't.

(7) Segment 3:

Sherry: My name is Sherry and I am in perimenopause. I am concerned about osteoporosis and I have horrible hot flashes … so my doctor said I should be on HRT and I love it.

Bette: Are you worried about breast cancer?

Sherry: There's no breast cancer in my family and the studies say you should be concerned about heart disease and weak bones.

Bette: That's what you want to do … It makes sense to you.

What we notice in these and similar utterances is a form of "lay diagnosis," a way in which these women "assess and accomplish their health-related belief systems on a contingent basis" (Sarangi 2001: 4). This communicative act involves, for these women, several possible ingredients. We will discuss these under the general title of a self-assessment of their physical condition. This involves commentary along the following lines: a) the stage of menopause; b) the name, and age of the woman; c) the woman's family situation; d) the woman's medical history; and e) the woman as a bearer of symptoms.

The stage of menopause: In the above and similar excerpts, the women identify themselves as *in* one of three general stages of menopause, perimenopause, menopausal, and postmenopausal. The stage of "perimenopause," as identified

by Phyllis, Pam, and Sherry, refers specifically to being around the point when symptoms are anticipated or beginning to appear. The stage of being "menopausal," as mentioned by Sally, refers to a woman in the "heat" of menopause, experiencing its symptoms. And postmenopausal refers to women having moved "out of" menopause.

Name, age, family situation: Most often a woman identifies herself through her name and age, with there being quite great variability in our data regarding age, ranging from the twenties (typically from women who had a hysterectomy) to the fifties. Also, women sometimes mention, as Kim did, a history of "disease in the family," or much less frequently, their partners and/or children.

The woman as symptom-bearer: By far the most elaborate discourse and discussion in our data focused upon the nature, intensity, and status of symptoms which a woman considered (possibly) associated with menopause. The most frequently discussed of these were "hot flashes," "difficulty in sleeping," "being tired," and "mood swings." Also mentioned were "vaginal dryness," "tender breasts," "difficulty in working," "being forgetful," "heart palpitations," "anxiety attacks," "periods gone haywire," and "swollen ankles," among many others.

We have come to identify this kind of menopausal talk as a "personal impact statement" or PIS (Suopis 2002). The PIS is a two-part statement where the woman accomplishes a considerable amount of interactional work. She identifies herself possibly by name, by age and/or by the particular phase of menopause she is *in*. She further can specify her physical condition through a discussion of her symptoms and perhaps her medical history. Then she explains how she experiences her symptoms. In these rather brief segments, we can then hear how a menopausal woman identifies herself as such, as at a symptomatic stage of life which might warrant some kind of treatment.

Three unspoken features are being presumed by and created in this very discourse. We will introduce these here, and return to them below. In particular, age is being linked to menopause as a strong causal agent, such that progressing age creates symptoms at this later stage of life, yet also that the age at which symptoms may appear can vary greatly. Second, when in this life stage, expectations for living are being established for a woman's life such as anticipating and living with symptoms, something like those being discussed above. Third, there is the belief that this condition can be treated, as is mentioned in the comments of Sally, Kim, and Sherry. So, what about this treatment?

4. Treatment talk

The expressed need for treatment is sometimes accompanied by a tremendous sense of urgency. Consider the following:

(8) Segment 4:

Meg: I'm Meg and I am definitely in perimenopause. My hot flashes are terrible! I simply cannot live with these any longer. Is anyone else experiencing this? I need to do something about this and this is why I am here. I can't work and I can't sleep because I feel like I am in a hot oven.

We mention this datum because treatment talk can be deemed urgent, at times responding to an immediate and serious situation. A woman might feel any symptom intensely and thus search for remedies by talking and engaging in a deliberative discourse about treatments. One woman called for "help!" and wondered if she was "going crazy." Such intense reactions can be addressed perhaps initially through a Personal Impact Statement, but sometimes by participating directly in treatment talk.

In segment two above, Sally mentions she is "not on HRT" (Hormone Replacement Therapy) but has "started black cohosh" (an herbal remedy). The latter treatment she has found to be a successful way of treating a variety of symptoms from "vaginal dryness," to "tender breasts," and "hot flashes," and perhaps this will even help her difficulties in sleeping. Kim mentions, on the other hand, that she is "taking HRT," and with it hopes to alleviate her symptoms including hot flashes, sleep deprivation, mood swings, and other diseases such as heart disease and osteoporosis?

Through this kind of "treatment talk," we find women deliberating about various ways of treating menopause, discussing various objectives in these treatments, as well as debating various effects of these treatments. Let us treat each in turn.

One kind of treatment, HRT, is synthetic and chemical and is deemed "unnatural" by some women, yet greatly effective by others, as alluded to by Sally and Kim above, and by Beth, below. We also see in what follows how various treatments are mentioned as possible treatments, from "hormones" to herbs to "vitamin E":

(9) Segment 5:

Lesley: I really need some help with these hot flashes.
Carrie: Have you tried black cohosh?
Lesley: Well, I've heard of it, but I'm not sure...
Beth: Ever since I started on HRT, my hot flashes are not as bad.
Lesley: I know, my doctor says I should take hormones but I am worried about...
Meg: I don't blame you. Have you tried Vitamin E? It works most of the time.

Similarly, the following posting demonstrates how "estrogen replacement therapy" is deemed at times as a "drug" or "chemicals," and thus as less "natural" than other treatments such as "de-fatted soy flour." This distinction between "natural" and "unnatural" treatments appears throughout our data:

(10) Segment 6:
Message Board Posting 23: I had some very negative side effects to estrogen replacement therapy so I had to find a natural alternative. I checked several hundred medical research studies and concluded that de-fatted soy flour was the best alternative available as a natural way to replace my estrogen. I have a summary of the research reasons on my homepage (homepage given). I also have a series of recipes using de-fatted soy flour on that page. De-fatted soy tastes great when it's used in good recipes, and costs very little. I hope this helps you as it has me.

One of the problems mentioned repeatedly, concerning treatment, is the way it effects one's body. Further complicating the effects are interactions among natural remedies, as in the following segment, and interactions among various natural and unnatural remedies in others.

(11) Segment 7:
Pam: So that you find if you're taking something there might be the possibility that they're interacting. I was thinking of flaxseed, soy – those kinds of things – have you ever heard of interacting with them?
Mary: Just like fiber it takes time for your body to get used to it. The point that I I'm trying to say is that if you tried soy at one point and you didn't care for it – it may just have been the brand. And they've just come on the market with some of these newer ones that are in the refrigerator section and you may find that they're more palatable to you. You might want to try that.

The expressed objectives in treating menopause are both to address the symptoms, and to enhance one's "quality of life." Consensus about increasing one's "quality of life" is reached below by Pam and Leslie.

(12) Segment 8:
Lesley: Well, I am going to continue with the vitex. I just want to control my period and I want to prolong [prevent?] menopause as long as possible.
Cheryl: How long do you think you can avoid it?
Lesley: Probably only a few more years, but I am going to stay with it.
Pam: It's a quality of life thing.

Lesley: Yes, it is...it is what I want to do.

Difficulties and complications, however, also can arise. Consider, for example, the discussion below where HRT and its positive and negative side effects are being discussed.

(13) Segment 9
Message Board Post 1: I'm staying on the HRT. I don't want to fall and break my hip because my mother ended up that way ... when you break your hip, it is almost over.

(14) Segment 10
Message Board Post 2: It's your quality of life. That's why you take HRT.

(15) Segment 11
Message Board Post 3: I'm more concerned about breast cancer.

(16) Segment 12
Message Board Post 4: Then you probably shouldn't take HRT.

This discussion and the ones above help make the point that there are a variety of treatments for menopause, any one might work for some but not others, and each one has possible side effects which can be positive and/or negative. In any case, each is discussed as alleviating some symptoms for some (e.g., hot flashes, sleep deprivation, mood swings, control of menstrual periods), having some expressed positive side effects (e.g., helps prevent osteoporosis), but may also be risky (e.g., can increase the risk of breast cancer).

In sum, then, treatment talk is a complex kind of talk: 1) it can be sought in response to urgent needs; 2) it provides a variety of treatments deemed natural (e.g., black cohosh, flaxseed, soy, vitamin E) and unnatural (HRT, vitex, provera, prempro, premphase); 3) each treatment has its own benefits and disadvantages; 4) in an effort to alleviate symptoms, treatment talk is designed to reach decisions which enhance one's quality of life; and 5) further, there is no one treatment that helps all women. As a result, women feel that they must engage in this talk as a way of taking the initiative for their own health concerns, sorting through all of its possibilities, and doing something about this stage of life. While advice may be given by a doctor or medical counselor, the ultimate authority in the these matters is placed squarely on the shoulders of the woman. While this choice can be empowering, it can also be a heavy burden to bear. There is, as a result, an urgency and frustration heard in the talk that illustrates how physicians and medical science have left the decision of whether to treat menopause, and if so how

so, up to the patient, suggesting that the patient is now somehow responsible for her own healthcare. This unique position can be veiled in the popular theme of patient empowerment, but in reality, there is a practical cry from the women for guidance on what to "do" about the choices being offered to them.

5. Menopausal discourse: Problems and the personhood of "baby boomer"

In the above discourse is a complex of communication practices. These embody a folk logic of menopause, a discourse of a woman's life world that is given voice through the idioms of a life stage *and* a medical condition. This discourse is given a particular form as it flows through a specific sequence of communicative acts and phases, and can be understood more particularly as active in "personal impact statements" and treatment talk. In our concluding discussion, we want to sketch a system of cultural premises we hear as both created in and a condition for this discourse.

Any physical condition is experienced and expressed as a realization of particular beliefs and values. For example, in Japan, we are told that women do not use the phrase, "hot flashes," as symptomatic during menopause (Lock 1991). We wonder, then, do Japanese women experience these symptoms, and menopause in the ways the women in our study do? Similarly, in Argentina today (Berti 2001), we understand women do not discuss (nor experience?) menopause in the ways presented here, but express it as a natural part of life which is not worthy of much comment, like the passing of another day. Yet in Nova Scotia, there is a similar entitlement of menopausal symptoms as "blood and nerves," as a way of encapsulating psychological and physical changes during this stage of life (Davis 1983). One can only wonder what the Hmong have to say about menopause. Each such comment from elsewhere suggests its own cultural discourse, its own idioms, its own sequences and system of communication practices.

One set of premises we want to highlight regarding menopausal talk is the result of combining a life stage and medical idiom. We have come to think of the result as the "medicalization of a life stage." In effect, this has created a mounting sense of dis-ease concerning this life stage, and an urgency that something be done about it. In short, menopause has been transformed from a natural stage of life to a *problem in need of a remedy*. This transformative quality of this discourse includes the following features: 1) as a medicalized condition, this life stage is deemed "unnatural," sub-optimal, or in some sense flawed or abnormal; 2) as a result, a diagnosis is possible, although in any one case this diagnosis may be inexact and uncertain; 3) possible treatments are varied and of variable use; 4) there are various opinions from medical experts concerning any one treatment, thus many treatments carry a controversial "air" about them.

In addition to the above features, an economic dimension serves to precipitate a diagnosis to ensure reimbursement for an office visit. In short, menopause must be diagnosed before its symptoms can be treated from a medical and economic perspective.

Menopause, then, unlike a natural stage of life, is talked here through a discourse which envisions it largely as a problem. And it is not only expressed as a problem, but moreover what can and should be done about it is problematic.

Coupled with the above conception of menopause is an identity of women who, throughout this discourse, collectively avow a *"baby boomer" identity*. They have said things like, "my mother didn't talk about it" (see Suopis 2002). Through this and related sayings, the women invoke a set of premises regarding problems generally, and menopause in particular. Some of these can be made explicit. For example, we are a generation unlike our mothers. They did not talk about menopause, we do. They did nothing about menopause, but we are going to do something about it. They did not support each other by talking this through, but we are. Through these premises about the social identity of a "baby boomer," we can hear a generational stance to problems like menopause. Problems are to be talked about, solutions sought, support given. In the process, we become informed and empowered to "do something!"

The combination of the premises casting menopause as a problem, and crafting the woman as a boomer, creates a cultural scene in which menopause becomes not only a physical but a cultural condition, one more problem to be "worked through" in an informed and assertive way. This way involves coming together in support and informational sessions, getting all necessary information, and consulting with medical experts. Through a personal impact statement, women inform each other about who each is, and what one is going through. Through treatment talk, they wrestle with what exactly can and should be done, given their unique circumstances. And so we notice in this way of speaking, as in all such ways, cultural premises in its production, for these are the ways people in various places know who they are, physically and culturally, and what to do about their life's circumstances.

Notes

1. The following form is constructed with the benefit of Pietro Barbetta's comments on "diagnosis as a colonial practice," University of Massachusetts, April 25, 2001.

References

Beach, Wayne A.
1996 *Conversations about Illness: Family Preoccupations with Bulimia*. Mahwah, NJ: Erlbaum.
2001 Introduction: Diagnosing "lay diagnosis". *Text* 21(1/2), 13–18.

Carbaugh, Donal
1996 *Situating Selves*. Albany: State University of New York Press.

Carbaugh, Donal, T. Gibson, and T. Milburn
1997 A view of communication and culture: Scenes in an ethnic cultural center and a private college. In Kovacic, B. (ed.), *Emerging Theories of Human Communication*. Albany, NY: SUNY Press, 1–24.

Drew, Paul
2001 Spotlight on the patient. *Text* 21(1/2), 261–268.

Fadiman, A.
1997 *The Spirit Catches You and You Fall Down*. New York: Farrar, Straus, and Giroux.

Frankel, Richard M.
2001 Clinical care and conversational contingencies: The role of patients' self-diagnosis in medical encounters. *Text* 21(1/2), 83–111.

Lock, M.
1991 Contested meaning of the menopause. *The Lancet* 337(8752), 1270–1272.

Mishler, Eliot G.
1984 *The Discourse of Medicine: Dialectics of Medical Interviews*. Norwood, NJ: Ablex.

Robinson, J. D.
2001 Asymmetry in action: Sequential resources in the negotiation of a prescription request. *Text* 21(1/2), 19–54.

Sarangi, S.
2001 Editorial. On demarcating the space between 'lay expertise' and 'expert laity'. *Text* 21(1/2), 3–11.

Suopis, Cindy A.
2002 Women speaking about menopause and Hormone Replacement Therapy: An ethnographic exploration in communicating personhood. Unpublished doctoral dissertation, University of Massachusetts, Amherst.

ten Have, Paul
2001 Lay diagnosis in interaction. *Text* 21(1), 251–260.

Chapter 14
The diagnosis of the constituents of communication in everyday discourse: Some functions, enabling conditions, consequences, and remedies

Christian Nelson

Christian Nelson offers another poignant illustration of how diagnostic thinking is embedded in everyday reasoning and action. Nelson shows how a disease metaphor is commonly used to depict communication such as when the media is diagnosed as being "sick" or "viral." He finds this disease metaphor depicting communication in a variety of discourse contexts, discusses its function and its potential negative impact, and ends by making a plea for minimizing its use.

Diagnosis is not the purview of professionals alone; laypeople also offer up diagnoses of themselves, others, and a variety of other social phenomena. Some of these diagnoses are manifestations of a particular metaphor about communication commonly utilized in everyday discourse – the COMMUNICATION IS THE TRANSMISSION OF A DISEASE metaphor. Because diagnosis is an action associated with the occurrence of disease, and because metaphors are the articulation of more elaborate schemas (Johnson 1987), speaking of the transmission of messages as the transmission of disease gives rise to acts of diagnosis. Thus, in our everyday communication about communication we quite commonly diagnose communication recipients including ourselves (e.g., *I'm sick of the media's conservative slant* or *I'm sickened by the coverage of Columbine*). In addition, we commonly diagnose communication sources. For instance, it is not unusual to hear complaints like *I think the recent spate of school shootings is a result of a sick media*. Further, we commonly diagnose communication messages themselves (e.g., *That was a sick show* or *That was a sick joke*).

In what follows, I will examine this metaphorically motivated practice of diagnosing communicators and communicative messages not only because of its pervasiveness in our everyday talk, but also because of its significant potential consequences. More specifically, I will examine the function of this practice and the sociolinguistic conditions that support the underlying metaphor's use. Following this, I will briefly consider the possible detrimental consequences of metaphorically diagnosing communication and its constituents, after which I will discuss some means for preventing these consequences.