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Article

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Queer menopause: Expertise, ways of (not) knowing and resisting biomedicalisation

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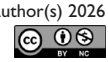

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Rebecca Ann Simmons[1]

Abstract

In the current climate of increasing menopause coverage and visibility in the West, there are moral imperatives to *know* menopause – particularly its symptoms and treatments – and to act accordingly. However, existing knowledge around the menopause is limited and limiting through its reliance on the biomedical model and the assumption of a cisgender, heterosexual, middle-aged woman as the prototypical menopausal woman. This article applies and develops sociological theories around 'expert' and lay knowledges, ignorance and biomedicalisation through a queer feminist lens. The need to reimagine menopause is demonstrated throughout this article, which elucidates the importance of centralising marginalised experiences not only to fill a research gap but as a new starting point from which to unflatten menopause and construct a multidimensional, nuanced, bio-psycho-social understanding of menopause. Within this article I explore how 16 LGBTQ+ participants in the UK navigated the knowledge landscape around menopause and were compelled to reimagine menopause knowledge in a way that was useful and affirming for them. Participants often negotiated with biomedical and popular knowledges around menopause but did so critically and selectively. Participants expressed frustration around the limits and constraints of this knowledge, especially around the particularities of LGBTQ+ experiences. Participants worked around these challenges by reimagining menopause by creating, sharing and sourcing their own forms of knowledge. Participants also found the utilisation of creative research methods such as body mapping to be helpful in processing their experiences and reimagining menopause knowledge through a more complex and holistic visual depiction of menopause.

Keywords

body mapping, creative research methods, expert knowledge, ignorance, lay knowledge, LGBTQ+ menopause, queer menopause, United Kingdom

[1]University of Leeds, UK

Corresponding author:
Rebecca Ann Simmons, School of Sociology & Social Policy, University of Leeds, Woodhouse, Leeds, LS2 9JT, UK.
Email: r.simmons@leeds.ac.uk

Introduction

Queer menopause refers to the ways in which menopause can be experienced by LGBTQ+ people and thus becomes queer through its interaction with non-normative identities. It also refers more broadly to the construction of menopause as inherently queer and queering no matter who is experiencing it (Gambaudo, 2015). For example, the ways in which menopause symptoms can sometimes be understood as gender queering such as through facial hair growth and the cessation of reproductive capacity mean that menopause is, I argue, innately queer. Knowledge about queer menopause is limited as most research about menopause has focused on heterosexual, cisgender women.[1] This article attends to the need to examine menopause knowledges, and to analyse how these knowledges are internalised, challenged and/or refuted by LGBTQ+ people experiencing menopause. Exploring what is known and not known about menopause, as well as the knowledge that LGBTQ+ people draw upon and construct, is crucial to the project of reimagining menopause and beginning to *unflatten* (Sousanis, 2015) menopause as a diverse, contradictory and complicated lived experience.

Despite calls for women to educate themselves about menopause and its associated treatments (Throsby, 2026; Throsby & Roberts, 2024), existing knowledge about menopause is limited and *limiting*. Although empirical studies, medical literature and popular coverage of menopause are increasing, much of this material relies on biomedical conceptualisations of menopause and proposes menopause hormone therapy (MHT) as the primary or only 'solution' to the 'problem' of menopause (Throsby & Roberts, 2024). Biomedical knowledge sources and popular discourses have tended to emphasise menopause as a result of a 'hormone deficiency' while also homogenising the experiences of people transitioning through menopause to that of an imagined cisgender, heterosexual, white and middle-class woman (Glyde, 2022; Throsby, 2026). Knowledge about menopause has been alternately portrayed as mysterious and unknowable due to its characterisation as a 'women's issue', or as self-evident, which produces a moral imperative to know and internalise the biomedical approach to menopause (Throsby & Roberts, 2024). Such an approach demands an engaged patient who appropriately recognises their menopause symptoms, receives a diagnosis from an appropriate biomedical 'expert' and then pursues a biomedical treatment, usually in the form of MHT.

In this article, I analyse how 16 LGBTQ+ people in the UK navigated this challenging knowledge terrain and use these findings to illuminate the shortcomings of existing knowledges for all who transition through menopause. For the participants, this often meant negotiating with 'expert' knowledge while simultaneously developing and sharing their own counter-knowledges. I place 'expert' in inverted commas to challenge the uncritical granting of cognitive authority to anyone who possesses certain qualifications or a particular position of power. There are many 'experts' on the subject of menopause who often hold conflicting views and knowledges (Orgad, 2026). Throughout this article, I use 'expert' knowledge as a synonym for biomedical knowledge as this conflation of expertise with biomedicine was common among the participants. Other expertise, such as that of sociological researchers, has had much less publicity and was, therefore, not understood by participants as being part of the 'expert' body of knowledge.

Critical feminist researchers have argued that menopause cannot be understood only as a biological phenomenon. It has been argued that menopause should be thought of as 'bio-psycho-social' (Throsby & Roberts, 2024). Such a conceptualisation of menopause affirms that knowledge about menopause cannot be purely based on biomedical knowledge of menopause but must legitimise 'messy' understandings of menopause that see it as both affecting and affected by biological, psychological and social experiences. Contemporary feminist researchers have therefore worked towards a more holistic and nuanced conceptualisation of menopause as a partly medical (and medicalised) phenomenon, but also as one which can affect a person's sense of self (Beck et al., 2023; de Salis et al., 2018), their relationship with their body (Whiley et al., 2023), and as often connected to the social significance of ageing (Ballard et al., 2009). Feminist concerns around the biomedicalisation of menopause have been particularly related to who *constructs* knowledge about menopause, who *possesses* this knowledge, and what (moral) imperatives result from the *circulation* of such knowledge.

Despite an emerging consensus among social scientists that menopause is best understood as bio-psycho-social (see Orgad & Steffan, 2026), medical authorities have been slower to take up this new theorisation. As such, much of the widely accessible knowledge about menopause is biomedical, as is discussed below. However, there is evidence that a more nuanced understanding of menopause is also being taken up within biomedical assemblages. In the UK, the most recent 2024 National Institute for Health and Care Excellence (NICE) guidelines on menopause now use less medicalising language and acknowledge that menopause has effects beyond vasomotor symptoms. Likewise, a recent special issue of the medical journal *The Lancet* (2024) acknowledged that 'commercial companies and individuals with vested interests have over-medicalised menopause', often appropriating 'feminist narratives' in doing so (p. 877). However, the extent to which this changing attitude is filtering down to individual healthcare professionals is unclear. Moreover, the 'Davina effect', as analysed by Jermyn (2025) referring to the increased uptake of menopausal hormone therapy (MHT) after the transmission of Davina McCall's two menopause documentaries (Channel 4, 2021, 2022), shows that popular narratives such as those found in celebrity documentaries continue to espouse the idea of menopause as inherently problematic and therefore requiring medical intervention (Orgad & Rottenberg, 2024a).

In this article, I consider the significance of knowledge(s) in constructing and shaping participants' experiences of menopause, while also understanding menopause transitions as a site of knowledge production. Testimonies and artistic creations from the participants demonstrate how lay and expert knowledges confront and conflict with each other, but also how they can be negotiated simultaneously. This article thus explores the interactions and (in)compatibility of dichotomies such as lay/expert knowledge and mainstream/counter-knowledges and problematises simplistic conceptualisations of these binaries as zero-sum games. In doing so, I consider how participants manage ongoing renegotiations between these sources of knowledge and instruction, provoking a reimagining of menopause through their creation of a patchwork menopause knowledge. This article proceeds by engaging with the existing literature on expert knowledge, biomedicalisation, lay knowledge, counter-knowledges and taxonomies of ignorance before outlining the methodology and then discussing the key findings of the research.

Expert knowledge and the biomedicalisation of menopause

Within the menopause field, there is an increasing number of 'experts' who contribute to the development of knowledge around menopause and possess cognitive authority on the subject due to their academic credentials, job title and/or public visibility (Orgad, 2026; Throsby, 2026). These 'experts' include academic researchers, pharmaceutical companies and their employees, and healthcare professionals, alongside lay-experts such as celebrities with lived experience of menopause. However, 'expertise' about menopause has, for the past century, been the primary domain of healthcare professionals and biomedicine.

'Expert' knowledge has been critiqued for masquerading 'as neutral fact . . . [despite being] another ideology' (Turner, 2001, p. 127). Arksey (1994) similarly argued that medical knowledge, as a form of 'expert' knowledge is 'invented rather than discovered' (pp. 449–450), thus mirroring the way in which menopause was seen to be constructed rather than discovered to be a 'deficiency disease' (McCrea, 1983). Other sociologists such as Prior (2003) have argued that 'the world of professional dominance . . . [has] waned' (p. 43).

However, throughout this article, I illustrate the ways in which medical expertise still dominates when it comes to the defining, diagnosing and treating of menopause. Attitudes towards 'expert' knowledge do appear to be changing – Au and Eyal (2022) use the example of COVID-19 to demonstrate the ways in which public health 'experts' have been challenged in recent years and the validity of expertise has been questioned. Likewise, as this article explores, people experiencing menopause, especially LGBTQ+ individuals, seem to be dissatisfied with only drawing upon the advice and knowledge of medical 'experts'. As such, there are parallels with how LGBTQ+ activists of ACT-UP expressed frustration with the way in which AIDS was being researched and the paucity of available treatments (Epstein, 1995). Biomedicine has also been critiqued for its production of 'bio-Others', a term used by Sebring (2021) to encapsulate the way that marginalised individuals such as gender non-conforming people and other members of the LGBTQ+ community are often othered by the biomedical establishment. As I explore below, the feeling of being bio-Othered by medical professionals was an experience recalled by many participants as they recounted confronting assumptions that they were heterosexual or fighting against ignorance of the existence of queer and trans menopause.

Since the defining of menopause in the West as a 'deficiency disorder' in the 1960s (McCrea, 1983), its existence in discourse and as an embodied lived experience has been entangled with 'expert' knowledge and often characterised by biomedicalisation. Clarke et al. (2003) define biomedicalisation as the 'increasingly complex, multi-sited, multidirectional processes' (p. 161) which create a moral imperative to engage in self-surveillance; to seek to prevent 'ill health' through risk assessment and the treatment of risk; and to consume appropriate biomedical goods and services. Medicine itself has long been critiqued by sociologists and feminist academics, who have variously understood it as a tool of social control (Zola, 1972), as an invading arm of paternalism and patriarchy (Boston Women's Health Book Collective, 2011; Ehrenreich & English, 2005) and as the superseding of expert knowledge over the knowledges of lay people (Arksey, 1994). Zola's (1972) conceptualisation of medicine as 'the new repository of truth' (p. 487) elucidates how menopause is 'treated' within the biomedical complex and how certain medicalised mainstream discourses insist that anyone experiencing menopause must take MHT

in order to protect their health, pursue longevity and age 'well' (Raisborough, 2019). This critical analysis demonstrates the overlap with knowledges of various gendered biological phenomena such as polycystic ovarian syndrome (PCOS) and endometriosis, which Hudson (2022) writes is replete with 'ambiguity' due to a 'wider constellation of discursive, material and political factors which enrol certain forms of knowledge whilst silencing, ignoring or marginalizing other forms of knowledge' (p. 21).

Biomedical approaches have been critiqued for classifying menopause as a pathological phenomenon characterised by a perceived lack of the 'female hormone' oestrogen thus positioning any person experiencing menopause as inherently 'lacking' and in need of intervention (McCrea, 1983). I also challenge the characterisation of oestrogen as a 'female hormone' as (cisgender) men also have this hormone (Oudshoorn, 2003). However, feminists diverge on what a more appropriate consideration of menopause might look like. In refuting the medicalisation of menopause and its insistence on MHT, some radical feminists turn to emphasising the ageing body of women in menopause as natural and therefore not requiring (biomedical) intervention (Coney, 1994; Greer, 2019). While these approaches are useful in critiquing biomedicalisation and the construction of women's bodies as always troublesome and in need of correction, they have been criticised for ignoring the possibility of menopause as a painful or uncomfortable experience (Ballard et al., 2009). Such an approach also ignores potentially positive biomedical interventions on/in the body such as gender-affirming surgery or hormone therapy, as well as the foreclosing of any nuanced discussion around MHT and its potential usefulness for some people experiencing menopause (Throsby & Roberts, 2024). As such, there is a need for a nuanced understanding of menopause that understands and allows for medical intervention as potentially helpful whilst also resisting the wholesale entrenchment of menopause within biomedicine. The usefulness of medical intervention is also demonstrated through the uptake of gender-affirming hormone therapy (GAHT) by trans people, although the difficulties in accessing this treatment is well documented (Gill-Peterson, 2022).

Lay knowledge and counter-knowledges

Lay knowledge has been a site of contestation in recent decades with social scientists exploring its validity, usefulness and hierarchical relationship with 'expert' knowledge. The dichotomy of lay and 'expert' knowledge is debated within sociology, with some arguing that there is not a clear division between 'experts' and lay people, but rather, that there exists a hierarchy of expertise which might be understood as 'expert specialists', 'general specialists' and then 'lay people' (Arksey, 1994). Similarly, Prior (2003) observed the emergence of a hybrid archetype which he called the 'lay expert', meaning a lay person who has acquired 'expert' knowledge. As such, Arksey (1994) argues that there is 'an opening for persons commonly assumed to be technically incompetent to acquire (lay) medical power with regard to the construction of scientific facts' (p. 464). However, other scholars warn against the proliferation of lay 'experts' and note that equating lay knowledge with professional knowledge is unjustified and dangerous as lay people 'are not experts' and are often 'plain wrong' (Prior, 2003, p. 45). However, this perspective ignores the multiple occasions when professional 'experts' have also been

'plain wrong', ranging from lobotomies to the prescription of thalidomide. In relation to menopause, the errors of 'experts' are also visible through the discussion of MHT and its attendant risks, which have alternately been ignored, exaggerated and described with unjustified certainty (Panay et al., 2024). Other scholarship has explicitly critiqued biomedicine for its refusal to acknowledge lay knowledge, thus marginalising any 'other forms of knowledge' outside of biomedical expertise (Popay & Williams, 1996, p. 760). Jennie Popay and Gareth Williams further argue that the promotion and privileging of 'bio-scientific methods . . . [has] replaced the political commitment to social improvements' (p. 759) thus consolidating the individualisation (and biomedicalisation) of health concerns rather than addressing the social production and political treatment of these issues. For menopause this has meant the promotion of MHT as a silver bullet and promoting 'lifestyle changes', instead of challenging public misconceptions and discrimination against people experiencing menopause. Biomedicalisation also ignores that people experiencing menopause are often also struggling with other life events such as caring for ageing parents and children leaving home (Winterich & Umberson, 1999).

Lay knowledge has been considered to carry radical potential as it can challenge 'medical hegemony' (Prior, 2003, p. 45) through a refusal to 'grant cognitive authority' (Tuana, 2006, p. 9) to medical 'experts'. Nancy Tuana points to the women's health movement (WHM) as a poignant example of when women challenged medical hegemony and instead fostered their own embodied knowledge through lived experience and communal knowledge-sharing. The movement was highly critical of biomedicine for what was perceived to be its inherent paternalism and misogyny which constructed women's bodies as multiply deficient and in need of correction by medicine and medical institutions (Boston Women's Health Book Collective, 2011; Ehrenreich & English, 2005). The WHM instead promoted the validity of experiential knowledge and called upon women to explore and learn from their bodies through practices such as a genital self-examination (Tuana, 2006). The movement also produced materials that challenged the medicalisation of menopause and gave holistic advice for any unwanted symptoms by recommending diets and self-care (National Women's Health Network, 1977).

The formation and distribution of lay knowledge have been radically changed through the proliferation and availability of online health information. The internet can be further understood as a site of complexity and contradiction, both democratising health information but also expanding the moral imperative upon patients to self-educate and to become 'empowered' by becoming patient-consumers (Hardey, 1999). Moreover, while 'expert' knowledge is readily available online, so are counter-knowledges which promote complementary and alternative medicines or even reject interventions of any kind. Maslen and Lupton (2019) argue that the internet enables patients to develop their 'experiential authority' (p. 1638) and that social media groups in particular enable patients to access both lay knowledge and 'expert' knowledge and learn from traditional 'experts' as well as their peers. However, there are also limitations to the use of the internet due to the proliferation of inaccurate and potentially harmful information. Academics have cautioned that the use of the internet and argue that 'Dr. Google' (and now AI tools) wrongly assumes a health literate patient who is able to parse out appropriate information from the internet and who will ultimately cede agency to a medical professional when necessary (Davis, 2018). Short (2017) notes that the internet contains both accurate and

inaccurate health information about menopause. Moreover, she argues that while social media platforms can be beneficial for raising awareness and that 'many genuine healthcare practitioners are active in the field [of social media] there are countless other self-proclaimed experts peddling (often damaging) misinformation' (p. 5). As such, while the internet and social media do offer a way for patients to empower themselves through pursuing knowledge, it also requires cautious and critical engagement.

This literature demonstrates the tensions embedded within attempts to construct and explore lay knowledges which might offer an alternative to 'expert' biomedical knowledge. As the participants discuss below, navigating information and knowledge about menopause is similarly convoluted and participants often reflected upon the limitations of 'expert' knowledge and sometimes developed and demonstrated their own lay expertise.

Taxonomies of ignorance

Ignorance and a lack of education among medical professionals around menopause is well documented (Dillaway, 2006; Tuana, 2006) and although societal taboos around menopause are decreasing (Orgad & Rottenberg, 2024b), there is still a need for better education and knowledge production regarding menopause. However, women are seen as 'suffering' from self-imposed ignorance about menopause, thus explaining their 'failure' to approach medical professionals about their presumed uncomfortable and distressing menopause experience (Throsby & Roberts, 2024). As such, any refusal to accumulate and internalise the biomedical information about menopause which is promoted by both popular texts and medical professionals is seen as deviant and harmful. I draw upon Tuana's (2006) 'taxonomy of ignorance' (p. 3) to explore some possible reasons for an ignorance regarding (queer) menopause. Tuana suggests that one reason for ignorance is that developing knowledge is 'not linked to present interests' (p. 4), or rather, that those in positions of (cognitive) authority do not care to know what they do not know. Tuana argues that menopause long fell within this category, although she notes that recently there have been 'shifts in perceived marketability', meaning that menopause has developed into a 'far more sophisticated site of knowledge production' (p. 5). Although the late twentieth century did see a substantial increase in the amount of research conducted about menopause, this predominantly concerned menopause as a medical condition and, specifically, as a 'deficiency disease'. As such, while there has been increased production of knowledge around menopause, it 'remains remarkably inadequate to women's health needs' (Tuana, 2006, p. 6) and, I would add, to the bio-psycho-social needs of anyone experiencing menopause (see also Steffan et al., 2026).

Tuana's taxonomy of ignorance is especially useful when utilised in conjunction with the concepts of medicalisation and biomedicalisation in helping to theorise the uneven distribution of research about menopause. As discussed above, biomedicalisation helps to explain why there is an ever-increasing body of literature about how the symptoms of menopause are best treated with MHT. The taxonomy of ignorance provides an explanation for why conceptualisations of menopause as a neutral or even positive experience have been discussed less than portrayals of menopause as a time of loss. The taxonomy similarly explains why medicalised understandings of menopause, which have promoted menopause as a site of marketability, attract more publicity more than sociological,

anthropological or autobiographical studies of menopause. Tuana further argues that ignorance can be partially produced 'by the construction of epistemically disadvantaged identities' (p. 13). Thus, while historically menopause has been *known* by women – and humans of all genders – for millennia, this knowledge has been dismissed or suppressed. This is because certain people – often women and marginalised gender identities – are not seen as credible and are deemed 'not knowers' (Tuana, 2006, p. 13), thereby discrediting their knowledge as an 'old wives' tale' or 'unscientific' and thus useless.

Ignorance is not a neutral phenomenon; it can be deployed and enshrined for political ends. McGoey (2012) articulates the ways in which ignorance can be considered an asset and a vehicle of power and thus argues that we must 'resist the customary assumption than knowledge is more powerful than ignorance' (p. 571). Drawing upon examples from the pharmaceutical industry, McGoey argues that there can be situations where 'cultivating ignorance' can be more useful than 'cultivating knowledge' (p. 555). McGoey terms this 'strategic ignorance' and defines it as 'the mobilization of the unknowns in a situation in order to command resources, deny liability in the aftermath of disaster, and to assert expert control in the face of both foreseeable unpredictable outcomes' (p. 555). In the context of menopause, strategic ignorance is visible in relation to the possible side effects of MHT, but also in relation to menopause itself as it has sometimes been constructed as an unknowable phenomenon conjured by the supposedly inherent mystery of the female body and the unthinkability of a post/non-reproductive woman (Throsby & Roberts, 2024). Ignorance around menopause can be further understood through the literature written about other bodily events and illnesses which primarily affect women and trans people. Writing about endometriosis, Hudson (2022) argues that an 'absence of knowledge on a particular subject . . . is a result of structural, cultural and political processes and forces which privilege certain voices and communities' (p. 21). Endometriosis, and menopause to a lesser extent, can therefore be understood as a site of 'undone science' (Frickel et al., 2010, cited in Hudson, 2022, p. 21) where 'androcentric biomedicine' (p. 21) has ensured the 'systematic non-production of knowledge about women's health' (p. 22).

Ignorance can thus be understood as a primary concern around menopause, while the matter of who is ignorant and who is knowledgeable is contested. This article will consider how participants encountered both ignorance and knowledge and how this is related to knowledge constructed around 'the menopausal woman'.

Methodology

This article is based on a PhD research project which explored LGBTQ+ experiences of menopause through a combination of semi-structured interviews and arts-based research (ABR), primarily through body mapping. The research was ethically approved by the University of Leeds.[2]

Participants were recruited using non-probabilistic availability sampling with heterogeneity followed by snowball sampling. The eligibility requirements were that participants identified as LGBTQ+ and currently, or previously, experiencing any aspect of menopause. All participants were living in the UK at the time of interview and the study's findings are therefore shaped by the role of the National Health Service and the centrality

of GPs as the first line of primary care. I include information about each participant when first introduced in the following format: pseudonym, gender identity and sexuality.

Participant demographics

Table 1 includes demographic information about each participant. Participants were invited to describe each of these characteristics in whichever way they chose and were also free to not answer any question. Each item of the given demographic information is verbatim, hence the inconsistencies in ethnicity labels with some participants choosing to give their nationality while others did not. A limitation of this research is that all 16 participants identified as White. As such, this research cannot speak to, or speak for, people of colour's experiences of menopause, and it cannot address the intersection of ethnicity and LGBTQ+ experiences and is less able to confront the entanglements of homophobia, transphobia and sexism with racism and White supremacy. This limitation does not foreclose the possibilities of the research as the findings are not intended to be generalisable to the general population but instead act as insights into the lived experiences of a specific group of LGBTQ+ individuals.

Creative methods and interviews

Body mapping was chosen to help participants convey their experiences of menopause and aid participants as they interpret and assign meaning to their experiences (Datta et al., 2026; de Jager et al., 2016). The basic premise of body mapping begins by tracing around a person's body to create a life-sized outline, or free drawing the outline of a human body that resembles oneself, before then annotating, filling in and/or affixing symbols and pictures to the drawing that is meant to represent an embodied experience such as menopause (Gastaldo et al., 2012). The body map is then narrated by the participant during the interview stage. Body mapping was able to help foreground the ways in which participants embraced alternative modes of knowledge productions and to encapsulate the complexity of counter-knowledge construction. Multiple participants also reflected that creating a body map helped them to reimagine menopause by centring their embodied lived experience. Additional advantages include potentially therapeutic effects, encouraging 'embodied awareness', and aiding 'knowledge translation' (de Jager et al., 2016). Furthermore, it has been noted as particularly useful when the researched phenomenon is stigmatised – as menopause is (Whiley et al., 2023) – as it 'facilitates participants reclaiming or creating a preferred view of the body, thus bringing into question negative assumptions inherent in dominant narratives' (de Jager et al., 2016, p. 3). An analysis of body mapping as a feminist visceral method is also explored by Datta et al. (2026) in this monograph.

To ensure that this part of the research was as accessible as possible to all participants I proposed alternative and flexible methods such as any form of 'mark-making', creating a wholly written narrative, an object elicitation pathway (Willig, 2017) or choosing only to take part in the interview. Of the total sample size of 16, a subset of eight participants chose to take part in a body mapping exercise while another participant created a timeline and self-portrait, and a further three participants took part in object elicitation instead

Table 1. Participant demographics.

Pseudonym	Gender	Pronouns	Sexuality	Ethnicity	Class	Disability	**CRM**
ALEX	Non-binary	They/them	Queer/ Pansexual	White New Zealander	Working/Middle	-	OE
BETH	Female	She/her	Lesbian	White British	Middle	-	-
CLEO	Agender	Ze/hir	Queer/ Pansexual	White	Middle	Crohn's disease, cancer, ADHD	OE
ELLEN	Cis woman	She/her	Bisexual	White British	Middle	-	OE
EMILY	Female	She/her	Gay/Lesbian	White British	Working/Middle	Fibromyalgia	BM
HANNAH	Woman	She/her	Bisexual[a]	White British	Middle	-	Self-portrait & timeline
JAMIE	Queer Tomboy Dyke	She/her	Dyke	White British	Middle	-	BM
JANET	Cisgender female	She/her	Lesbian/Gay woman	White British	Working/Middle	Autism, cancer	BM
JOAN	Non-binary, gender non-conforming	They/them	Queer	White British	Working/ 'Underclass'	Dyspraxia, dyslexia, ADHD	-
JULIET	Female	She/her	Lesbian	White Scottish	Middle	-	-
MAYA	Agender (non-binary)	They/them	Queer	White British	None	Chronic illness	-
ROBYN	Woman – 'masculine side of non-binary'	She/they	Lesbian	White British	Middle	-	BM
SAM	Gender responsive	She/her	Queer	White British	Middle	-	BM
SARAH	Female	She/her	Lesbian	White British	Working/Middle	-	BM
STUART	Transgender, genderqueer, transmasculine	He/him	Pansexual	White European	Working	-	BM
ZARA	Female	She/her	Queer/ Bisexual	White British	Working/Middle	ADHD and other mental health	BM

Note. CRM = Creative research method; BM = Body map; OE = Object elicitation.
[a]Preferred no label.

of body mapping. There were four participants who only took part in the interviewing stage of the research. Of the four participants who chose only to take part in an interview and the three participants who chose object elicitation instead, the reasons for choosing not to take part in the body mapping were time constraints; not feeling comfortable with creative tasks; and worrying that focusing on their body might be upsetting due to gender discomfort and/or body image concerns.

Reflexivity and positionality

Drawing upon queer and feminist sensibilities I acknowledge and emphasise the importance of reflexivity throughout the research journey, including through awareness of my own positionality. As a young woman who has not experienced menopause I cannot speak directly to an experience of menopause, I therefore do not write from a place of knowing but rather from a place of listening and learning. However, as someone who has been diagnosed with PCOS I do recognise some parallels between menopause and PCOS as both are constructed as hormone-related and the symptoms of which are sometimes positioned as dangerously gender-bending (Roberts, 2007) due to symptoms such as hirsutism being constructed as masculinising. Moreover, as a white, middle-class, non-disabled, cisgender woman, born and based in the UK, I have various privileges which may have impacted the relationships with the participants and interviewer–interviewee power dynamics. Writing within the context of this article I must also acknowledge the potential tension in writing critically *about* 'experts' and expertise, while also writing *as* an 'expert' within a journal of sociological expertise. As such, I position myself not as an 'expert' writing about the experiences of lay people but as an intermediary and ally of the participants, meaning that my primary aim is to share their experiences faithfully and interpret them through a queer feminist sociological lens.

All data from the fieldwork was analysed in NVivo 12 using reflexive thematic analysis (RTA) as outlined by Braun and Clarke (2019). This type of thematic analysis is distinguished from others by seeking to centre researcher subjectivity and the importance of reflexivity.

In the next section I draw upon quotes from the interviews alongside body map extracts, often giving detail about each participant to contextualise the data and honour their own complex experience.

Challenging biomedical and popular knowledges and confronting ignorance

All participants shared that they had encountered and engaged with biomedical knowledges and many also interrogated the way in which menopause is being presented in popular discourse. Both biomedical and popular sources of knowledge and narratives around menopause were often highly entangled for participants as popular portrayals of menopause often draw upon outdated conceptualisations of it as a purely negative phenomenon which must be 'treated' with MHT (Jermyn, 2025; Throsby, 2026). As such, I detail some of the problems that participants experienced in navigating these knowledges as well as their struggles against what they perceived as ignorance around (queer) menopause.

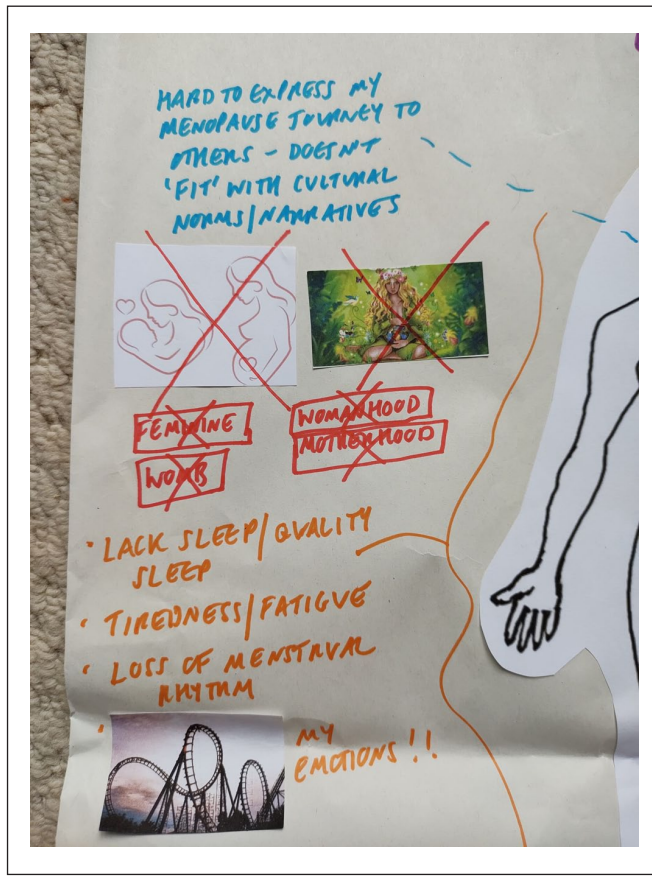

Figure 1. Jamie's body map extract (1).

Jamie (queer tomboy dyke, dyke) became critical of popular knowledge sources upon entering her menopause transition and discovering that it is a 'completely different thing to how it's portrayed!' Jamie referred to how much of the popular coverage around menopause focuses on negative physical symptoms and also criticised available information for being cis-heteronormative, which is visualised through her rejection of different symbols of femininity as are depicted on the left side of her body map (Figure 1). Two images are crossed out in red pen: an outline of a woman with long hair kissing a baby next to an image of the same woman shown as pregnant with a heart presenting the embryo; and a stock photo representing what is sometimes called 'the divine feminine'. Jamie shared that these images represented the gendered norms and stereotypes that she does not connect with – motherhood, femininity, and biologically essentialist narratives connected to the womb and what she describes as 'wombanhood'. As written above the images, these gendered associations impacted Jamie's experience of menopause because she feels her experience 'doesn't "fit" with cultural norms/narratives'. This section of Jamie's body

Figure 2. Sam's body map extract.

map draws attention to the incompatibility that some participants experienced when trying to relate their experiences of menopause to popular cis-heteronormative discourses about the phenomenon.

Similarly, Sam (gender responsive, queer) used her body map (Figure 2) to vent frustration around what she termed the 'three Fs'. Sam used this term to encapsulate her experiences of encounters with medical professionals as any physical pain or discomfort were dismissed as due to her being 'fat, female and over forty'. The picture to the right of the three Fs visualises her experience of being spoken over and shut up by the medical professionals she encountered. Sam described her gender responsive identity as meaning it fluctuates depending on who she is around. For example, she feels more masculine when around women and feminine-presenting people but feels feminine when around men and masculine-presenting people. Sam therefore struggled particularly with being positioned as 'female' and noted that some of the symptoms of menopause such as weight gain meant that she felt more 'matronly', prompting feelings of gender discomfort.

Participants' criticisms of menopause knowledges were often connected to what they perceived as an ignorance about menopause from both healthcare professionals and lay people. In particular, participants struggled against forms of ignorance in relation to how menopause might present, who experiences it and how it can be medically diagnosed. The production of ignorance around menopause was particularly legible in discussions with participants who were gender non-conforming or trans and were therefore bio-Othered within biomedical assemblages. However, the degree to which people are othered depends on their (il)legibility within the cis-heterosexual matrix (Butler, 2006).

Another section of Jamie's body map (Figure 3) summarises just some of the difficulties faced by gender questioning/non-conforming people experiencing menopause. Jamie's experiences are encapsulated with her bullet point that reads '(lack of) resources re: menopause that I can relate to'. Jamie expanded upon this idea during our interview and argued that any menopause information she accessed tended to conform to certain

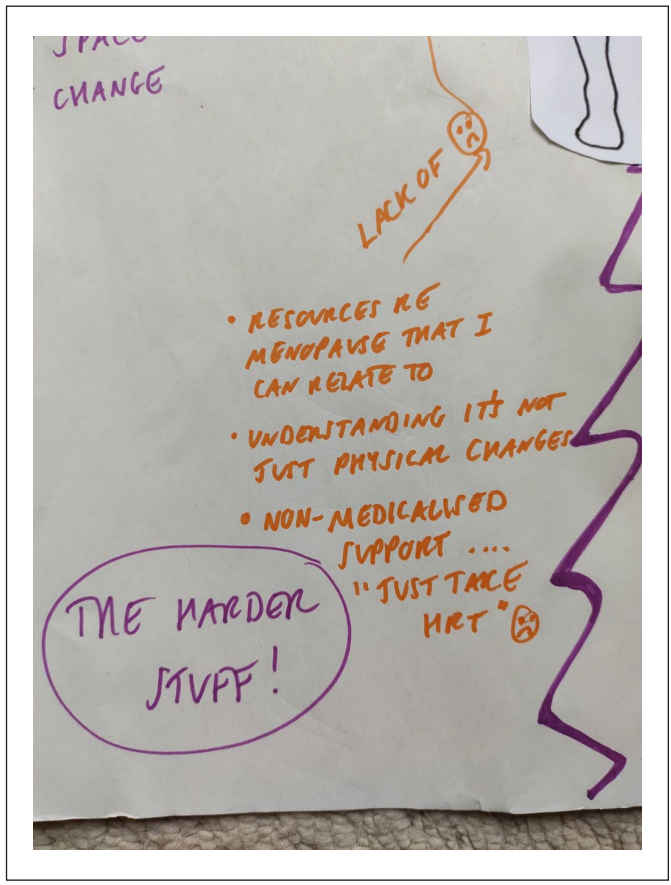

Figure 3. Jamie's body map extract (2).

stereotypes – that only (cis) women experienced menopause, that most are in heterosexual (married) relationships, and that menopause is a purely biological phenomenon. Knowledge of LGBTQ+ people experiencing menopause was absent from any available literature that Jamie found, thus bio-Othering Jamie during her menopause journey. The limits of available knowledge – and the borderlands of ignorance – were also visible through Jamie's encounters with pro-MHT literature and medicalised menopause support, epitomised through her recollection of the refrain 'just take HRT'. Jamie, therefore, struggled against ignorance in her attempts to find information about menopause that appealed to people who are not cisgender heterosexual women, and who do not want to understand or 'treat' their menopause through a biomedical lens. Jamie's testimony demonstrates the disjuncture caused by a desire to know colliding with insufficient and inappropriate knowledge sources. As such, while people experiencing menopause are told to educate – and thus 'empower' – themselves, they are faced with a flawed and lacking account of menopause.

Figure 4. Stuart's body map extract.

For other participants who identified as trans or non-binary, criticisms of prominent knowledge sources were oriented around being labelled as 'other' due to disrupting assumptions around who experiences menopause. Stuart's (transmasculine, pansexual) body map (Figure 4) pays tribute to his direct challenge to biomedical and mainstream ignorance about who experiences menopause. This title of his body map is accompanied by a three-dimensional box on which is stuck a red cross. Stuart articulated that this box represented that he does not fit in any boxes and that this relates to his menopause status as well as his gender identity and the interaction of the two.

Throughout his interview, Stuart expressed frustration and anger about the limitations of current understandings about menopause, both for cisgender women and for trans people. These frustrations were echoed by Alex (non-binary, queer/pansexual), who works within the NHS, as they discussed the explicit barriers they faced in accessing testosterone for gender-affirming reasons, and (oestrogen-only) MHT to help alleviate menopause symptoms. Likewise, Beth (female, lesbian) noted the strategic ignorance (McGoey, 2012) around testosterone as a form of support during menopause. Beth argued that it is because testosterone and oestrogen are seen as male and female hormones respectively, and as such, testosterone is seen as dangerously masculinising for (cis) women – an argument explored by extensive literature (Fine, 2017; Roberts, 2007). Alex reflects similarly on the gendering of hormones and notes the corresponding concerns about the feminising effects of oestrogen among trans AFABs (assigned female at birth) and the lack of education around the need for a 'hormonal mix' in people of all genders. As professional medical bodies such as the British Menopause Society (2022) warn against prescribing

testosterone to women in menopause due its potentially 'androgenic' effects, it is clear that exogenous testosterone therapy is seen as appropriate only for men and (possibly) non-binary people but rarely women (except for low libido), while oestrogen is deemed only for women. For participants to pursue both therefore positions them as dangerously gender bending. As such, while informal knowledge among participants acknowledged the importance of a hormonal mix and potential testosterone supplementation for all genders experiencing menopause, NICE (2024) guidelines currently only recommend testosterone for people in menopause who are experiencing a low libido despite research suggesting that testosterone is beneficial in alleviating multiple 'symptoms' of menopause (e.g. Glaser et al., 2011). However, the use of testosterone is also debated within medical circles with some private doctors prescribing and encouraging the use of testosterone for people transitioning through menopause.

Alex successfully acquired their first testosterone prescription through a private referral to a gender specialist, the timing of which coincided with their menopausal transition, and which was followed by their pursuit of oestrogen-only MHT to help with menopause symptoms. Alex noted, 'I think what I was doing was trying to leverage the legitimate route of HRT to try to score for myself what I really wanted, which was the testosterone'. They first attempted to access this therapy through their GP. However, none of the doctors at this practice was 'comfortable' prescribing MHT alongside testosterone due to 'not knowing enough' about mixing these hormones. As a result, Alex was referred to a 'specialist', which they experienced as unwarranted and othering – they reported feeling like they are an 'anomaly', and perhaps even as 'frightening'. Alex suggests that these actions effectively say, 'we don't even know what to do with you'. The symbiosis of bio-Othering and ignorance is evident as the medical professionals that Alex first interacts with show their lack of knowledge of menopause for anyone who is not cisgender, and thus position Alex as an exceptional case who requires a specialist. Moreover, Alex points out that if they were not already taking testosterone, there would be no 'medical intervention to flag me to the world' as genderqueer, and as such, their journey to acquire a 'maintenance dose' of oestrogen from their GP would be vastly easier. They note that it is this 'flagging' that creates a problem, not that Alex *is* genderqueer, but that they are now *legible* as genderqueer and as a 'bio-Other'.

Reimagining menopause knowledge(s)

In response to encountering ignorance among medical professionals many of the participants spoke about pursuing knowledge around menopause which they felt they could trust and which they perceived to be relatable to their own circumstances. Pursuing knowledge in the face of ignorance around menopause is shared by Franks (2026) in her autoethnographic study, alongside the research of Orgad (2026) whose expert-participants were drawn to the menopause field in a quest to educate themselves and others. Participants sought knowledge for distinct reasons, with some looking to avoid or mitigate symptoms, while for others this pursuit was largely oriented around acquiring a diagnosis. Participants utilised a variety of sources including television and radio shows, podcasts, social media platforms, complementary and alternative medicine practitioners, as well as biomedical professionals.

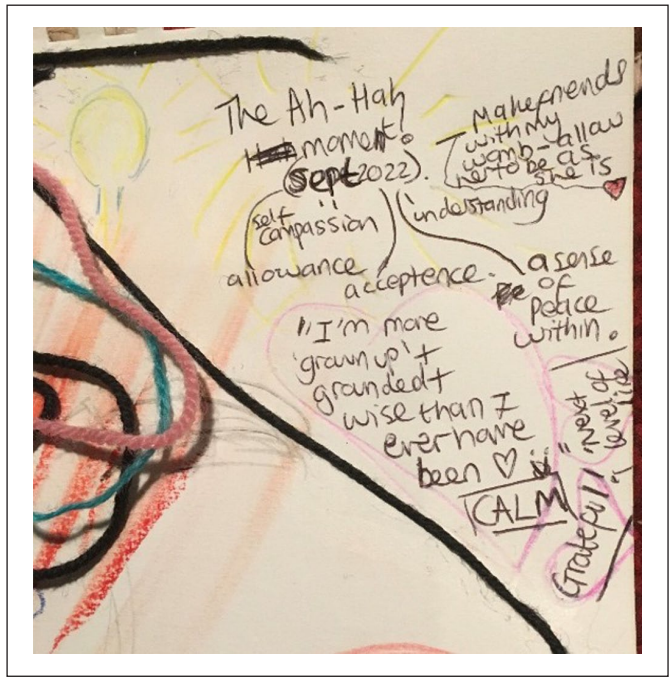

Figure 5. Zara's body map extract.

Zara's (female, queer/bisexual) story of frustration and confusion around her undiagnosed menopausal symptoms ultimately progressed into one of 'peace and acceptance' (as represented by the 'ah-hah' moment, Figure 5) after her own self-diagnosis of menopause. During our interview, Zara recalled that near the end of a festival where she had been 'in a place of complete and utter rage', she spoke to a herbalist who suggested that her experience might be due to menopause, after which she felt much calmer. Although I term this a self-diagnosis, it is notable that Zara gained this awareness through her interaction with a 'lay expert' (Prior, 2003) – the herbalist at a festival. The herbalist gains authority and legitimacy through her position as 'the herbalist' – a title that demonstrates her connections to the sphere of complementary and alternative medicines. Thus, although without medical credentials, the herbalist acts within a position of implicitly negotiated authority and suggests a 'diagnosis' which is easily accepted by the pseudo-patient (Hirschkorn, 2006).

Other participants prioritised embodied knowledge as they pursued forms of knowledge that were applicable to their lived experience, and which did not constrain them within cis-heteronormative or biomedical knowledge forms. Stuart noted that he considers himself 'quite in touch with my body and my brain and my mind' and tries not to 'block out' what his body is 'saying' by turning to pharmaceutical solutions. Stuart and other participants chose to 'listen' to their body and therefore embrace 'embodied ways of knowing' which, Barbour (2004) argues, could be a beneficial 'alternative epistemological strategy (p. 227). Stuart anticipated that his embodied ways of knowing would

affect his experience of menopause as he pays close attention to any signs or symptoms he experiences and tries to alleviate any physical problems without resorting to biomedical interventions where possible. Furthermore, he considered that this connection to his body might be 'partially because I'm trans' as this has led to a heightened awareness of the body and how it does (or does not) align with his internal sense of self. Thus, Stuart places trust in his body to know what to do, rather than to listen to an 'expert' opinion on the body. Other participants suggested that LGBTQ+ people might pay more attention to the body generally and are more likely to discuss menopause and how it interacts with their gender and sexuality. The centrality of Stuart's embodied experience is also visible on his body map (Figure 6), which uses his foods to represent parts of his body and his enjoyment, ambivalence and fear of his changing body – through menopause and through gender affirming care.

Sharing knowledge and raising awareness

> We're not gonna pretend it's not happening, we're gonna talk about it, so when they ask, 'how are you?' We're gonna tell them! (Sam, gender responsive, queer)

Communally sharing knowledge and raising awareness of 'women's health issues' have a strong tradition within feminist movements, particularly the Boston WHM (Boston Women's Health Book Collective, 2011) and also within queer (Epstein, 1995) and trans communities (Gill-Peterson, 2022). Narratives from the participants suggest that the (re) distribution of knowledge often concerned the sharing of experiential knowledge rather than formal resources. Feminists have critiqued the arbitrary dualism of knowledge/experience which acts as a way of demeaning experience and constructing an invalid way of knowing (Barbour, 2004; Tuana, 2006). Moreover, Popay and Williams (1996) call attention to the importance of accepting that life events can be transformed into an '"expert" body of knowledge' (p. 760) and therefore should be conferred with cognitive authority as would a medical professional.

Communal knowledge-sharing is particularly important within LGBTQ+ communities. Cleo (agender, queer/pansexual) drew attention to this, noting that for some advice – such as recommending the best vaginal moisturisers and lubricants – there is 'no chance my GP is going to tell me this'. Ze also noted that seeking biomedical help can be triggering or traumatic as it can result in misgendering by medical professionals or an uncomfortable focus on perceived sexed and gendered parts of the body. Multiple participants recalled painful or frustrating interactions with medical professionals at GP surgeries, IUD insertions and breast cancer screening appointments. Cleo noted that knowledge-sharing across intergenerational family lines can be difficult due to a fraught or 'minimal relationship' existing because of their queer identity. As such, Cleo argued that there is a potential for 'those kinds of intergenerational links to get lost a little bit'. Similarly, Stuart noted that although he has attempted to speak with his mother about menopause on a few occasions, he struggles to do so because 'she doesn't really get me'. Although he said 'they [his parents] totally accept me', he also rations the information he gives them as he is not sure how much they can cope with it and struggles

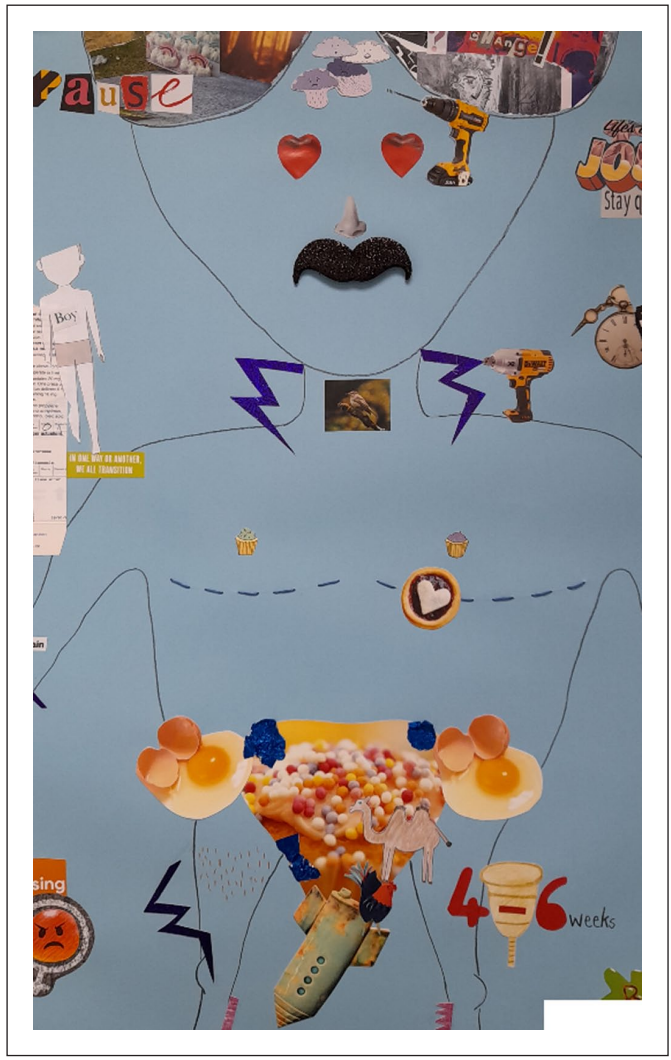

Figure 6. Stuart's body map extract (2).

himself to 'feel comfortable in those conversations'. Stuart observed that 'the way she [his mother] refers to me, or things about me' are sometimes upsetting. Due to such familial difficulties alongside frustrations with medical institutions, multiple participants referenced a Facebook group which was formed to discuss queer and trans experiences of menopause and which they utilised to find information about menopause that was gender-neutral and to find solidarity within a queer community in which they could develop counter-knowledges.

Other participants also emphasised the need to raise awareness and talk about menopause with friends and co-workers (see also Bertola et al., 2026). Jamie noted that there was a 'movement . . . in this generation . . . to speak up' and reflected that although she is critical of Davina McCall's programmes, she still felt that they were beneficial because of the 'awareness raising'. Ellen (cis woman, bisexual) argued that menopause is still 'something that's not talked about that much . . . certainly not for queer women'. In response to this she shared that she consciously tells her younger co-workers about her menopause experience and warns them that she might forget things because she is 'peri-menopausal'. As Ellen runs a queer bookshop, talking to her colleagues about menopause has meant talking to other people within the queer community. As such, Ellen has been raising awareness of menopause with colleagues, but also within her local LGBTQ+ community, including with cisgender men who will not directly experience menopause themselves. Many of the participants sought to increase awareness around menopause because they experienced mainstream narratives around menopause as cis-heteronormative and that often promoted a biomedical discourse that did not always meet their needs. In doing so, many participants looked forward to a 'queer futurity' (Muñoz, 2007) by employing a critical hopefulness in looking towards a future in which there is more inclusive and accessible situated knowledge around menopause, alongside wider ambitions of social justice for LGBTQ+ equality and trans inclusion.

Conclusion

Knowledge(s) around menopause are circulating widely during this 'menopause moment' (Orgad & Rottenberg, 2024b). However, this article demonstrates how proliferating dominant knowledges are creating an external pressure to learn and internalise appropriate ('expert') knowledge while LGBTQ+ people struggle with the cis-heteronormativity and biomedical framing that characterise much of this knowledge and popular discourse. As such, while biomedical assemblages and popular discourses implore people to educate themselves and 'know' menopause, this knowledge is itself limited and limiting. This article has demonstrated the ways in which 'expert' knowledge is insufficient in helping people navigate their menopause transition such that LGBTQ+ people regularly supplement and/or supersede normative menopause knowledges with a patchwork array of knowledges that affirms experiential and embodied knowledge and the informal networks through which this knowledge is shared. These informal networks of knowledge and support gesture towards a queer futurity in which menopause, ageing and queer lives can be reimagined, and participants anticipated a better future both for themselves and their communities.

The use of body maps in this study helped to visualise this embodied knowledge and demonstrates the way in which creative research methods can help to generate and uncover counter-knowledges while critically analysing normative knowledge sources. Body mapping and other creative research methods are therefore a vital resource in reimagining menopause and ensuring that marginalised people whose experiences have been sidelined are centred in an ongoing reconceptualisation of menopause (see also Datta et al., 2026). Alongside demonstrating the applicability of creative research methods for studying menopause, this article also develops the bodies of literature on knowledges

and biomedicalisation by demonstrating the minefield that LGBTQ+ people experiencing menopause must navigate as they grapple with 'expert' and lay knowledges and the plethora of both which is entangled online. Furthermore, this article demonstrates the ways in which a feminist critical engagement with biomedicalisation is necessary when exploring LGBTQ+ experiences of menopause, while also acknowledging the benefits and at times liberatory potential of biomedical interventions for people experiencing menopause as well as trans individuals pursuing gender-affirming care.

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Ethical considerations

This study was approved by the School of Business, Environment and Social Services (AREA) Research Ethics Committee (approval no. AREA 21-079) on 23 February 2022.

Consent to participate

Respondents gave written consent for review and signature before starting interviews and this was confirmed at the start of each interview.

Consent for publication

Participants gave written consent for their body maps to be published with any identifying information removed.

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Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Data availability statement

The datasets generated during and analysed during the current study are available from the author on reasonable request.

Notes

1. I subsequently use 'woman' to refer to anyone who identifies as such.
2. See notes above on ethical approval and participants' consent.

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