Menopause in The Public Sphere: The Consciousness-Raising Practices of Technical and Experiential Experts

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MENOPAUSE IN THE PUBLIC SPHERE: THE CONSCIOUSNESS-RAISING PRACTICES
OF TECHNICAL AND EXPERIENTIAL EXPERTS

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ABSTRACT

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Menopause in The Public Sphere: The Consciousness-Raising Practices of Technical and Experiential Experts

Chairperson: Dr. Sara Hayden

Menopause is frequently discussed through a biomedical lens, which stresses technical language and knowledge, yet emerging in popular culture is experiential experts sharing how they feel about menopause. This paper analyses Michelle Obama's podcast episode titled “What Your Mother Never Told You” (2022) featuring Dr. Sharon Malone, a medical doctor and menopause experiential expert. Using consciousness-raising and the spheres of argumentation, I analyze how the experiential and technical experts of the podcast address and speak about menopause. This paper aims to question how consciousness-raising can reconstruct the understanding of menopause through an experiential-centric lens by placing personal testimony and experiences in tandem with technical language and understanding. The implications of this essay show how the construction of menopause through experiential and technical language can help challenge the inaccessibility, incongruence, and shame around such topics.
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Chapter 1

Menopause is biological and cultural; like everything else about human bodies, the biological process can never be removed from the culturally embedded meaning that impacts an individual’s life and outlook (Krajewski, 2019a; Ussher et al., 2019). As over half the population are individuals who will go through menopause, the menopausal experience is not a novel one. Yet around the world, the discourse surrounding menopause is dominated by the biomedical framing, which casts menopause as shameful (Bell, 1987; Hvas & Gannik, 2008a; Krajewski, 2019b; Lupton, 1996). This biomedical framing involves complex, technical jargon that limits the accessibility of menopausal information for those who do not have access to the technical language and knowledge (Lyons & Griffin, 2003). Additionally, the biomedical articulation of menopause is often at odds with women’s lived experiences (Perz & Ussher, 2008).

The definition of menopause has gone through many transitions; in the 1960s, the medical description of menopause came from Dr. Robert Wilson, who defined menopause as the castration of womanhood because it prevented women's ability to conceive children (Wilson, 1966). Mayo Clinic (2023) now defines menopause as the time that marks the end of an individual's menstrual cycle; menopause can only be diagnosed after an individual goes 12 consecutive months without a menstrual cycle ultimately, “Menopause is a natural biological process” (“Menopause”, para. 1), though socially, menopause is still often defined through a shameful lens, which underscores aging as a negative experience (Dillaway, 2005).

The negative impacts of the biomedical framing of menopause are not surprising. Feminist scholars have illustrated that the rhetoric surrounding women’s bodies and health is often a site of patriarchal oppression. They have argued that one way to challenge that oppression is for women to talk back to biomedical authority by generating health knowledge through reference to personal, bodily experiences (e.g., Dubriwny, 2005, 2012; Hayden, 2018).
Scholars have pointed to the actions of feminists and women’s health movement activists from the 1960s and 1970s as models for this sort of work, drawing specific attention to the role of consciousness-raising, a process through which women reflected on the circumstances of their everyday lives to unearth patterns of structural oppression. These efforts yielded some success. In response to the women’s health movement activism, the medical profession has altered some of the ways it interacts with patients, and people now have access to a broader corpus of information about their bodies, their health, and their sexuality (Dubriwny, 2005; Murphy, 2012; Hayden, 1997; Willard, 2005). Nonetheless, contemporary US discourse surrounding women’s health continues to be dominated by biomedical authorities, something clearly evident in discourses of menopause.

In spite of the continued dominance of biomedical voices in menopause discourse, recently, popular culture figures outside of the biomedical arena have discussed menopause in public settings. Some of these efforts, I argue, echo the efforts of earlier women’s health movement activists. In this thesis, I explore one of these contemporary efforts, an episode of former First Lady Michelle Obama’s *The Lighthouse* podcast titled “What Your Mother Never Told You” (2021). Like most podcasts, the format of this episode is conversational. In this case, Obama and “her friend” Dr. Sharon Malone, “an OB-GYN,” talk “about women’s health, menopause, and aging” (Obama, 2021). Through this project, I explore whether and how the women in conversation simulate a consciousness-raising process, and I investigate how the podcast format affects that process.

This project defines consciousness-raising practices as generating knowledge through hearing and sharing personal experiences (Rosen, 2000). In 1970, Kathie Sarachild described consciousness-raising as a process White US Second-Wave US feminists employed to illuminate
the sexist structures that marked their personal and public lives (Sarachild, 1970). The process Sarachild described occurred in small, face-to-face groups. However, in 1973, Campbell expanded the scholarly understanding of consciousness-raising, illuminating that the process can and does occur through other mediums, including public performances, pamphlets, cartoons, and magazine articles. Sowards and Renegar (2004) build on Campbell to state that consciousness-raising can be generated through an even wider variety of media, including books, popular music, and feminist blogs. This project extends this earlier work to examine how consciousness-raising can happen within podcast media, as well.

I appeal to Thomas Goodnight's spheres of argumentation to explore the implications of changing the medium through which the consciousness-raising process occurs. Goodnight (1982) argued that places, rules, and norms determine the space where arguments are built and the authorities to which arguers appeal. Goodnight (1982) outlines three spheres of argumentation: the personal, the technical, and the public. Each "sphere" denotes branches of activity; the differences among the three spheres are illustrated when one considers the differences between the standards for arguments among friends versus those for judging political disputes. The personal sphere is the least formal sphere and is a space where evidence is based on personal testimony (Goodnight, 1982). When women discuss their personal experiences of menopause with one another, this typically occurs in the personal sphere. The technical sphere is where technical information and language are situated; this information is considered “professional,” dictated by rules about what can be said and who is authorized to speak. Presently, menopause is dominated by biomedical discourse that stems from medical language and knowledge (Lyons & Griffin, 2003; Willard, 2005; Worcester & Whatley, 1992), which, as a result, situates it in the technical sphere. The public sphere is the most diverse sphere of argumentation and allows for a
wide variety of knowledge, values, and beliefs to make arguments (Johnson & Quinlan, 2015). The wide array of knowledge within the public sphere is because it is pliant and functions as the space of overlap between all the spheres. Scholars often examine how the technical sphere invades the public by introducing technical language and understanding to public discourse (e.g., Boyd, 2002; Fabj & Sobnosky, 1995; Goodwin, 2011); others examine how the public sphere breaks down the technical language to bring understanding to non-experts (e.g., Whidden, 2012). These scholars illustrate that the spheres are not ridged spaces, but instead, as Goodnight (1982) contends, spheres overlap and change based on how people engage in argumentation. The podcast I analyzed for this project occurs in the public sphere and reflects the overlap between technical and personal argumentation.

The questions I explore revolve around understanding how menopause is represented within the chosen artifacts. As a result, throughout this paper, I argue that the podcast “What Your Mother Never Told You” (Obama, 2021) functions as a form of consciousness-raising to reconstruct menopause through an experiential-centric lens which places personal testimony and experiences in tandem with technical language and understanding. I also argue that the experiential-centric lens of the podcasts means that Obama and Malone are constantly reframing, adding to, and challenging basic technical knowledge, which is necessary to create a broader understanding of menopause outside of its biomedical construction.

The following sections and chapters unfold as follows. First, I provide background on the discourses of menopause, which include biomedical, shame, and taboo framing. Next, I discuss the theories of analysis; consciousness-raising and the spheres of argumentation. To end the chapter, I discuss the artifact of analysis. In chapter two, I analyze the artifact by discussing how
the podcast engage in consciousness-raising. In the last chapter, I conclude with my findings and the unique implications of podcasts being a site of consciousness-raising for menopause.

**Discourses of Menopause**

**Menopause as Biomedical**

Menopause is historically understood within a biomedical framework that casts menopause as a negative experience marked by physical deterioration, heightened emotionality, and psychological fragility that must be mediated. Hormone replacement therapy (HRT) is a biomedical solution that is prescribed to mitigate the perceived negative effects of menopause. When sex hormones were discovered in the late 1930s, the experience of menopause became heavily medicalized (Bell, 1987; Hvas & Gannik, 2008a; Lupton, 1996). Hvas and Gannik (2008a) link the discovery of sex hormones with a new push for older women to medically eradicate menopause by taking HRT. By the late 1960s, HRT was the primary way menopause was presented in discourses, showing how pervasive HRT was in the public sphere (Ussher et al., 2019). Lupton (1996) found that discourse on HRT played a role in the broader societal construction of menopause. For example, the discourse of HRT and the biomedicalization of hormones that focus on aging well or health as protection against menopause reinforces a schema of illness management and that HRT can “cure” menopause (Lyons & Griffin, 2003). Gannon and Stevens (1998) found that in American popular print magazines discussing menopause during 1981-1994, over half discuss menopause as an illness that needs medical intervention both physically and psychologically, which HRT can solve. The medicalized discourse was reflected years later in British self-help books where menopause was constructed as an illness (Lyons & Griffin, 2003). As a result, HRT is a prescribed solution to menopause which biomedically reiterates the negative view of menopause.
The biomedical view of menopause frequently constructs aging as something to be mediated. Menopausal bodies are frequently tied with aging bodies, and a negative construction of aging is conflated with seeing menopause as negative (Dillaway, 2005). Markson (2003) points out that the aging female body may have been ignored and negated within popular culture because they have lost their “reproductive (and by implication, sexual) charm” (p. 80). Thus, the negativity of aging and menopause may be more tied to the end of reproduction. Women historically have been defined by their ability to reproduce (Bell, 1987), and as a result, menopause has been constructed as an abnormal and unnatural experience that needs to be fixed (Bell, 1987; Ferguson & Parry, 1998). Thus, the biomedicalization of menopause is impacted by the socialized view of women as reproductive beings.

When constructing the body through a biomedical lens, researchers and scholars identified the existence of various negative impacts. When utilizing a biomedical perspective, there is a working assumption that biological changes negatively affect the enjoyment of life and experiences of all aging women (Hinchliff et al., 2010)—a problematic generalization considering not all women have the same experience of menopause. Furthermore, the medical jargon often associated with the biomedical framework decontextualizes health and illness from its social context (Hinchliff et al., 2010). Hinchliff et al. (2010) argue that bio-medicalized discourse sees menopause only as an illness, not something that is impacted by socially constructed issues of shame and taboo. Instead, medicalized discourse often reacts to the body as an object (Tolman et al., 2014) by prescribing solutions for HRT. Subsequently, the discourse does not acknowledge that some people do not need HRT or the fact that, more often than not, women do not see menopause as something to manage or cure (Ussher et al., 2019). The impacts of seeing health as a sole aspect of biology fail to encompass the entirety of an individual behind
the health condition. As a result, the biomedicalization of menopause contributes to the social construction of the body as only one “norm” as opposed to many diverse experiences.

**Menopause as Taboo**

Menopause is often placed within taboo discourse and avoidance. Taboo, for the purpose of this paper, will be defined as “part of impoliteness, or of negative other-presentation, that is, as part of a strategy to insult and cause offense to someone or some group of people” (Abdel-Raheem, 2022 p. 1). Krajewski (2019b) was one of the first scholars to place Western menopause in a taboo discourse, “which sees menopause situated in the realm of avoidance” (p. 138). By situating menopause within avoidance, Krajewski (2019b) was able to see how discourse neglects to see menopause as natural and instead reiterates a negative understanding of a natural biological process.

Taboos regarding the discussion of menopause often reflect and reinforce an avoidance of old age. Ussher et al. (2019) state that women are often entrenched in a discourse of silence and secrecy because of the negative stereotypes of older women as ‘less than’. Krajewski (2019b) expands on this and argues the negative view of aging drives “discourse around menopause to manipulate women into doing whatever counteracts the process of aging (plastic surgery, hormone therapy, hiding hot flushes, taking medication)” (p. 615). Because discourse casts menopause as negative, it encourages the avoidance of aging (Utz, 2011). Therefore, the socially constructed view of menopause signifies a new phase of life in predominantly negative terms, which encourages avoidance through silence and suppression.

The taboo construction and understanding of menopause also relate to its medical construction within the disease framework (Ferguson & Parry, 1998; Hyde et al., 2010). For example, in the West, expectations of menopause are much more negative than reality due to the
biomedical construction of disease (Hunter et al., 1997). Women repeatedly reported surprise and relief that their experiences do not match the pessimistic framing that biomedical and popular cultural discourse creates (Joffe & Bromberger, 2016; Ussher et al., 2015). For example, due to the disease framework of the biomedical construction of menopause, it is popular to conceal menopause in the workplace for fear of being regarded as less competent (Atkinson et al., 2021). When constructing something as taboo, shame often follows and works as a reinforcement for the avoidance.

The Rhetoric of Shame Through Taboo Construction of Menopause

Many researchers trace the dominant Western medical construction and shame of menopause to the popularization of Dr. Robert Wilson’s writings in the late 1960s (Coney, 1994; Murtagh & Hepworth, 2005), where he implied that hormones defined femininity (Coney, 1994). Coney (1994) states that what was understood as symptoms of menopause became synonymous with symptoms of aging and permanently lost femininity. In critical feminist and sociological literature, Robert Wilson is credited with the over-exaggerated need to be hyper-feminine during menopause (Loppie & Keddy, 2002; Murtagh & Hepworth, 2005). These representations of menopause reveal a pervasive societal view of menopause being a taboo topic and an experience that individuals should avoid in favor of staying young. This perspective then leads to a general lack of education and open discourse on menopause.

There is a widespread absence of peri/menopause education throughout one’s life (Hayfield & Campbell, 2022), which stems from and reinforces various forms of shame and taboo to be attached to the experience (Krajewski, 2019b; Spitzer, 2009) because there is a lack of normalizing it. When topics are pushed out of the status quo and pushed to only being able to be talked about in the technical or private sphere, taboo avoidance is created. Perz and Ussher
(2008) describe the construction of menopause within specific cultural contexts as the discursive framework in which women understand menopause as a distressing experience. Since menopause is understood as a negative process associated with physical decline, women may want to neutralize the perceived shame by not acknowledging it, thus creating taboo avoidance.

**Theoretical Background**

**Consciousness-raising**

Consciousness-raising is a process through which similarly marginalized individuals reflect on and share personal experiences together to shed light on and push back against their marginalization. Through this process, new knowledge can emerge. Consciousness-raising groups as feminist interventions emerged in the US during the latter half of the 1960s. Kathie Sarachild is the feminist credited with developing feminist consciousness-raising (Rosen, 2000). In early consciousness-raising groups, women would discuss various topics, including body image, sexuality, relationships, and reproductive health. Reproductive health conversations would range from discussing women’s vaginas to discussing abortion (Murphy, 2012). While these topics may seem personal, Frye (1983) argued within this context that group discussions meant that women could view the challenges they faced as collective issues brought on by societal barriers.

Consciousness-raising groups’ focus on reproductive health was often in response to the medicalization of information in the status quo. The Western medical institutions created an environment where knowledge and information were only accessible to doctors rather than individuals (Whidden, 2012). Doctors then functioned as gatekeepers of knowledge, controlling access to women’s health information (Murphy, 2012). Murphy (2012) outlines that information on women’s bodies was so inaccessible to individuals that women did not even know the basic
anatomy of their vaginas in the 1960s. To learn about their vaginas, consciousness-raising groups in California stole medical supplies from hospitals and used mirrors to see and explore their own bodies (Murphy, 2012). As a result, consciousness-raising groups functioned as an educational location for women’s health because it was a space to discuss things in an easy-to-understand way about topics that were inaccessible to the public (Winkler, 1997).

Consciousness-raising started as a small group space where everyone participated equally in generating knowledge. Campbell (1973) describes these small groups as; “small leaderless groups in which each person is encouraged to express her personal feelings and experiences. There is no leader, rhetor, or expert. All participate and lead; all are considered experts” (p. 128). The leaderless epistemology of consciousness-raising creates an environment where people are equal in experiencing, learning, and deconstructing hegemonic norms. The most poignant part of engaging in consciousness-raising practices is the equality of knowledge and participation in deconstructing norms.

Consciousness-raising has also taken place in other forms apart from small groups; in Campbell’s (1973) essay, she also expanded on where consciousness-raising takes place in second-wave feminism, arguing it happened in larger communication and through other mediums such as public performances, pamphlets, cartoons, and magazine articles. Similarly, Sowards and Renegar (2004) point out that consciousness-raising in third-wave feminism is not limited to the private sphere. Instead, consciousness-raising topics like body image are in more public places, including magazines, blogs, and books. Rather than such information only being accessible in small groups, information is now abundant within the public sphere from which people can learn. Following Sowards and Renegar, Bessette (2013) examined how books can produce consciousness-raising by providing a space for people to read and learn, focusing
specifically on a book titled *Lesbians/Women*, which was 293 pages of letters from lesbians regarding their experience of being queer from the 1960s until the 1970s. The collection allowed readers to contextualize the stigma of being a lesbian within society. Bessette (2013) argued that artifacts could provide important consciousness-raising learning long after the initial conception, titling it archival consciousness-raising. In this process, readers can gain consciousness-raising and a sense of community across time and place. As Bessette (2013) argued, people were using *Lesbian/Women* as a tool for understanding the gendered experiences of lesbians long after the creation of the artifact.

The significance of experience as the epistemic core of consciousness-raising means that consciousness-raising is formed through individuals and their articulation of events, feelings, and thoughts. Experiential epistemology empowers audience members because it furthers a "reliance on their own instincts and perceptions of reality, even if these dispute dominant models" (Dow & Tonn, 1993, p. 291). In the 1960s, women started to rely more on information from other women and experience-based knowledge rather than medical doctors (Murphy, 2012). In large part, this reflected the fact that, at the time, women’s voices and experiences were absent from medicalized discourse about women’s health. Because doctors were the gatekeepers of women’s health advice, information was often based on what doctors perceived as best rather than what women felt (Murphy, 2012). For instance, birth practices transformed from women-centric, where squatting was the practice, to placing women in stirrups, where they were required to push against gravity in order to deliver their children (Ehrenreich & English, 1993). The shift in how women gave birth was to help the male doctors rather than what made women the most comfortable (Ehrenreich & English, 1993). In the 1960s and 1970s, feminists resisted these norms, replacing the male-dominated biomedical standard with insights based on birthing
women’s personal experiences (Hayden, 1997). The importance of favoring experiential knowledge within social context provides the ability to share personal knowledge and understand how systems work to oppress marginalized groups. This paper will also situate collective rhetoric as a form of consciousness-raising.

**Collective Rhetoric**

Collective rhetoric stems from consciousness-raising practices and promotes the same feminist goals but centers on large-group communication (Dubriwny, 2005; Hayden, 2018). Dubriwny (2005) situates collective rhetoric within a feminist lens, defining it as; "the exploration of persuasive engagements that are truly collaborative in form, rhetorics that are generated through the interaction of many voices" (p. 397). This conceptualization of collective rhetoric emphasizes how large group back-and-forth communication provides a space to build on discussions of similar marginalization.

Collective rhetorics are often required when disrupting hegemonic norms because they call to action a large group rather than a single individual (Crow, 2023). For instance, in examining the victim impact statements of the Nassar trial\(^2\), Gibson (2021) states that the very presence of multiple storytellers, the mass of lived experiences mobilized through collective rhetoric, can serve to amplify the emotional intensity of angry speech and protect against forces of diminishment (p. 536). Thus, collective rhetoric helps create ruptures in the norms of the status quo by presenting opposing information in large quantities (Dubriwny, 2005; Gibson, 2021; Hayden, 2018). The opposing information then furthers the understanding of how marginalized groups can rhetorically resist oppressive conditions (Crow, 2023). By coming together and sharing similar
experiences, large, marginalized groups are able to create a combined voice that helps reveal oppressive conditions.

In women's health specifically, collective rhetorics create a space to advocate for women's personal experiences and push back against the medicalized status quo (Dubriwny, 2005). This was seen in 1969 when the feminist group The Redstockings hosted a “speak-out,” where women voiced their experiences of abortion and pushed back on the medical norms of seeing abortion as only a negative procedure (Dubriwny, 2005). Dubriwny (2005) argues that the collective sharing during the Redstockings speak-out created a space of advocacy where women could speak candidly about their personal experiences and build on the experiences of others. By pushing back on the status quo, collective rhetoric gives women a space to highlight their own experiences within the medical establishment and society at large.

The conclusions that collective rhetoric comes to are based on group participation. Dubriwny (2005) states that collective rhetoric allowed the Red Stockings to reach a shared conclusion that all audience members agreed with. The collective engagement from audience members and rhetors formed a single conclusion that was aimed at repealing abortion laws (Dubriwny, 2005). Hayden (2018) has pushed back and stated that because of the “universal nature of the speak-out conclusions, there seemingly was no place for dissension or alternative views, potentially alienating women whose attitudes toward abortion differed from those of the group” (p.251). In other words, the collective voice of consciousness-raising presents limitations that can exclude other experiences.

**Forms of engaging in Consciousness-raising**

**Narrative.** Storytelling is a significant point of consciousness-raising because individuals can connect by sharing stories of personal experiences. Angus (2012) argues that telling and
retelling emotionally charged stories can help individuals understand difficult experiences by communicating their feelings about the situation. Dubriwny and Siegfried (2021) analyzed stories women told about their late-term abortions of wanted pregnancies in prominent news outlets, such as *The New York Times*. In these personal narratives, women spoke about how they had to sacrifice their child because if they did keep the fetus, the child would have a difficult life full of pain due to their disability. Dubriwny and Siegfried (2021) argue that while the narratives tried to function as reproductive justice, the rhetoric instead functioned as problematic by defining a good mother as someone who performs the ultimate self-sacrifice. There is the potential for narratives to reiterate problematic ideologies, as Dubriwny and Sigfriend’s (2021) findings suggest; however, there is also the potential for narratives to challenge ideologies and suggest alternative possibilities. Furthermore, it is possible to encourage others to share challenges and alternatives within narratives (Murphy, 2012), as such narratives can also function as activism to challenge the status quo. Narratives within public health do not and cannot capture every facet of an experience. Nonetheless, Ellis and Bochner (2000) state that stories “create the effect of reality, showing characters embedded in the complexities of lived moments of struggle” (p. 744). As Dubriwny (2012) points out, they capture poignant experiences and make certain aspects salient, which can inform and craft a reality for the audience.

**Blurring lines between the orator and the audience.** Collective rhetoric requires that participants actively create and collaborate about meaning (Dubriwny, 2005). Scholars argue that active participants create social movements (e.g., Enck-Wanzer, 2006) because it is the act of everyday people enacting public resistance (Pezzullo, 2001, 2003). For example, in July 1969, working-class Puerto Ricans in New York living in the district known as East Harlem (known
colloquially as Spanish Harlem or El Barrio) enacted resistance to the oppression they were facing, leading to people creating the Young Lords Organization (YLO) (Enck-Wanzer, 2006). Enck-Wanzer (2006) argues that the YLO spread information to the large community of Spanish Harlem by getting active participants who questioned the dominant status quo. Through active participation, the YLO was able to help their community and spread awareness of the oppression that Puerto Ricans in Spanish Harlem experienced. As seen by the YLO, active participation in social movements accomplishes the same thing as blurring the line between orators, which is the ability to collaborate about meaning regarding shared experiences. Through creating shared meaning, active participants can question dominant structures together.

**Blurring the line of experiential and technical authority** This project takes blurring the line of orators and audience but sees a different way to engage in this tactic- blurring the line of experiential and technical authority. Dubrwiny (2005) points out that blurring lines between orators and audience encourages sharing information about topics not normalized in the status quo. Thus, blurring lines between orators and audience and encouraging audience participation is a "tactic of demystification concerned with unmasking the craft of knowledge hidden by professionalism, thereby drawing attention to who (is) allowed to participate" (Murphy, 2012, p.76 emphasis in the original). Similarly, blurring the lines of authority functions the same way, to bring experiential-based conversations to the forefront. However, instead of blurring the lines between orators and audience, it uses authority to blur the lines of technical information and who gets to use technical knowledge. Blurring the lines of experiential and technical authority places less emphasis on technical knowledge and more on experiences that may add or contradict the technical information doctors provide. Gross (1994) outlines that arguments within the public sphere depend upon an interaction framework, meaning communication is “a two-way flow
between science and publics” (p. 6) and is often translated for both spheres (Johnson & Quinlan, 2015). Blurring the role of experiential and technical authority entails translating technical language and information in a way that is easy to understand.

**Critical perspective.** The importance of discussing personal experience tied with the social context provides the ability to share personal knowledge and understand how systems work to oppress marginalized groups. Dubriwny (2005) contends that experiential knowledge must be situated in larger structures by the continuous engagement of a seeing self within the social reality. The Redstockings abortion speak-out let women voice their frustrations regarding the medical establishment by referring back to their personal experience and bringing context to why they experienced it the way they did by calling into question the information given by the dominant medical discourse (Dubriwny, 2005). By continually engaging in how systems impact personal experiences, the critical perspective of consciousness-raising brings understanding to the overarching systems of oppression. Through sharing personal experiences, women can ultimately reflect on why topics are shameful. In women's health, sharing personal narratives about women's experiences gives them a space that is often missing from medical discourse. In the Redstockings speak-out, participants spoke and reflected on why they felt shame around their abortions and questioned why their experiences had been ignored by doctors (Dubriwny, 2005). This emphasis on personal reflection through actively participating in rhetorical acts brings a deeper personal understanding of the collective experience of oppression.

Consciousness-raising is a practice that generates knowledge through hearing and sharing personal experiences. Therefore, as this project examines how the podcast “What Your Mother Never Told You” (Obama, 2021) which I argue functions as a consciousness-raising space where individuals explore barriers and structural problems through reflecting on their personal
experiences and feelings (Campbell, 1979). To understand how to shift the medium from the forms of media discussed by prior scholars, I turn to a more detailed explanation of Thomas Goodnight’s spheres of argumentation.

**Spheres of Argumentation**

Goodnight (1982) defines three specific spheres where argumentation happens: the personal, technical, and public. Each sphere has norms that guide argumentation. As mentioned previously, the spheres often overlap, showing that the spheres are not ridged but rather function as pliant based on how people are engaging in argumentation (Goodnight, 1982). The following sections will define and detail the personal sphere, the technical, and the public spheres.

**The Personal Sphere**

The personal sphere is the most informal and private. Goodnight (1982) defines the personal sphere as a place where “disagreements are created in such a way as to require only the most informal demands for evidence, proof sequences, claim establishment, and language use” (p. 202). As a result of its informality, the personal sphere for many US women in the 1960s was a space where they talked about their families, health, or the social barriers they faced (Wood, 1998). The personal sphere is where personal experiences are at the center (James & Brown, 2019). Informal conversation within the personal sphere is the norm; discussions revolve around narratives and personal feelings. Whidden (2012) posits this example: when a doctor tells a mother that her child’s ear infection will get better on its own, the mother may consider the medical advice in the context of the personal sphere by talking to other mothers about their children’s previous ear infections. The conversations then revolve around whether they feel the treatment is necessary and how the mothers feel about ear infections (Whidden, 2012).
The personal sphere conversations can be deeply intimate and often involve topics kept from larger public discourse, as seen in many women’s health conversations. In California consciousness-raising groups, women would talk about their experiences with doctors to each other and had a list of approved doctors to go to for their health-related experiences (Murphy, 2012). Murphy (2012) argues that the openness within the consciousness-raising groups about their experiences and feelings regarding doctors helped create a guide for how doctors in California would perform abortions in the 1970s. As a result, the conversations within the personal sphere helped women discuss where they could go for abortions because it was information that was inaccessible in the larger public discourse. Historically, conversations around menopause as an experience outside of the dominant biomedical construction happen within the personal sphere, where women talk to close friends or family about their personal feelings regarding menopause (e.g., Dillaway & Burton, 2011; Dillaway et al., 2008; Ussher et al., 2015). This project, then, explores how Obama and Malone combine arguments from the personal sphere and the technical sphere in the podcast — a public sphere entity — reshaping public understanding of menopause.

**The Technical Sphere**

Professionals such as lawyers, doctors, and medical experts usually make arguments within the technical sphere. The arguments focus on scientific fact and use a deficit model of science (Gross, 1994), which states that the public is uninformed about science and medicine, which implies they cannot make knowledgeable choices about their health (Carmack, 2014; Gross, 1994). The medical technical sphere’s assumptions of ignorance can create controversy—one such example is the Tuskegee Syphilis Experiment, where doctors refused to share important medical information regarding vaccines for African American men in order to continue
observing the effects of syphilis on their test subjects (Solomon, 1985). This serves as one example of how the technical sphere’s assumption of ignorance created mistrust in generations of African Americans (Carmack et al., 2008). When patients were given information, it was through very technical language that Mishler coined the “voice of medicine” (Mishler, 1984, p. 14). People without access to the structure of medical arguments or medical terminology cannot understand medical information due to its complexity. As a result, the technical sphere is often inaccessible for people outside of technical knowledge holders.

Technical sphere arguments tend to privilege facts and dismiss people's experiential knowledge. When a layperson seeks to address arguments that have been relegated to the technical sphere in public, they often adapt by adopting technical language to claim authority (Blok et al., 2008; Gross, 1994). For instance, during the discussions of twilight sleep in 1914, a practice of giving birth where women would take medication to completely forget the experience, white upper- and middle-class women fought for their right to use twilight sleep during birth (Johnson & Quinlan, 2015). The pro-Twilight sleep activists used technical language to show how beneficial it was for women to forget the birthing experience thus, women adopted medical language to fit within the technical sphere (Johnson & Quinlan, 2015). Johnson and Quinlan (2013) argue that for experienced experts to be taken seriously during the 1914 Twilight sleep debate, they needed technical language to be persuasive. The scientific process—and the technical insights it generates—continue to be considered the gold standard for creating knowledge. Thus, the technical sphere continues to dominate conversations about health.

The Public Sphere
The public sphere is defined as a place where citizens come together to exchange ideas, debate, and deliberate about public matters (Goodnight, 1982). As such, DeLuca (1999) explains “the public sphere is a compelling spatial metaphor that has captured the imagination of social theorists across disciplines. As a conceptual tool, it is a particularly apt lever for getting at the dilemmas of democracy in an industrial/technological age of mass communication and oligarchy” (p. 21). Unlike the technical sphere, the public sphere is diverse and allows for a variety of knowledge, values, and beliefs to frame and reframe arguments (Johnson & Quinlan, 2015). Gross (1994) outlines that arguments within the public sphere depend upon an interaction framework, meaning communication is “a two-way flow between science and publics” (p. 6). It is often translated for both spheres (Johnson & Quinlan, 2015). In their arguments of the Twilight sleep debate, for example, Johnson and Quinlan (2015) outline that public sphere activists used descriptive storytelling of the birthing experience to bring context around medical language, thus blending the technical and personal sphere into the public sphere. Johnson and Quinlan (2015) show that the public sphere is a space where technical knowledge must interact with the knowledge of non-technical people to be as persuasive as possible.

Conflict in the public sphere stems from whose argument to value, the technical or experiential (Carmack, 2014). The argument that becomes the preferred knowledge within the public sphere depends on how it is constructed. Fabj and Sobnosky (1995) examined how AIDS activists constructed arguments by redefinition, which strips away the mystique that surrounds science and enables others to participate in the discourse of people with experience to claim authority. AIDS activists redefined the understanding of what was happening in the public by utilizing medical terms and centered on the experience and big picture of the disease (Fabj & Sobnosky, 1995). By constructing complex medical information into more accessible, more
contextualized knowledge that lay people could understand, the AIDS activists were able to enable others to participate, such as people who were experiencing AIDS or other activists (Fabj & Sobnosky, 1995). The public sphere accepts technical language by constructing arguments within the public sphere by redefining and translating complex medicalized terms.

In sum, Consciousness-raising in the 1960s occurred in small groups within the personal sphere (Sarachild, 1970), in 1970s it could happen in more public rhetoric documents (Campbell, 1973), in early 2000 electronic formats in the public sphere (Sowards and Renegar). Now, I contend that it exists in the public sphere through a podcast. As a result, this paper also explores how podcasts in the public sphere use personal and technical argumentation in such a way to encourage consciousness-raising.

**Podcasting as Public Rhetoric**

Podcasts are a unique form of media where the creators curate a public space that feels informal and personal for the audience. In examining Black-created and focused podcasts, Florini (2015) argues that the most notable departure from traditional media conventions podcasts make, are their embrace of a free-flowing, flexible, and conversational approach. As a result, podcasts are less formal and embrace more of a conversational norm, including personal stories and anecdotes specific to the creators rather than a formal interview (Vrikki & Malik, 2019). Similarly, consciousness-raising is an act where individuals discuss their lived experiences in an easy-to-understand way about topics that center their personal feelings and experiences. (Winkler, 1997). Thus, podcasts can be considered a consciousness-raising space because participants discuss their experiences in a mediated way, similar to consciousness-raising in magazines, blogs, and books.
Because podcasts perform as a space of casual conversation, they subsequently can be a space where creators talk about their marginalization, which may help break down dominant racialized representations and narratives produced by mainstream media (Vrikki, 2019). García and Martínez (2021) examined three podcasts distributed by NPR: the award-winning Radio Ambulante and Latino USA and the music-centered Alt. Latino, with the intent to figure out how podcasts construct Latinidad for its Latina/o/x audiences. They argue that podcasting provides an avenue for creating a space for missing Latin American voices and connecting them to others across America—the continent, not exclusively the United States (García & Martínez, 2021). The connection was created through the diversity of the stories displayed in the podcast since each episode highlights a new guest and new personal stories, which helps the audience learn something new each time (García & Martínez, 2021). This is further seen in Florini’s (2015) examination of Black podcasts which see podcasts as a space “to reproduce the sonic experience of enclaved Black spaces like barber/beauty shops and churches and the sense of intimate, friendly uncensored conversation they produce” (p. 216). Podcasts ultimately function to bring private conversations, which may illuminate marginalized cultural nuances and norms, to the public sphere, which helps bring attention to individuals’ marginalization. These podcasts focus on racial marginalization; as such, they allow exploration of topics typically undiscussed. Thus, the podcast format can also allow for a discussion of menopause because it is a similar and under-discussed topic.

This paper explores how podcasts in the public sphere featuring two people engage in consciousness-raising. I contend that because the podcast “What Your Mother Never Told You” (Obama, 2021) only features two people, it is unable to create the same sense of consciousness-raising as other podcasts because there is not a diversity of stories highlighted in the podcast.
Artifact Description

Michelle Obama

The former first lady Michelle Obama is a highly educated lawyer, philanthropist, and devoted wife and mother. She is a great rhetor to examine because “she has become a role model for women and an advocate for poverty awareness, higher education, and healthy living” (whitehouse.gov, 2015). Obama’s impact is further seen in her book *Becoming*, which has sold over 17 million copies worldwide (Harris, 2022). Michelle Obama has several podcasts including, *The Michelle Obama Podcast*, and the one associated with her book *Becoming*; for the focus of this rhetorical analysis the episode is one out of her larger podcast, *The Light Podcast* which had a 22-episode run from 2020-2023 and covers a wide range of experiences that she has had throughout her life. The episodes range from 30 minutes to an hour and for each episode Obama brings on a technical expert of the topic or someone well acquainted with it. During the episode, Obama asks questions, and personal stories from both Obama and her guest are shared. Similarly to other podcasts, the style is that of a conversation between friends, where they share personal stories and have easy-to-understand conversations.

The artifact chosen for my analysis, “What Your Mother Never Told You” (2021), features a conversation between two individuals, Obama and Dr. Sharon Malone. Malone and Obama met during Barack Obama's presidency, and Obama refers to Malone as “one of [her] amazing friends” (Obama, 2021, 8) whom she has known “for well over a decade” (Obama, 2021, 9). Malone serves as a great technical expert in the field of menopause; she is board-certified by the American College of Obstetricians and Gynecologists and, more significantly, certified by the North American Menopause Society as a National Menopause Practitioner (Malone, 2024). As a result, Malone has spent her career advocating for better education around
multiple reproductive topics, including menopause. Malone was a practicing OB/GYN in Washington, D.C., for over 20 years, and more recently serves as the Chief Medical Advisor at Alloy Women’s Health, a telehealth company that focuses on women over 40 and menopausal information (Malone, 2024). Beyond being technically knowledgeable, Malone is an experience expert, too, because she is, at the time of the podcast, experiencing menopause.

Throughout the 48-minute episode she Obama and Dr. Malone share personal stories about the menopause experience including hot flashes, as well as discussions on hormones and what biologically happens to the body. This artifact is rich for analysis because of the intertwining of narratives and technical knowledge through the process of consciousness-raising since there are no audience members adding to stories. Thus, it highlights consciousness-raising coming from two individuals instead of a collective.
Chapter Two: Analysis

In the following chapter I will analyze the artifact “What Your Mother Never Told you” (Obama, 2021) through the lens of consciousness-raising and the spheres of argumentation. First, I analyze how the artifact uses consciousness-raising through storytelling. Second an analysis of how the artifact employes the blurring the line of expert and experiential authority. Lastly, I examine how the podcast employs a critical perspective.

Consciousness-raising through storytelling

Consciousness-raising utilizes storytelling as a means of engagement that centers feelings and validates personal experiences. The podcast “What Your Mother Never Told You” (Obama, 2021) engages in storytelling, which adds experiential knowledge to the technical understanding and challenges it by questioning the dominant biological lens. This is done in two ways: first, Obama and Malone focus on the feelings of menopause, which counteract the depersonalization that happens in women's health; second, they place experiential stories at the forefront of the conversation. The form of storytelling in consciousness-raising is an important practice that generates knowledge through hearing and sharing personal experiences, where feelings of anger, frustration, and first-person accounts are centered. Storytelling empowers audience members because it furthers a "reliance on their own instincts and perceptions of reality" (Dow & Tonn, 1993, p. 291); in other words, women see their experiences of events as important and valid. In the 1960s, women started to rely more on information received from other women and experience-based knowledge rather than medical doctors (Murphy, 2012). In large part, this reflected the fact that, at the time, women’s voices and experiences were absent from medicalized discourse about women’s health. As a result, utilizing storytelling in menopause
discourse creates a space where technical knowledge is added and challenged to bring context to how women feel and experience menopause.

When talking about menopausal symptoms, Michelle Obama shares a personal story about hot flashes, which ultimately adds a tactile and emotional view of menopause to the biological understanding. Showing that storytelling centering feelings helps women understand knowledge better because it makes information accessible and connects to the lived experiences of the audience. When discussing hot flashes, Obama recalled an experience she had:

I remember having one on Marine One. I'm dressed. I need to get out, walk into an event. And literally, it was like somebody put a furnace in my core and turned it on high. And then everything started melting, and I thought, well, this is crazy, I can't, I can't, I can't do this (Obama, 2021, 306-309).

By centering her feelings of hopelessness, Obama invites the listeners to understand the raw emotions brought about by the physical and mental changes a person experiences in menopause. The discourse around health often depersonalizes people by focusing on biology rather than the accompanying feelings and psychological impacts (Ferguson & Parry, 1998). Hot flashes constitute one of the most common symptoms of menopause, which over 80% of menopausal women will experience (Bansal & Aggarwal, 2019). However, it is a symptom mainly discussed through a biomedical lens where doctors highlight what causes hot flashes through discussions of hormonal imbalances (Bansal & Aggarwal, 2019). Obama counteracts this biomedical narrative by using a detailed description of the event, emphasizing her sensory experiences. Obama's statement, as a result, functions to push back on the depersonalization that happens in biomedical conversations about health and creates a unique space where she prioritizes feelings and psychological distress. Obama’s experiential knowledge adds to the biomedical technical
understanding of a hot flash because the technical understanding cannot capture the psychological experience. The personal knowledge Obama offers adds to the understanding of how hot flashes are experienced. By acknowledging her own feelings of helplessness, Obama prioritizes experiential discussions of menopause because a purely biomedical view is unable to capture the feelings someone has while experiencing menopause. In this way, Obama adds context to the medical descriptions, thus counteracting the way highly technical language makes menopause information inaccessible to non-medical people because she talks about hot flashes in an easy-to-understand way that women with menopause may connect with. As a result, complex technical information can be made more accessible to non-technical experts if the information is accompanied by descriptions of the technical and emotional experiences to show how technical information is present in lived experiences.

Furthermore, in sharing her experiences, Malone highlights a first-person account of how frustrating life can be during midlife. In doing so Malone challenges technical understanding of seeing menopause as the only thing happening during midlife for women by showing that it is inconsistent with people’s personal experiences. In doing so, she validates women's lived experiences. During a conversation about mood changes, Malone makes a point to underscore that midlife is stressful, stating,

Which makes it even more complicated because usually, in your mid-40s to your mid-50s, there's a lot of stuff going on in your life, too- And sometimes you're just mad and upset because sometimes they're really maddening and upsetting things too, you know, going on in your life. So, there's that. (Obama, 2021, 214-218).

Malone underscores that women are facing many factors outside of menopause that may impact their emotions. Western biomedical discourse often represents women during midlife as tied to
menopause, which relates all behaviors of midlife to hormonal distress wherein women's moods are explained through hormonal change, and any physical pains or changes are a result of the physiological impact of menopause (e.g., Coupland & Williams, 2002; Mansfield & Voda, 1993; Lyons & Griffin, 2003; Willson, 1966). As a result, any change during midlife is tied to the biological process of menopause, which sees women only through the medical lens thus erasing an individual's desires and reactions to events. Malone's statement functions to bring attention to the fact that menopausal women can be stressed because of experiences outside the biological process of menopause. Malone expands on the context of women's lives during midlife showing that a purely biomedical lens reduces individuals to only experiencing menopause. Malone’s statement functions to show that changes women go through in midlife cannot always be explained by the biology of menopause and that the lived experience differs from the technical understanding. By opening a conversation around midlife and menopause, Malone calls attention to an experience that is often missing from discourse. As a result, audience members who have similar experiences will have those experiences validated because it is represented in a conversation where they were once absent (Dubriwny, 2005). Audience members may feel the same as Malone so by talking about it, Malone reaffirms to the audience that their experience is shared by other people (Dubriwny, 2005). Using personal stories to show how experience differs from technical understanding creates a space where listeners hear that their experiences are not out of the norm and instead are validated that it is how other women feel about menopause.

**Blurring The Line of Expert and Experiential Authority**

Blurring orator and audience is a form of consciousness-raising that utilizes participation as meaning-building, an act of reciprocity, and establishes a relationship of equity in meaning-building with the audience and rhetor (Dubriwny, 2005). Similarly, in the podcast “What Your
Mother Never Told You” (2021), Obama and Malone blur the line between expert and experiential authority to build on a new meaning of menopause, utilizing technical and experiential information. Blurring the line of expert and experiential authority is done in three ways. First, Malone uses her technical authority to redefine information to prefer experiential knowledge. Second, Obama uses experiential and technical language to build equity in information. Lastly, Malone uses role reversal to amplify experiential knowledge. By blurring the line of expert and experiential authority, Obama and Malone challenge the inaccessibility and incongruence of technical information that exists in menopause discourse.

Malone, as a technical expert, has the authority to redefine understanding around health; in doing so, she sets a precedent of experiential knowledge, subsequently creating a space where women can see and discuss how their experiences of health may be inconsistent with the narratives around health. One of the effects of hormonal changes during menopause can be weight gain. In a discussion about aging and weight, Malone states:

Women's value goes up with how little space you take up, you know, so the smaller you can make yourself, the, the higher perceived, you know, socioeconomic group that you're in, whatever it's all about being thin. But you're right, being thin and being healthy are two completely different things. I'm going to focus more on function than form. And, you know, so what you look like and how much you weigh is less of an issue, particularly as you get older, because the question is, what can you do? What's your function level like? (Obama, 2021, 420-430).

Malone places emphasis on the physical abilities one has rather than the weight of an individual. Malone redefines how women should view health, using her authority as a technical expert to redefine and substitute a more experiential-focused one that aligns with women's lived
experiences and abilities. Malone uses her technical knowledge to stress the importance of function after she expresses her frustration with how the imposed ideals of health and weight are placed on women. Scholars often argue that cultural and political ideologies permeate medical knowledge and advice so that it becomes laden with moral, political, and cultural values (Haraway, 1991; Harding, 1986; Segal, 2003). Wray and Deery (2008) specifically argue that when scientific knowledge travels away from its sites of production and is transformed, by the media, into popular science, it becomes a site of information fueled by the social condemnation of fatness or thinness depending on the particular vogue of female beauty. Thus, social ideals around weight and technical knowledge are conflating the social and technical perspective of health, wherein thin becomes the standard marker of health. Malone speaks to the social and technical conflation around health and refocuses it on function because the current standard does not reflect how women may experience health. In the public sphere, experiential experts often adopt technical language to seem credible (Blok et al., 2008; Gross, 1994). In this instance, Malone flips the script, adopting an experiential view of health based on individual experience. In doing so, Malone creates a bridge where experience experts can talk about how their lived experiences differ because they can use Malone’s authority.

Fabj and Sobnosky (1995) argue that redefining technical information through experience strips away the mystique that surrounds science and enables others to participate in the discourse. Similarly, Malone’s redefinition enables an understanding of health that uses personal experience to show that dominant information around health does not always relate to the lived experience. This allows participants to see how lived experiences challenge technical knowledge. As a result, redefining through an experiential lens by a technical expert helps call attention to the incongruence between experience and technical understanding. Ultimately, expanding the role of
expert and technical information to be more experiential-focused allows more experiential participation and meaning-building of menopause by creating a bridge of information. Because Malone makes information more experiential and focused on menopause, she creates a bridge where experiential experts can speak from the same place of knowledge with authority.

In the podcast, Malone suggests that health should be talked about in terms of function rather than appearance, which opens the door for experiential knowledge because she redefines it through an experiential lens. In turn, Obama offers her experiential knowledge, placing more emphasis on the need to learn about what function means through experience. Obama uses her authority as an experiential expert to add to technical information in an easy-to-understand way. This shows that experiential experts are vital in the equity in meaning-building of technical and experiential information. During her explanation, Obama describes menopause as something that is different for everyone. In doing so, she brings more context around medical language, and makes information accessible to the audience. During a conversation around mood fluctuations during menopause, Obama explains how menopause impacts a person's emotions and mood in different ways, stating:

But then you don't have those mood fluctuations that you have in the transition and then everybody's emotional changes are different, right? Because of your genetic makeup, your size, everything. Right. Will, will impact how you feel (Obama, 2021, 208-211).

Obama underscores how everyone will experience mood fluctuations during menopause differently, thus bringing more context to the public and medical understanding of menopausal mood fluctuation. In the discussion of menopause, mood fluctuations are frequently described as a symptom when hormones are in surplus or undersupplied, which impacts cognitive function (Coney 1994). Frequently, to combat the preferred technical language and understanding within
the public sphere, people adapt by using technical language and expanding on it, adding their personal narratives (Johnson & Quinlan, 2015). Similarly, Obama adopts technical language like genetics and expands on the technical understanding in an easy-to-understand way that makes information about mood fluctuations accessible to the audience. Obama brings context to how a person's individual genetics impact menopause, but underscores how experience differs, allowing equity in meaning-building with technical and experiential information. Obama's ability to call on technical information and blend it with experiential knowledge comes from the blurring of experts and the tactic of demystification. Murphy (2012) describes demystification as a strategy that breaks technical knowledge down into easy-to-understand ways, thereby drawing attention to who can use technical information. Because Malone breaks down technical information and created a space where experienced experts are required to participate to gain a better understanding of the experience of menopause, Obama is able to become a person who can utilize technical knowledge and make it accessible to other non-technical experts. By expanding on the technical understanding of genetics to bring it into the context of how individuals differ, a stronger connection is made on how women individually and uniquely experience menopause. Obama's use of technical language and adding to it further allows experiential experts to engage in the discourse around menopause by making information accessible. As a result, Obama's use of technical language with experiential information furthers experiential experts' ability to speak with authority around menopause.

In blurring the lines between the orator and the audience, Dubrwiny (2005) notes that role reversal is important in participation; in other words, all become participants in meaning-building. Similarly, in blurring the lines of technical and experiential authority, Malone engages in role reversal where she shares her experiences with menopause instead of technical
information. In doing so, Malone rejects the idea that doctors should only talk about menopause through a scientific lens and uses role reversal to amplify experiential knowledge. In a discussion about HRT, Malone shares her personal experience with deciding whether HRT was right for her, thus centering an experiential approach to how HRT is discussed, Malone states:

I will, you know, not be oversharing and say that I take hormones, and I take hormones because at the time that I was having those things, there was just too much else going on in my life. Well, you know where I was ten years ago, and we've had this conversation. I said [at the time] I can't be any madder than I am right now. I just cannot (Obama, 2021, 273-277).

Malone, through a personal story, shares why she took HRT during menopause, which underscores her experience rather than her professional opinion. To make science seem unbiased in the public sphere, doctors frequently avoid inserting their own personal experiences into the conversation, instead relying on scientific and biological facts (Blok et al., 2008; Gross, 1994). Consequently, in menopause discourse, doctors frequently describe HRT through complex technical language, which describes how synthetic hormones regulate the body by supplying the necessary amounts that individuals need to mitigate the physiological symptoms of menopause (Coney, 1994). Subsequently, doctors within the public sphere simply promote HRT as something that helps an individual biologically (e.g., Hunter et al., 1997; Willson, 1966; Lupton, 1996). This may be because doctors historically have been primarily men (Coney, 1994), so they do not have the experience of taking or not taking HRT during menopause. Either way, doctors are firmly viewed as technical experts in menopause. As a result, Malone uniquely calls attention to her experiences, therefore rejecting the idea that as a doctor she should only present information through science. Furthermore, by centering experience, Malone amplifies the
importance of experiential knowledge in the discourses of menopause instead of relying on her technical authority. By amplifying an experiential lens, Malone encourages sharing information about menopause from a first-person account. As a result, the significance of role reversing in blurring the lines of technical and experiential authority is a way to amplify experiential conversations in topics that are heavily constructed through a technical lens.

Critical Perspective

An important form of consciousness-raising is a critical perspective, wherein women see how their experiences are made difficult by oppression and discrimination. Throughout the podcast, Obama and Malone problematize their experiences of menopause in ways that allow the audience to see a critical view of the ideological and material expectations placed on menopausal women. This is done in three distinctive ways: first, the use of self-reflection around the ideal of menopause equips the audience with the vocabulary to talk about it. Second, using critical consciousness creates the possibility to question dominant discourse. Lastly, using a critical perspective reveals how experiences of oppression or discrimination are not isolated to single individuals, but instead are collectively felt. Each of these strategies of a critical perspective helps to reveal how the biomedical articulation of menopause is inconsistent with lived experiences and challenges the shame and silence around experiential discussions of menopause.

Self-reflecting on experiences with a critical perspective connects gender inequality with lived experiences and, most importantly, equips the audience with the vocabulary to talk about it. In the podcast, Obama and Malone use critical consciousness to discuss the experience of menopause and give the audience new vocabulary about the gender inequality women experience at work due to menopause. During a discussion of experiencing a hot flash in a professional work environment, Malone states:
down to your core in the middle of a freezing cold office and have to shower and change
clothes and fix your hair all over again [exasperation in tone]. There's a lot of stuff that
women need to talk about. So, some, some of these cultural norms need to change,
[Obama interrupts and agrees] like how you dress, the temperature in the room. But
again, if we're trying to hide this stuff right and we're not talking about it, that doesn't
mean you bring it up in the meeting. But it's like we've got to be aware that this is
happening. If it's happening to women beginning in their 40s, the whole system of the
workplace doesn't work for us in the right way. What a woman's body is taking her
through is important information. It's an important thing to take up space in a society
because half of us are going through this (Obama, 2021, 323-332).

Malone connects that the experiences of menopause in the workplace are made harder because of
the secrecy around menopause and the avoidance to discuss it. Ussher et al. (2019) state that
women are often entrenched in a discourse of silence and secrecy because of the negative
stereotypes of older women and seeing menopause as a sickness. In the workplace, women often
avoid talking about or disclosing their menopause to coworkers because of a fear of seeming
incompetent (Atkinson et al., 2021). More specifically, Atkinson et al. (2021) claim that the
cultural construction of menopause as a disease prevents discussion of menopause at work
because of the fear that management is going to see them as incompetent or too old to do their
job effectively. As a result, due to perceived incompetence and old age, the shame around
menopause reinforces women not to discuss their experiences at work, especially if it impacts
their ability to do their jobs. The secrecy of menopause leads to an absence of discussing the
experience of menopause more openly, pushing it to only be discussed in the private or technical
sphere. Because menopause is pushed into the private sphere due to the perceived shame of
discussing it, women have a challenging time negotiating how to bring menopause into a public dialogue. Malone similarly struggles to negotiate where menopause should be discussed at work, but underscores the gender inequality that women experience in their 40s due to the shame around menopause. Thus, Malone's critical consciousness regarding how the workplace is set up for women helps the audience build the vocabulary around menopause and its relationship to taboo avoidance. Sowards and Renegar (2004) argue that making critical connections starts a conversation about topics never before discussed and gives people a vocabulary around the topic “because once something has been named and described, it can become the target of social change” (p. 546). Malone, though she struggles with naming how to combat the taboo avoidance, does equip the audience with seeing the connection of how experiences of menopause are made difficult by gender inequality in the workplace. The critical perspective helps to open new conversations around taboo topics, thus challenging the avoidance of discussing them and equipping the audience with the vocabulary to discuss it.

A critical perspective also provides an opportunity to question the dominant ideals around gender and their impact on individuals' experiences. During the interview, Obama points out that the narratives of menopause teach women that the experience is shameful. In doing so, she shows the audience that the shame around menopause is a dominant ideal that does not reflect lived experience and starts to question why it is this way for menopausal women. In a discussion about the lived experiences of menopause Obama states:

When you think of all that a woman's body has to do over the course of her lifetime, going from being prepared to give birth to actually giving birth and then having that whole reproductive system shut down in menopause. Right. That changes the highs and lows and the hormonal shifts. There is power in that. But we were taught to be ashamed
of it and to not even seek to understand it or explore it for our own edification, let alone to help the next generation (Obama, 2021, 357-363).

Obama points out that many women are uneducated about menopause and are taught to see menopause as shameful. Being uneducated about the experience of menopause may be because it is often discussed in complex, technical jargon so women without the technical knowledge are unable to understand it. Menopause is primarily discussed through a biomedical lens marked with complex, technical jargon which is often not accessible information for women because it is hard to understand for those who do not have access to the technical language and knowledge (Lyons & Griffin, 2003). Furthermore, the biomedical lens of menopause casts the experience as negative, and that women should avoid it through cosmetic means and avoid mentioning it in conversation (Krajewski, 2019b). Women have stated that the taught technical and biomedical view of menopause does not represent how they experience menopause (Perz & Ussher, 2008). Additionally, women have repeatedly reported and expressed relief that their experiences differ from what they were taught (Joffe & Bromberger, 2016; Ussher, et al., 2015). As a result, the narratives of menopause from which women learn highlight a pessimistic biomedical lens instead of a realistic view of menopause which can be negative, positive, and neutral. By calling attention to the shame around menopause, Obama highlights that it is a collective experience rather than individual. Dubriwny (2005) states that the Redstockings Abortion Speak-out let women voice their frustrations regarding the medical establishment and how its viewpoint of abortion was inconsistent with how women felt. The critical consciousness leads the women to question the information given by the dominant medical discourse. Similarly, Obama calls into question why women are uneducated and ashamed of menopause, thus challenging the shame around the topic of menopause and encouraging the audience to be critical of the negative
viewpoint of menopause. Utilizing a critical lens allows the audience to see how dominant discourse does not reflect lived experiences and allows them to challenge shame around the topic.

A critical perspective also provides an opportunity to recognize that material experiences of oppression or discrimination are not isolated to single individuals (Sowards & Renegar, 2004). As mentioned previously, during the interview, Obama and Malone talk about function as an understanding of health rather than form – or in this case, thinness. Not only does this passage allow Malone to redefine information to point out that the material expectations around health are inconsistent with women's actual experience of health, but they also show the audience that gender inequality around health is not an individual experience, but a collective experience. In a discussion about aging and weight gain, Obama and Malone state:

Obama: I think, well, what's what being healthy means for women, period. And we've always talked about how there's so many conflicting messages out there about weight, about mostly about weight. Right. First of all, because it seems to be that that's the only thing from a PR standpoint that people tend to care about. But we don't sort of have a real clear baseline for what health means for a woman.

Malone: Women's value goes up with how little space you take up, you know, so the smaller you can make yourself, the the higher perceived, you know, socioeconomic group that you're in, whatever it's all about being thin. But you're right, being thin and being healthy are two completely different things. I'm going to focus more on function than form. And, you know, so what you look like and how much you weigh is less of an issue, particularly as you get older, because the question is, what can you do? What's your function level like? (Obama, 2021, 416-430).
Above I pointed out how this passage functioned as an illustration of a technical expert, Malone, appealing to experiential knowledge, thus highlighting the importance of experiential knowledge for a full understanding of a person’s health. In the context of the current argument, this passage shows that the conversations around health that emphasize weight are not individually felt but instead function systemically. Because doctors are frequently the gatekeepers of women’s health advice, information is often based on what doctors perceive as best rather than what women feel (Murphy, 2012). For instance, as noted in the introduction, in the 1950s in the US and Europe, birth practices transformed from women-centric, where squatting was the norm, to placing women in stirrups, where they were required to push against gravity to deliver their children (Ehrenreich & English, 1993). As a result, large groups of women were forced to birth in an alternate way. Similarly with weight, the health risks associated with a larger body size and weight are often communicated as a scientifically based fact (Wray & Deery, 2008). The measure of health being weight-centric places large groups of women within a male-centric standard which does not consider how women may have different weight standards and still be healthy (Bordo, 1993). Ultimately, health being centered on women's weight places unattainable standards for women and instead places a male-centric and technical view of health on all women. By redefining what should be considered a measure of health, Malone brings attention to the fact that how doctors frequently view health for women is wrong. The conversation Obama and Malone have underscores that many women may feel the pressure to stay thin yet it is inconsistent with how individuals may experience health. By showing that health is collectively used against women to reinforce a thin aesthetic, the podcast reveals that oppression and discrimination based on health during menopause is a significant issue. Ultimately, encouraging the audience to see how their lived experiences around health and material weight are
collectively experienced thus illuminating the interconnected nature of oppression and inculcating a more critical perspective on the world (Sowards & Renegar, 2004).

The Limitations of Podcasts as Consciousness-Raising Devices

The dominant discourse of menopause, as framed by biomedicine, is steeped in shame, inaccessible to non-medical experts, and inconsistent with women’s personal experiences. The podcast, as a result, challenges these problems through consciousness-raising. Through the forms of narratives, blurring the lines of expert and experiential authority and a critical perspective, the podcast reshapes menopause information to be experiential-centered. Ultimately, the experiential-centered discussion throughout the podcast invites the audience to participate in a highly medicalized topic because it illustrates that without experiential knowledge, information about menopause is incomplete. Nonetheless, while at points, the podcast functions as a consciousness-raising device that helps the audience understand menopause through an experiential lens, there are shortfalls because it features only two people.

Podcasts are frequently considered to be a medium that creates space for multiple perspectives. However, throughout the podcast, Obama and Malone exhibit multiple risks of seeing podcasts as consciousness-raising spaces. The podcast “What Your Mother Never Told You” (2021) is formatted in a way that highlights a conversation between two people where there are no differing experiences or opinions. The podcasts exhibit two risks of consciousness-raising that impact the audience's ability to connect with the discussion: first, the podcast exhibits a monolithic portrayal of menopause, and second, the podcast has a distinct lack of disagreement. Ultimately, the podcast cannot collectively discuss menopause, which can lead to the alienation of an audience because the audience may have incongruence with what is being said.
A monolithic portrayal of experiences is frequently a risk of consciousness-raising, wherein diverse experiences are unable to be represented or seen in the discussions. Bessette's (2013) discussion of the Lesbian/Woman book notes that the monolithic picture of middle-class, gender-conforming lesbians excluded and alienated lesbians who did not conform to the values represented in the book. Similarly, Obama and Malone exhibit a monolithic portrayal of menopause because they have experienced similar things. They continually focus on menopause in the workplace, specifically a workplace where women are expected to dress professionally, stating:

Obama: there's a lot of the functions of day-to-day life when you're going through menopause that just don't work [frustrating tone]. It's like how we dress. Wearing a suit [emphasized]. Any person who's going through menopause, who's going to work every day in a suit, you can be drenched in sweat [frustrating tone]

Malone: Yes, totally! down to your core in the middle of a freezing cold office and have to shower and change clothes and fix your hair all over again (Obama, 2021, 315-325).

The focus of menopause in a professional environment has the potential to alienate women who do not fit this notion of experience. Because the podcasts only highlight two people's experiences of menopause and they are similar, it misses the opportunity that collective rhetoric uniquely brings to consciousness-raising wherein the presence of multiple participants creates a space where differences are highlighted and underscored to understand how individual experiences are different (Murphy, 2012). To avoid a monolithic portrayal of menopause, there needs to be a more diverse set of experiences. Hayden (2018) states that the collective participation of individuals creates an always-transforming text that shapes meaning through the inclusion of many voices. By the inclusion of multiple experiences of menopause, there would be a more
well-rounded understanding of how menopausal women experience barriers in a diverse set of environments. As a result, by having multiple storytellers, there would be a greater chance for the audience to see the relevance of information and make the experience of menopause more widely talked about. The podcast ultimately promotes an understanding of some experiences of menopause, specifically menopause in a professional workplace, but those who differ are excluded, unable to see their experiences represented leading to a continued absence of it from discourse.

Furthermore, the podcast exhibits a risk of not having disagreement which may further alienate audience members who have dissenting opinions. Dubriwny (2005) points out that the Redstockings’ 1969 abortion speak-out helped the group of women attending conclude around repealing abortion laws. However, as Hayden (2018) points out, because of the universal nature of the speak-out’s conclusions, there was no place for disagreement or alternative views around the experience of abortion, having the potential to alienate women whose attitudes toward abortion differed from the conclusion to which the group came. Similarly, in the podcast because there is no one to push back on Obama and Malone’s beliefs, there is a possible alienation of audience members who do not think the way they do. Particularly, in a conversation around menopause being a fresh start for women, Obama and Malone underscore that menopause is a time of new freedom, stating:

Malone: after you've given birth, then your children become your priority. So, you know, still there's still this point at which. You kind of say, all right, when is it my turn and this is I think the good news about menopause is that. Even though getting there is complicated, you know, it may be the first time in a lot of women's lives when you're not tied down by the other things that are that are just part of your day-to-day life, the notion
of trying to present yourself. To someone other than your truly authentic self kind of fades away.

Obama: Yeah,

Malone: You know,

Obama: Yeah,

Malone: You just get to say, you know, this is this you know,

Obama: I have changed and tried to adapt, and I've been accommodating, accommodated my husband, accommodated society, have accommodated my children. Now I'm done. phew!

Malone: When I turned 60, I said to myself, you know, I'm going to give myself this gift and the gift is I'm going to say yes to everything. I want to say yes to and no to everything. I don't and I don't think I have ever in my life given myself permission to do it (Obama, 2021, 365-389).

Obama and Malone have a similar viewpoint of menopause being a time of peace for women wherein they have fewer responsibilities. Without disagreement or a push back on this viewpoint, Obama and Malone are unable to see how audience members may disagree because the two of them have similar lived experiences of menopause to each other. Murphy (2012) argues that during consciousness-raising, groups in California in the 70’s frequently disagreed with each other. In doing so, women attending learned to reflect on their own biases and question personal beliefs around the medical institution. By presenting or disagreeing with each other, Obama and Malone would have the ability to question why menopause may not be a time of relief from responsibilities and question why they personally believe it is. Ultimately, a lack of disagreement during consciousness-raising has the potential to alienate audience members who
have dissenting opinions and impacts the rhetors ability to self-reflect on personal beliefs. To avoid a lack of disagreement, a more collective rhetoric around menopause is needed where the audience can actively interrupt, agree, or question information to represent multiple experiences. As a result, the processes of consciousness-raising in the podcast provides an opportunity to discuss menopause in a productive way, but has the potential to alienate the audience if they have dissenting views than the one represented.
Chapter 3: Conclusion

In this thesis, I have argued that the podcast “What Your Mother Never Told You” (Obama, 2021) employs consciousness-raising in a similar way to how other scholars have argued, employing experiential-centric language and argumentation to center women's experiences of menopause. By centering experiential knowledge, the podcast combats technical understanding, pushing back and adding context to it. In essence, the podcast used consciousness-raising similarly to how Campbell (1973) and Sowards and Renegar (2004) argue, meaning that it is moving outside of the private sphere and into the public through mass-mediated communication. Podcasts become a conversation space where individuals can discuss their marginalization, centering personal experiences in a mediated way like consciousness-raising in magazines, blogs, and books. As the public sphere becomes more inundated with podcasts that tackle topics of conversations, typically secluded to the private and personal sphere, it is essential to see how they contribute to consciousness-raising. In Florini’s (2015) study of Black podcasts, they state that podcasts are a unique space because they draw on community communicative processes and “unapologetically represent the fullness and complexity of Black American experiences” (p. 217). In other words, podcasts, because of their conversational aspect, present the ability to be candid about marginalization that may not be in present other forms of media; thus, studying how podcasts produce consciousness-raising is imperative. It is another way to talk about marginalization that is becoming more popular.

Nevertheless, as I have argued, the podcast under examination in this thesis ultimately promotes an understanding of some experiences of menopause by highlighting personal narratives and challenging the technical understanding of menopause. I have also argued that the experiential lens of the podcast challenges the shame, inaccessibility, and incongruence of
experience within the technical construction of menopause. The conversations Obama and Malone have throughout the podcast provide the ability to see how consciousness-raising shifts discourse around a topic heavily discussed in a biomedical lens to an experiential lens. The biomedical lens of menopause casts it as shameful and uses complex, technical jargon that limits the accessibility of information (Lyons & Griffin, 2003) leading to an inability to discuss menopause openly. By creating a space where experiential knowledge is the set precedent, the podcast reveals a shift in menopause discourse wherein experience is seen in tandem with technical knowledge. As a result, reframing, adding and challenging technical language through an experiential-centric lens makes information more accessible and encourages listeners to explore their own personal experiences. Hayden (1997) argues that the Boston Women’s Health Book Collective participated in consciousness-raising wherein they helped their audience come to their own conclusion because “the authors believe that each woman's experiences are unique, they do not tell women how to work for change. Instead, they provide suggestions for how to engage in group action when and where the readers feel change is needed” (153). Similarly, Obama and Malone largely stay away from stating that menopause is experienced one way; instead, they underscore the uniqueness of individuals. As a result, the listeners can overhear the podcast, gain vocabulary, and understand the accessible information presented so that they are able to come to their own conclusions about their experiences of menopause.

However, I have also pointed out the limitations of the podcast format; specifically, the limited number of people in conversation potentially obscures the diversity of the menopause experience. Malone and Obama acknowledge that every woman’s experience of menopause will be unique, they are only able to offer experiential evidence from their own perspectives. For listeners in similar situations to the rhetors, the podcast may raise consciousness around their
experiences with menopause; for women differently situated, it is unlikely to function as well. Nonetheless, the very acknowledgement that women’s experiences differ may function to invite women who are differently situated to explore their own experiences. Podcast hosts whose goals include promoting such individual reflection might want to consider inviting guests with diverse experiences to join them in conversation.

In utilizing consciousness-raising and the spheres of argumentation, it is evident how important it is to explore implications of the experiential-centric lens, which places personal testimony and experiences in tandem with technical language. As this paper has revealed, utilizing a technical expert who has personal experience reveals new ways that authority within the spheres can function to create a more experiential lens. Malone’s choice to speak both as a technical authority and an experiential authority suggests that the two forms of knowledge are both necessary to understand what menopause means and how conversations around menopause function. Other scholars have argued that for experiential experts to have authority in the public sphere, they adopt technical language to be taken seriously and to utilize the technical authority (e.g., Blok et al., 2008; Johnson & Quinlan, 2015). As this paper showed, technical authority can also use experiential authority, thus legitimizing a more experiential view and showing a new way to center experience in the public sphere. The podcast’s ability to blur the lines of technical and experiential authority makes it easier for experiential experts to engage in discourse because it sets a precedent of experience wherein a technical expert validates and supports experiential-centric learning and knowledge. As a result, the choice Malone makes to center her experiential knowledge in addition to her technical knowledge means that the norm of discussing menopause through only technical language is shifted, allowing more lay people to engage in discourse with authority.
Ultimately, by speaking through experience and technical expertise about an issue related to women’s health in the public sphere, Malone and Obama both show that menopause should not be relegated to only the personal or technical sphere – it should be discussed in public. Furthermore, speaking through experiences also shows that each sphere is unable to capture the full experience, thus the interaction of personal and technical needs to happen. This illustrates that technical experts that use experiential knowledge and language can create a bridge of information leading to experiential experts' ability to engage in topics that are highly technical, such as menopause. Dubriwny (2005) argues a result of blurring the lines of orator and audience. Similarly, blurring the lines of experiential and expert authority allows meaning-building to happen through an equitable lens, thus helping more people to engage in discourse with accessible information. Ultimately, there is a continued importance of discovery on how the personal and technical sphere function in the public as it reveals more ways that experiential knowledge can be utilized within highly technical discourse, such as women's health.

Rhetorical scholars should continue to examine unique spaces where consciousness-raising takes place over time. Many aspects of how women's health is discussed continue to be dominated by technical experts and experiential knowledge is pushed aside. As this paper has shown, there has been a substantial change in how experiential and technical experts create rhetoric together to situate an experiential precedent of knowledge; thus, it is imperative to continue to examine how it functions. The uniqueness that is offered in discussions of women's health that utilizes both an experiential expert and an experiential expert with a technical background cannot be overstated in its ability to challenge the biomedical standard. Ultimately, it allows experiential experts to gain authority in the public sphere without having to learn and adopt rigorous technical language since the technical expert does that for them. Thus,
consciousness-raising that can utilize such a background while emphasizing experiential knowledge will continue to be important in bringing experience into conversation with technical understanding to help understand the ways in which biological and cultural views impact women.
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1 Until recently, feminist health activists and scholars used the term “woman” excluding trans men and non-binary people. It is important to acknowledge the limits this term has, but in the interest to stay uniform with cited texts and participants within the artifacts, which self-identify as women, this paper uses the term women but encourages readers to understand that trans men and non-binary people also go through menopause.

2 “On January 16, 2018, an army of survivors took over a small courtroom in Lansing, Michigan, and delivered 156 impact statements at the sentencing hearing of Larry Nassar. As an athletic trainer for USA Gymnastics and an osteopathic physician at Michigan State University, Nassar sexually assaulted hundreds of female athletes—most of them minors—while fellow coaches and administrators ignored allegations of his abuse for decades. In 2017, after he was sentenced to 60 years in federal prison on child pornography charges, Nassar pled guilty to multiple counts of sexual assault. In an unprecedented move that drew national media attention, Judge Rosemarie Aquilina cleared her docket at the Ingham County courthouse and invited Nassar’s victims to speak for as long as they wished before she handed down her sentence. While the hearing was initially expected to last four days, the number of survivors asking to participate rapidly multiplied—each voice of testimony emboldening another survivor to join their ranks” (Gibson, 2021 p. 1).

3 The podcast had a public domain transcription, which was then cleaned by the author, wherein filler words were added.