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The Shaping of Midlife Women's Views of Health and Health Behaviors

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Abstract

The menopausal transition is a marker of aging for women and a time when health professionals urge women to prevent disease. This research adopted a constructivist inductive approach in exploring how and why midlife women think about health in general, about being healthy and about factors that influence engaging in healthy behaviors. The sample constituted 23 women who had participated in a Women's Wellness Program intervention trial and subsequent interviews. The women described lives of healthy eating and exercise. Yet, their perceptions of health and healthy behavior at midlife contradicted that history. Midlife was associated with risk and guilt at not doing enough to be healthy. Health professionals provided a very limited frame within which to judge what is healthy. Mostly this was left up to individual women. Those who were successful framed health as "being able to do what you want to do when you want to do it." This article presents study findings of how meanings attached to health and being healthy were constructed through social expectations, family relationships and life experiences.

Key Words: gender; interpretive methods; menopause; midlife; risk; risk, perceptions; women's health; women's issues

The menopausal transition is a marker of aging for women and a time when health care professionals exhort women in earnest to avoid chronic diseases by engaging in specific health behaviors. With 20 percent of Australian women reporting cardiovascular disease (CVD) and 53 percent of the CVD deaths in the United States occurring in women (Australian Bureau of Statistics, 2006; Centers for Disease Control and Prevention, 2008), behaviors linked to cardiovascular risk, including obesity and inactivity, receive particular attention (Dennis, 2007; Im, Chee, Lim, Liu, & Kim, 2008; Lewis & Cachelin, 2001; Sternfeld et al., 2004; Williams, Germov, & Young, 2007). Interventions designed to prevent, delay or control cardiovascular and other chronic diseases seek to provide women with knowledge, skills and opportunities to improve eating habits, physical activity and other lifestyle behaviors. Research then tests the effectiveness of these interventions (Anderson, Mizzari, Kain, & Webster, 2006; Jackson et al., 2005; Linnan et al., 2005; Nies, Chruscial, & Hepworth, 2003; Nitz & Choy, 2007).

Several implicit assumptions underlie health promotion intervention and research efforts. First, aging is "successful" if chronic diseases can be prevented (Britton, Shipley, Singh-Manoux, & Marmot, 2008; Peel, McClure, & Bartlett, 2005). Second, health promotion/disease prevention/aging well are universally shared values. Third, individuals can and should be responsible for their health behaviors. Finally, all individuals would act in a health promoting fashion if barriers to individual action were removed and sufficient support for behavior change provided. A systematic review of published research articles on health promotion at retirement found these assumptions repeated often enough to be labeled themes (Wilson & Palha, 2007). In an exploration of how health care space is shaped Cheek (2009) concluded by encouraging qualitative researchers to explore the assumptions and modes of thought that impact the way that people think and speak about health.

The notion of individuals as agents responsible for their behaviors underpins models and theories of health promotion used for most chronic disease prevention programs (Fishbein et al., 2001; Pender, Murdaugh, & Parsons, 2005; Prochaska & DiClemente, 1992; Weinstein,

Rothmann, & Sutton, 1998). The social context in which behaviors occur is treated largely as a secondary factor. For example, although Bandura's (2004) Social Cognitive Theory acknowledged that individual behavior does not occur in isolation of the social environment, this connection and social factors affecting health behaviors have not been targeted in most health promotion programs developed from this theory. This is no doubt a result of the underlying assumption that chronic diseases can best be prevented if individuals are persuaded to exercise control over behaviors linked to health (Lupton, 2003). An additional and related factor that receives even less attention is how individuals respond to, experience and think about health promoting behaviors as part of their everyday lives.

There is some evidence that the targets of health promotion intervention programs do not share the same assumptions as those who design and operationalize the programs. For example, a focus group study of older adults found that they placed little emphasis on the absence of chronic disease or disability as a necessary condition for successful aging (Reichstadt, Depp, Palinkas, Folsom, & Jeste, 2007). In addition, study participants spoke of the connection between physical disease and social factors, such as support (Reichstadt et al., 2007). This representation suggested that social processes shape specific behaviors as much as an ability to exert control over the body (Wray, 2007).

Where the voices of participants in health promotion programs are heard it is usually for program evaluation purposes. Programs are deemed successful if individuals report specific changes to health behaviors (e.g., eating fewer calories) or related outcome improvements (e.g., decreased pulse and blood pressure). That is where this interpretive study began; its initial purpose was to determine if women who had completed an intervention program based on traditional health promotion assumptions had brought about sustained changes in eating and exercise patterns. As the study unfolded, the focus shifted to why and how women frame perceptions about health behaviors. Ultimately the research came to explore how these women think about health in general, about being healthy and about factors that influence their ability to

engage in healthy behaviors. Eliciting midlife women's perspectives on health is important to researchers and clinicians in framing studies and interventions.

Methods

A constructivist, inductive methodology (Charmaz, 2006, 2009) guided all aspects of this study. The inductive component draws on the classical grounded theory method of Glaser and Strauss (1967). The constructivist influence is in the understanding that knowledge is socially produced and thus participant meanings are situated within broader social institutions.

Women to be interviewed were selected from those who had participated in a randomized controlled Women's Wellness Program (WWP) intervention trial as a member of either the intervention or control group. The original sample has been previously described (Anderson, et. al., 2006). The present study was part of a larger project investigating whether the health behaviors of women involved in the WWP were sustainable over time. All procedures and materials in this study were approved by the Queensland University of Technology ethics committee prior to commencing the study.

Ninety women who completed the WWP were mailed a letter inviting participation in this study as well as a consent form describing the potential risks and benefits of participating. The women were asked to return the consent form and indicate whether they were willing to be contacted for an in-person interview.

Initial responses to the mailed questionnaire yielded 10 ineligible women: five permanently withdrew from the study, 2 had moved out of the area and 3 questionnaires were undeliverable. Sixty women returned the consent form for a response rate of 75%. Of these, 44 (73%) agreed to be interviewed, 33 were contacted and 23 were interviewed, 12 of whom had been in the Women's Wellness Program intervention group and 11 of whom had been in the control group. Those willing to be interviewed were purposively sampled so that both women who had made health behavior changes and those who had not were interviewed. Women contacted but not interviewed were unavailable for a variety of reasons including travel and family and personal illnesses.

Participants in the current study were between 57-66 years of age with a mean age of 61. The majority of women were married or partnered, retired with annual income above $40,000 and a high school education. All were White.

Initial interview questions focused on types of changes in eating and exercise behaviors the women had or had not made and facilitators of and impediments to change (or lack of change). Interviews were audio-taped and transcribed verbatim by the first author.

Data collection and analysis were concurrent. In the inductive analytical process, the initial coding saw the disaggregation of individual words, phrases and sentences in the data and the identification of concrete codes. Focused coding (Charmaz, 2006) followed whereby key analytical directions were identified which shaped subsequent interviews. Analytic and self-reflective memos were written after each interview and throughout the coding process. This ensured that abstract analytical ideas and analytical connections were captured as they appeared and that each analytical phase was transparently related to previous and subsequent phases. Codes and categories were collaboratively analyzed by the first and second authors using the constant comparison method.

The constructivist methodology guided the on-going development of the interview format (Bryant & Charmaz, 2007; Charmaz, 2006). For example, early in the analytical process it became evident that enacting healthy behaviors was not merely individually constructed from sufficient information and will power but also constructed within prevailing social structures. Thus the final analytical process moved the analysis to a deductive phase for the theoretical exploration of key categories as social construction reproducing current social conventions or power relationships (Charmaz, 2006; 2009). The goal was to answer how and why participants constructed meanings about health and health behaviors in general as well as in specific situations.

Results

"I Have Always Been Healthy"

When asked about healthy eating and exercise, responses were encapsulated in the statements “I always ate healthily” and “I always exercised”; activities that were integral to daily living. Early life was frequently described as simple, one in which the women did not focus on being healthy but “always ate healthily” because much of the food they ate was locally produced, either at home or nearby.

> We lived on a farm and ate our own produce. We ate basic stuff.
>
> The food was different then. Dad used to grow a lot of his own vegetables. We didn’t have preservatives and things.

In addition to eating healthily, the women had “always exercised”, whether as part of family and school activities or because the main form of transportation was walking.

> In my time there weren’t parents dropping you here, there and everywhere. We walked everywhere. And we never thought about how far it was. We just wanted to get there. And you didn’t realize you were exercising.

> It wasn’t a big thing when I was growing up to think of exercising as healthy. When I was growing up we just played outdoors. We were encouraged to be outdoors: ride bikes, swim, play. We never spent any time inside the house. Then in my 20s when I had my own home it was always out until the sunset raking or gardening or whatever. I don’t sit down a lot. I’m always doing something.

There was also a strong sense that eating and exercise habits, as they evolved over the course of a life, have continued to shape behaviors and practices.

> We just always ate at home, plain family meals which is what we’ve become accustomed to. And over the years it’s just evolved from that.

Yet, despite numerous references to always being active and always eating well, there were many expressions of feelings of guilt and depictions of the self as lazy, particularly in regards to exercise. One woman repeatedly described herself as lazy even though she walked 40 minutes every day and saw herself as fit compared to others. Another described herself as always being active, playing soccer until age 45, in earlier years windsurfing and playing tennis with her children and now routinely walking in the mornings with her husband. In addition, vacations were still organized around hiking expeditions. Yet, this woman repeatedly stated, "I'm just lazy." When talking about eating patterns she said, "I doubt I would change much because I'm fairly convinced that what we eat is fairly good."

KL believed she was not exercising enough despite walking as part of her every day activities and walking all day when traveling. On the other hand, MN who has "always walked" and now played golf 3-4 days a week stated that she had enough exercise raising 3 children of her own and 3 of her brother's and doing all the associated housework. "I don't think I lack exercise."

"Unless You're Living Under a Rock you Know you Need to Exercise"

The above responses indicated that women were exposed to information about the association between exercise and health. Yet, that information did not appear to provide a frame for evaluating whether a level of physical activity was sufficient to live a healthy life. Women are living longer than ever before; yet exhortations about adopting healthy lifestyles are more frequent. Messages that health is produced by behaviors for which one is individually responsible are hard to miss.

> But I did feel good to do that hour of exercise every day. And I felt good because that's what you are supposed to do. I didn't feel good within myself physically, it was all psychological – oh, you have to exercise, oh, I'm doing my hour a day; I am a good girl.

> Yes, they've had a big ad campaign on TV, about 30 minutes a day. I assimilate the information but whether I act on it is a different thing. I feel guilty when I don't exercise – and I think part of that guilt is brought about by the media . . . the media will say you should do this and should eat that . . . that creates a bit of a guilt complex for people.

Building on the early expressions of exercising and eating well because "I always have", ensuing interviews asked women to describe their ideal healthy state. In the first instance, health was characterized as multidimensional.

> I probably formerly would have thought that health was just absence from disease but I know how upset you can feel when you might be physically fine.

> Oh, physical activity (and) healthy includes psychological as well as physical doesn't it . . . feeling happy and fulfilled.

> Mind, body and spirit.

Beyond broadly defining health, a major theme was elicited; health as being able to do what you want to do when you want to do it.

"Being Able to do What you Want to do When you Want to do it"

Views about health were developed within the context of life experiences, as women, as wives and as mothers. Thus, health behaviors changed over the life course depending on the demands of any given time. We see that gender role expectations often constrained the ability to engage in exercise.

> Before I was married I played basketball but once you get married you stop doing things like that. After I got married I played squash with my husband.

> Then when I had children I found you're pretty confined, but then I used to play tennis with a group and I'd say the worse time for exercising in my life was when I went back to work when the children went to school because you run out of time.

Child care responsibilities, especially before children were in school, limited opportunities for exercise for many women. For others, new opportunities occurred. SH, who had been physically active all her life, started to play field hockey at the age of 39 because, watching her children play, she and another woman decided to play and started a team. Arthritis caused her to stop playing at the age of 57 and at 60 she maintained involvement by managing 2 hockey teams. Children also prompted UV to exercise but for different reasons.

> I started going to a gym in my 30s probably because when you have kids you want some sort of social interaction . . . a bit of social interaction and some exercise.

Women talked about transitions faced at this life stage – retirement for self or husband, aging parents, their own aging, children growing, grandchildren – and the adjustments required to be able to do what they wanted to do when they wanted to do it.

> I just want to feel energized and just general well-being for a person my age. I want to be able to chase the grandkids around. I've always been a very active person and I want to try to continue to be like that. I want to maximize the good health that I can keep for as long as possible so I can do what I want to do.

"I Think This has got to Change, but it Doesn't"

The extent to which women adhered to socially dominant gender roles appeared to affect their capacity to engage in healthy behaviors as they defined them. Of the women interviewed

those who viewed health as being able to do what they wanted to do when they wanted to do it had generally negotiated a role which allowed them to meet their own needs.

Woman WD articulated that her family came first and yet she had also established her own identity which she felt elicited greater respect from her children. She described her husband as supportive and noted he created some of the conditions to "allow" her to take a more independent role. The expectation that one put the needs of others first, indeed only being "allowed" to take care of self after having taken care of others was echoed by other women.

> I probably need to say no a bit more to people.

A woman who worked full time, cared for aging parents and had a daughter living at home had this to say:

> Well, you know, sometimes there are things you feel like you should do [based on extended family expectations] and I'm starting to think now, do I want to? If I don't really want to do it I won't. That's something I've never done. I've always done other things first. When you've not done that for most of your life, it's not easy.

"Life is Complicated, Isn't it"

It was difficult to sustain healthy practices if one's partner did not; living with someone who was supportive was important. QR had retired but her husband was working full time and dictated their activities. She said his being busy "holds her back." Conversely, a woman who was the breadwinner with her retired husband taking on home responsibilities found little opportunity to exercise because her husband resented her going to the gym after working all day. She made several unsuccessful attempts to negotiate a solution.

> When I get home he complains that I'm at the gym all the time. I think, well, at my age, if I can't go to the gym when I get home from work when am I going to be able to?

KL expressed frustration and resentment with the expectations imposed by her husband. Interestingly, she indicated the only factor that she felt she had control over was her food [she was overweight]. Similarly to other women, she expressed the desire to negotiate roles and responsibilities with her spouse but did not believe he was willing to meet her half way. For her, having her husband around meant she could not be healthy or do what she wanted to do when she wanted to do it.

> With the kids gone, there's just your husband and yourself to worry about. If I was on my own I'd be better still. He's doing his thing; has a full schedule; he's just living his life . . . and I'm there, incidental. I have to be his secretary when he's doing work. With someone else you can't do what you want to do when you want to do it. I'm a retired housewife and that means nothing changes. I resent that he gets to do all the things he really enjoys doing most days and I'm still stuck with the washing and cleaning. You get to the point where you've really had enough.

UF learned early on that her life was to be one of looking after others and while raising 6 children she found little support for acting on her own desires. She started a walking program with her husband but stopped because not only did he use the time to berate her for not fulfilling his expectations at home, he also walked up and down hills whereas she preferred to walk on the flat. When they got home, he had a drink of water and took a shower while she dealt with the children. Rather than respond differently to her husband she gave up walking. She continued:

> I worked a lot of weekends so my husband had to look after the kids and that wasn't always good because he wanted me to prepare the meals so it was easy for him to feed them. And if I said, there's a tin of soup, give them a tin of soup. I was being lazy, so I don't know what he wanted.

She still considered herself "lazy" if she cooked a simple meal. This woman acknowledged the tension between her husband's expectations and her desires but was unable to actively confront this tension or negotiate roles because she learned early on that her role was to care for others. Instead she said they "laugh" about it.

"It's About the Balance"

Women who were most able to balance self care and the care of others were explicit about the constraints on individual activities that being in a relationship created. A woman with a mentally ill son stated realistically but reluctantly: "There are restrictions on what you want to do sometimes. I suppose you have to consider other people." Another cautioned to "not let the balance tip so that it's 100% external, so that everything you do is for someone else, and there's nothing left over for you." A third articulated the need to take the opportunity to meet her needs now that she finally had the chance.

> While you're raising a family you don't have time to think about who you are and what you like. I didn't know what I liked doing. And you can't make your husband your life either. I'm at the stage where I need to figure out how to be retired. I know I can't spend all my days at home.

TG discussed restrictions on her activities because of the social norms of not working and taking care of the children. She made very clear how powerful the constraints imposed by social expectations were and stated that she did not consciously act in certain ways to please her husband but that was just the way things were then. Now they were both negotiating the next life stage. Her husband helped around the house following retirement and although they shared many activities they also enjoyed independent pursuits.

SH, who negotiated roles with her husband to allow mutual independence, now worried about "being awful" to him by leaving to go to her activities [he had a "nervous" breakdown 4 years ago. He still worked but was exhausted on returning home and tended to just sit]. Even

with an illness and continued disability she had not moved into the role of 'doing for' her husband to the exclusion of meeting her needs.

> The doctors say he's 97% good but they don't live with him. If I don't ask him to do something and if he doesn't do it straight away it doesn't get done. I feel like I'm nagging him but it's the only way I'm going to get anything done. But anyhow . . . we've been married for 41 years so we've always been there for one another.

Another woman described how it felt when such obligations were lifted, in her case, caring for aging parents, "I feel this tremendous lightening. I'm going to work on getting some time for myself back into my life." Even though very aware of social constraints on women's behaviors she felt empowered to chart her own course.

> My mum left me with a tremendous amount of confidence. She always let me do what I wanted to do. We grew up in a wholesome environment where we were loved by our aunties and uncles and you do get the confidence within yourself for your ability rather than for anything else.

Women who expressed such confidence or negotiated their own agendas within social expectations occasionally found themselves at odds in negotiating their health within the healthcare system.

"I'm not the Greatest Patient in the World"

EF described herself as a "bad" patient when she decided to reclaim some of her own power to make decisions about her health. "I decided I didn't like taking medication. So I asked my doctor to wean me off them [HRT] very slowly." Women who maintained a strong sense of personal power were more able to choose desired behaviors.

Women who had been made to believe that they were the main problem, that is "noncompliant" women, had sought alternative health care providers to achieve health goals.

Experiences with allopathic health care providers who did not listen to her perspective on treatment plans prompted one woman to seek care from a naturopath. After discussing a troubling experience with allopathic medicine in the care of her now adult son when he was 18 months old, RI stated. "I've learned [about health behaviors] from people who have the drive to promote health rather than fixing something after it happens." Said YB with rheumatoid arthritis:

> Some time ago I did see a rheumatologist and he was keen for me to have anti-inflammatories and heavier pain medication which I totally didn't want to take and so I think he just wrote me off . . . and that's what pushed me toward a naturopath. I'm trying to explore other methods that might be helpful without being drug-related.

Doctors were not generally perceived as helpful in regards to outlining specific actions to improve healthy behaviors. QR had talked to her doctor about weight and yet he offered her no advice or support in losing weight. "It's never been a big issue probably because I go to him for other things" . . . and she listed medical diagnoses.

> I think it's really important that health care be based on a 1 on 1. If I had somebody, like a health care professional, who was really helping to motivate me and keep me focused it would help. I think that's probably the key – someone is interested in you and working with you on your issues only.

ZA indicated that her doctor had told her to "try" and lose weight without any suggestion about what those efforts might entail. DB had a similar experience. "When I go to the doctor, the first thing he does is weigh me and then tell me I need to get rid of my midriff to help with the diabetes." This pronouncement failed to motivate her. Another stated that she *should* walk more because her doctor told her to (in addition to telling her to lose weight) but that "I do what I want to do; I'm happy." And UU echoed that sentiment saying she did not exercise because she "should" or "was told to" but because "loves it" and "it feels good."

> You've got to have some enjoyment. You never know what's going to happen tomorrow. I'd say this has been the most stress free time of our whole life. That may change as we age but we're appreciating it.

The alternative definition of an ideal healthy state, expressed by some women, was epitomized by absence; for example, "not taking medication" or "not having illness" either in general or a specific condition such as "free of asthma", "no sinus", "no arthritis", "no pain." Those who conceptualized health more narrowly as the absence of illness more often fulfilled their gender roles in accordance with others' expectations.

Discussion

At the outset, this interpretive study sought to determine the extent to which women who had participated in an intervention program to reduce cardiovascular risk factors adopted healthy behavioral changes. The initial purpose left unchallenged the assumption that the onus of responsibility for health lies with the individual. However, early in the data analysis, the social environments of the participants emerged as the framework within which the women made sense of the concepts of health and healthy behaviors. Locating the participants' behaviors within larger social structures and discourses broadened the research focus and enabled an analysis of how midlife women think about health in general, about being healthy and about factors that influence their ability to engage in healthy behaviors. The women described how their awareness of health and health behaviors as well as their ability to engage in such behaviors changed over the life course. Contradictions were exhibited in definitions of health, the location of authority over health behaviors and in how gender roles were negotiated.

The women in this study described always eating healthily and exercising when growing up regarding these behaviors as a routine part of daily life which they largely took for granted. In contrast, every woman in this study was now fully conscious of persistent messages to actively promote health with behaviors focused on smoking cessation, exercise and diet. It is difficult to pass a day without being reminded by acquaintances, the media, and health professionals that

health is fragile and at risk. Individuals are expected to safeguard, control and care for health or accept the consequences – at the very least social disapproval, and possibly illness.

This focus reflects the value that modern society places on health and the continued emergence and consolidation of health as one of the guiding mantras of both governments and individuals (Adam & Loon, 2000; Cheek, 2009). At the same time that people are generally living longer lives health is seen as precarious, problematic and at risk (Furedi, 2002). The association of health and risk appeared along with the awareness that many life-threatening diseases are caused by a combination of several lifestyle factors, such as smoking, obesity and inactivity (Petersen & Wilkinson, 2008). This association was consolidated as health promotion became a distinct field of clinical practice. Interventions aimed at reducing risk factors for disease are now the central targets of health promotion efforts and they are held up as the prime targets for human control and action (Skolbekken, 2008).

The discourse on risk, although not overtly articulated, underpinned the conceptualization of health in this study. This discourse reflected what Furedi (2002) referred to as a cultural shift from viewing risk as a neutral part of life to viewing it as intrinsically bad and to be avoided. Where health is concerned, being at risk becomes a permanent condition that exists separately from any particular health problem. What the women in this study learned about healthy eating and activity when growing up had been transferred from the private to the public sphere where an ever-widening definition of health was framed around risk avoidance. Thus health became an unfinished project, in need of constant vigilance and hard work (Petersen & Wilkinson, 2008).

Framing risk as intrinsically bad created an imperative for the individual to be good, that is to avoid risk and to promote health (Chamberlain, 2004). It was not difficult to see how social expectations of responsibility for risk avoidance appeared to constitute a moral obligation. This obligation was expressed by many of the women who repeatedly stated that they “should” exercise or be more active or lose weight. Thus to ignore risks to health was to transgress moral consensus and be subject to disapproval in the public sphere. Consider the derision often directed

toward smokers and obese people. Human behavior became pathology for which individuals are blamed and stigmatized.

Where risk cannot be avoided or minimized, feelings of demoralization might ensue. The women in this study talked about feeling "lazy" and "guilty" because they did not believe that they were conforming to expectations of risk avoidance. A woman with heart problems blamed herself for not paying attention to her family history. "I should have known better." Yet the genetic factor is lost to the message of personal culpability. It appears that health was no longer a matter of fate, but of ongoing moral self-transformation (Clarke, Shim, Mamo, Fosket, & Fishman, 2003). A demoralized person's actions focus more on survival than any drive to realize potential (Furedi, 2002).

A focus on survival leads to individuals being perceived as victims of their circumstances rather than makers of their destiny (Furedi, 2002, p. 143). In this study, women's definitions of the ideal healthy state reflected these contradictory stances. The same women who talked about feeling guilty or lazy defined health as the absence of illness or symptoms: the avoidance of risk. Decisions about behaviors to avoid health risks were left in the public sphere. They more willingly accepted the health promotion messages without privately determining how to act within their own life context. If they engaged in expected behaviors of, for example, exercising, it was seldom seen as sufficient. If they did not engage in expected behaviors they often felt beholden to the expectations of individuals in their immediate or extended families (victims of circumstances).

Women interested more in realizing potential ("being able to do what you want to do when you want to do it") actively dismissed the notion that they should be continuously engaged in risk reduction with statements such as "It's time to enjoy life"; "I treat myself." "I exercise because I enjoy it, not because I'm supposed to." These women mediated their knowledge of risk with positive discourses that emphasized enjoyment. In a study using interviews to assess a group of Australians' risk knowledges and experiences, Lupton and Tulloch (2002) identified discourses of self-improvement, control and emotional engagement when interviewees talked

about voluntarily choosing risky behaviors. The implication here was that living self-consciously to avoid risk limits opportunities to explore and be open to life's possibilities.

An individual responsibility to avoid health risks implies autonomous action yet the very nature of most risks as well as women's social roles act as constraints on autonomous activity. Ultimately we are all potentially sick or at risk of developing a disease and eventually dying. Because there are often no symptoms which bring health risks to an individual's attention it becomes the work of health care providers to ensure that individuals are aware of needs related to risk reduction. Risk can often only be identified through the application of technology, for example, blood tests to measure cholesterol levels and mammograms to detect cancer. As a consequence individuals become dependent on health care providers for confirmation of their health status (Skolbekken, 2008).

Although information about how to maintain one's health might originate with health care providers the requisite surveillance is transferred to individuals to govern themselves. The data illustrated the inherent tension between the expectation to acquiesce to expert wisdom about necessary conditions for risk reduction and the expectation that maintaining one's health is an individual obligation (Biggs & Daatland, 2004; Clarke et al., 2003; Furedi, 2004). The transition from monitoring (largely within the health care system) to individual action is usually not explicit and thus often results in confusion and frustration. Women described getting information about risk from their health care providers but often without any assistance in putting recommendations into action. Several women expressed disappointment in the lack of partnership for achieving their health goals. When women attempted to exert power in the relationship they felt like they weren't "the best patients in the world." Some chose to seek out alternative expertise, other care providers or those in roles created to assist individuals with body maintenance activities (Sointu, 2005).

Women's social roles also can limit an ability to make independent choices about behavior and to act on those choices. Fundamental changes in the context of women's lives have occurred over the past few decades, in public and private domains. Whereas there has been

movement from living for others toward living a life on one's own terms, social inequalities between men and women persist at a number of levels (Beck & Beck-Gernsheim, 2002). Women have to individually negotiate contradictions between individual conduct and primary social relationships as rules and conventions for each are no longer reliably established (McGuigan, 2006).

The household is the most intimate setting for negotiating power, authority and control, all of which affect women's health (Moss, 2002). Subservience to men is often assumed as nearly every culture in the world views women as subordinate to men (Bonita, 1998). Tasks of early adulthood tend to polarize values and behaviors related to gender roles (Muhlbauer, 2007). All of the women in this study talked about the social expectation that they embrace and adhere to socially ascribed roles of wife and mother. For some, social pressure dictated that, if working outside the home, they resign on becoming pregnant. "That's just what people did." It has been observed that families in Australia, more than those in a number of OECD countries, adopt traditional role separation (Organisation for Economic Co-operation and Development, 2002).

There is an inherent contradiction for most women in being held accountable for independently acting to reduce health risks and the real constraints to independent action imposed by women's social roles. Some women discovered and demanded new kinds of relationships that allowed some space for a life of their own; others have not. Women in this study who adhered to more traditional social roles faced more repercussions when attempting to make changes to those roles than did women with more flexible roles.

Women living traditional social roles adapted their behaviors to the ideal of woman as serving others and felt "selfish" if they acted on their own desires or frustrated if their husbands would not co-create mutual interests. Power in their relationships did not lie with them and they felt burdened by the expectation that they exert sufficient control in their lives to independently engage in behaviors to reduce health risks. For them, this expectation created additional risks as they juggled a desire for control with the need for stable relationships. One woman succinctly described the challenges many of them faced: "Life is complicated, isn't it?"

Women with a stronger sense of personal power negotiated gender roles to create the space to engage in healthy behaviors. For these women, the rigid, restrictive gender roles learned while growing up became more flexible in midlife, especially after the children were grown (Muhlbauer, 2007). Husbands were more likely to cook and several women entered the work force for the first time. Interestingly, although these women did create time to exercise, rarely was it with the specified intention to reduce risks to health. More often it was because they enjoyed the activity itself, getting together with other women or sharing a specific activity with their partner. Said one, "You hear of so many people who get to full retirement age and they either die or they don't enjoy it but we've (she and husband) just made the effort to enjoy our days and we do."

Similar findings were evident among an ethnically diverse group of midlife women living in the United Kingdom. They described feeling disempowered by the prevailing social messages of individual responsibility for their physical health (Wray, 2007). These women were exercising, not to reduce risk, but for the social interaction.

A diverse (gender, age, education, occupation) group of British and Australians were interviewed between 1997 and 2000 and asked their thoughts about risk and how it affected their lives (Tulloch & Lupton, 2003). Whereas there was a tendency to categorize risk as negative, there was also an expressed awareness that knowledge about risk is socially constructed and not fixed in meaning. This was illustrated in the current study by a handful of women who suggested that social conditions produce both health and the ability to engage in healthy behaviors. Given limited time and energy a focus on achieving individual risk reduction precludes collective attention to environmental factors that affect the health of all people, for example, quality of food, air and water (Sointu, 2005). If individual attention is focused on the fear of succumbing to risk then people might be less likely to organize around social factors contributing to illness and shortened lives.

In conclusion, women in this study either implicitly or explicitly communicated a perspective that health and health behaviors are shaped by a complex interaction of social

expectations and individual roles and relationships. This may reflect sample bias in that these women were educated, fairly well-off white women. It is possible that only women with enough resources to reflect on health behaviors were willing to participate.

Women in this study grew up in a time when roles were more prescribed. Presented with limited choices they generally did what was expected of them. This was a "simpler" life. Food was obtained locally and largely eaten at home with less opportunity to go to restaurants or fast food outlets. For some, activities took place closer to home because walking was the most available transportation option. As adults, many were only briefly engaged in waged work around pregnancies, as was expected. There thus was little need for negotiating childcare or housekeeping responsibilities as that was the "job" socially expected of them.

Women in this study were aware of changing expectations for their behaviors. Even if engaged in healthy behaviors they often felt they were not doing enough because they were unsure what enough might be. When attempting to transform their roles they often experienced resistance from spouses, parents or siblings. These women expressed the conflicts that arise with individual change occurring within a social context. They were very aware not only of the expectations various family members had for how they "should" act but also the broader social expectations. Women who were more successful in managing this contradiction spoke about trying to achieve "balance" in their lives so that they could act on their own needs and desires while also attending to those of their families and communities.

It is important for health care providers to understand that a person's health and health behaviors are not merely a function of knowledge, desire and will power but are also shaped by social, economic and physical environments. To urge specific behaviors designed to reduce risk for physical illness without exploring the potential risks to mental and emotional health that might ensue is to add to women's burdens around meeting others' expectations. It is a reality that women often feel more obligated to others than to themselves.

It is also important for health care professionals to not convey the unrealistic notion that all risk can be effectively managed. We are just beginning to learn the mechanisms whereby

genes and environments interact to create health risks. An individual might be able to influence some aspects of their environment but there is still no opportunity for individuals to influence their genetic make-up or genetic mutations.

More research is needed to explore the actual meaning of risk in relation to definitions of health and to explicate more clearly the process by which risk is negotiated to achieve specific health goals.

References

Adam, B., & Loon, J. V. (2000). Introduction: Repositioning risk; the challenge for social theory. In B. Adam, U. Beck & J. V. Loon (Eds.), *The risk society and beyond: Critical issues for social theory* (pp. 1-31). London: Sage Publications.

Anderson, D., Mizzari, K., Kain, V., & Webster, J. (2006). The effects of a multimodal intervention trial to promote lifestyle factors associated with the prevention of cardiovascular disease in menopausal and postmenopausal Australian women. *Health Care Women Int, 27*, 238-253.

Australian Bureau of Statistics. (2006). *Cardiovascular disease in Australia: A snapshot, 2004-05*. Canberra: Australian Capital Territory: Author.

Bandura, A. (2004). Health promotion by social cognitive means. *Health Education and Behavior, 31*, 143-164.

Beck, U., & Beck-Gernsheim, E. (2002). *Individualization*. London: Sage Publications.

Biggs, S., & Daatland, S. (2004). Ageing and diversity: a critical introduction. In S. Biggs & S. Daatland (Eds.), *Ageing and diversity: multiple pathways and cultural migrations* (pp. 1-12). Bristol, England: Policy Press.

Bonita, R. (1998). *Women, ageing and health: Achieving health across the life span*. Geneva: World Health Organization.

Britton, A., Shipley, M., Singh-Manoux, A., & Marmot, M. G. (2008). Successful aging: The contribution of early-life and midlife risk factors. *Journal of the American Geriatric Society, 56*, 1098-1105.

Bryant, A., & Charmaz, K. (Eds.) (2007). *The SAGE handbook of grounded theory*. Los Angeles: Sage Publications.

Centers for Disease Control and Prevention. (2008). *WISEWOMAN – well–integrated screening and evaluation for women across the nation*. Atlanta, Georgia: Department of Health and Human Services.

Chamberlain, K. (2004). Food and health: expanding the agenda for health psychology. *Journal of Health Psychology, 9*, 467-481.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications.

Charmaz, K. (2009). Shifting the boundaries: Constructivist grounded theory methods. In J. M. Morse, P. Noerager Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clark (Eds.), *Developing grounded theory: The second generation* (pp. 127-193). Walnut Creek, California: Left Coast Press.

Cheek, J. (2009). Healthism: A new conservatism? *Qualitative Health Research, 18,* 974-982.

Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R., & Fishman, J. R. (2003). Biomedicalization: Technoscientific transformations of health, illness, and U.S. biomedicine. *American Sociological Review, 68*, 161-194.

Dennis, K. E. (2007). Postmenopausal women and the health consequences of obesity. *Journal of Obstetric Gynecologic and Neonatal Nursing, 36*, 511-517.

Fishbein, M., Hennessy, M., Kamb, M., Bolan, G. A., Hoxworth, T., Iatesta, M., et al. (2001). Using intervention theory to model factors influencing behavior change. Project RESPECT. *Evaluation and the Health Professions, 24*, 363-384.

Furedi, F. (2002). *Culture of fear*. London: Continuum.

Furedi, F. (2004). *Therapy culture*. London: Routledge.

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory.* Chicago: Aldine.

Im, E. O., Chee, W., Lim, H. J., Liu, Y., & Kim, H. K. (2008). Midlife women's attitudes toward physical activity. *Journal of Obstetric Gynecologic and Neonatal Nursing, 37*, 203-213.

Jackson, C., Lawton, R., Knapp, P., Raynor, D. K., Conner, M., Lowe, C., et al. (2005). Beyond intention: Do specific plans increase health behaviors in patients in primary care? A study of fruit and vegetable consumption. *Social Science and Medicine, 60*, 2838-2391.

Lewis, D. M., & Cachelin, F. M. (2001). Body image, body dissatisfaction, and eating attitudes in midlife and elderly women. *Eating Disorders, 9*, 29-39.

Linnan, L. A., Ferguson, Y. O., Wasilewski, Y., Lee, A. M., Yang, J., Solomon, F., et al. (2005). Using community-based participatory research methods to reach women with health messages: Results from the North Carolina BEAUTY and Health Pilot Project. *Health Promotion Practice, 6*, 164-173.

Lupton, D. (2003). *Medicine as culture*. London: Sage Publications.

Lupton, D., & Tulloch, J. 'Life would be pretty dull without risk': Voluntary risk-taking and its pleasures. *Health, Risk & Society, 4*, 113-124.

McGuigan, J. (2006). *Modernity and postmodern culture*. Berkshire, England: Open University Press.

Moss, N. E. (2002). Gender equity and socioeconomic inequality: A framework for the patterning of women's health. *Social Science and Medicine, 54*, 649-661.

Muhlbauer, V. (2007). The well-being and quality of life of women over 50. In V. Muhlbauer & J. C. Chrisler (Eds.), *Women over 50* (pp. 95-111). New York: Springer.

Nies, M. A., Chruscial, H. L., & Hepworth, J. T. (2003). An intervention to promote walking in sedentary women in the community. *American Journal of Health Behaviors, 27*, 524-535.

Nitz, J. C., & Choy, N. L. (2007). Changes in activity level in women aged 40-80 years. *Climacteric, 10*, 408-415.

Organisation for Economic Co-operation and Development. (2002). *Babies and bosses: Reconciling work and family life*. Paris: OECD.

Peel, N. M., McClure, R. J., & Bartlett, H. P. (2005). Behavioral determinants of healthy aging. *American Journal of Preventive Medicine, 28*, 298-304.

Pender, N. J., Murdaugh, C. D., & Parsons, M. A. (2005). *Health promotion in nursing practice*. Upper Saddle River, N.J.: Prentice-Hall.

Petersen, A., & Wilkinson, I. (2008). Health, risk and vulnerability: An introduction. In A. Petersen & I. Wilkinson (Eds.), *Health, risk and vulnerability* (pp. 1-15). London: Routledge.

Prochaska, J. O., & DiClemente, C. C. (1992). Stages of change in the modification of problem behaviors. *Progress in Behavior Modification, 28*, 183-218.

Reichstadt, J., Depp, C. A., Palinkas, L. A., Folsom, D. P., & Jeste, D. V. (2007). Building blocks of successful aging: A focus group study of older adults' perceived contributors to successful aging. *American Journal of Geriatric Psychiatry, 15*, 194-201.

Skolbekken, J. A. (2008). Unlimited medicalization? Risk and the pathologization of normality. In A. Petersen & I. Wilkinson (Eds.), *Health, risk and vulnerability* (pp. 16-29). London: Routledge.

Sointu, E. (2005). The rise of an ideal: Tracing changing discourses of wellbeing. *The Sociological Review, 53*, 255-274.

Sternfeld, B., Wang, H., Quesenberry, C. P., Jr., Abrams, B., Everson-Rose, S. A., Greendale, G. A., et al. (2004). Physical activity and changes in weight and waist circumference in midlife women: Findings from the study of women's health across the nation. *American Journal of Epidemiology, 160*, 912-922.

Tulloch, J., & Lupton, D. (2003). *Risk and everyday life*. London: Sage Publications.

Weinstein, N. D., Rothmann, A., & Sutton, S. (1998). Stage theories of health behavior. *Health Psychology, 17*, 290-299.

Williams, L., Germov, J., & Young, A. (2007). Preventing weight gain: A population cohort study of the nature and effectiveness of mid-age women's weight control practices. *International Journal of Obesity (London), 31*, 978-986.

Wilson, D. M., & Palha, P. (2007). A systematic review of published research articles on health promotion at retirement. *Journal of Nursing Scholarship, 39*, 330-337.

Wray, S. (2007). Health, exercise and well-being: The experiences of midlife women from diverse ethnic backgrounds. *Social Theory & Health, 5*, 126-144.

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