

12 An Autobiography of Health: A Study of Health and Identity Amongst Perimenopausal Women

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This paper presents a qualitative exploration of how perimenopausal women construct and re-construct their health identity. Using a narrative approach, 30 women between the ages of 35 and 55 were interviewed twice. A narrative methodology was employed involving the study of tones and images in the narrative accounts, in addition to thematic analysis. The research shows that women consider reproductive health to be pathological, but of paramount importance in the construction of the health identity. The embodiment of these reproductive milestones in the world is explored through examining, personal, interpersonal, positioned and situated (Murray, 2000) tones, themes and images throughout the accounts. Additionally, themes of health strategising were explored and revealed the importance of both wellbeing and illness in social constructions of the health identity. A reflexive approach to the research grounds this study in Oldham, a socially and economically deprived regeneration area in the UK, and enables the voices of previously unheard women to emerge through the research in a person-centred account of health identity construction.

Introduction

Concepts of health are an integral part of being a person. The way that one considers health, not only in terms of illness, but also framing wellbeing into the way life is lived, affects all areas of lived experience. Health is also a highly gendered concept (Sixsmith and Boneham, 2003), with biological health and the reproductive cycle becoming a natural gender division. Within this division women's health has become objectified through patriarchal social constructions within health provision, science, economics, politics, society and culture. Women's health, whilst objectively structured around milestones in the reproductive cycle, also forms a continuous psychological sub-narrative which contributes to the construction of the individual woman's health identity. The person she has been, is now and will become is grounded in the status of health

enjoyed by the woman that, in turn, influences not only her ability to act on the world, but also her perceived position in society.

The perimenopause, a gradual developmental process that spans the time from childbearing years to loss of fertility, is a period where women have experienced some or all of the milestones of the reproductive cycle and experienced other health related events that have contributed to the construction of the health identity. Due to the uniqueness of the health experience over time, women have many different accounts of how health has affected them, and research has shown (Lyons, 2000) that it is not only direct health experiences which contribute to the internalisation of knowledge about illness and wellbeing.

Research Context

The 30 co-researchers were women aged 35 - 55 who expressed an interest in taking part in the research after seeing the poster or newspaper article appealing for interest. All the co-researchers could be described as working class even though this was not a recruitment strategy. The women in this study are currently living in Oldham in the North West of England and live in an economically challenged regeneration area. The health profile of this area is lower than the national level with more incidence of chronic diseases and disability. The numbers of people claiming welfare benefits in the area are high, as is the rate of teenage pregnancy and unemployment. Additionally, the number of single parent families is higher than the national average (Census 2000: Original Data Depositor). Eight of the co-researchers considered themselves to have long term health problems.

Research Methodology - A Narrative Approach

The methodology used in this study, narrative psychology methodology, was selected due to the explanatory nature of the narrative approach (McAdams, 1993; Mishler, 1995; Crossley, 2000). Narrative psychology is a qualitative method of enquiry which looks at the storied existence of a person through discourse.

Frank (2000) defends narrative analysis from various criticisms of quantitatively orientated psychology by pointing out the following about the relationship between the researcher and co-researcher:

A social scientist who engages the story shares this problem of how to sustain his or her part in the network of relationships created by the story.

(Frank, 2000, p.355)

Frank's work is concerned with not only the analysis of emergent themes in the narrative and the discovery of the narrative identity, but of construction through narrative.

Mishler's (1995) paper on narrative typology celebrates the rise of narrative analysis. In a response to Mishler's comments, Atkinson (1997) warns that:

We will not produce good research on the social world by stripping out the social, replacing it with solitary voices or individualized versions of experience.
(Atkinson, 1997, p.343)

This observation of narrative methodology points out the need to embed the lived experience in the social world, noting social and cultural levels of analysis alongside the personal and interpersonal. Whilst this is true of discourse analysis and qualitative work in general, narrative analysis brings a more personal perspective by considering the emplotment of the whole life story and examining the personal account in addition to the discourses within the account. This in turn allows for a person centred account to emerge which empowers the subject and not the discourse.

Reflexive Approach

Reflexivity is a multi faceted term used to describe the critical evaluation that occurs between the self and the social world. Etherington (2004) comments that:

To be reflexive we need to be aware of our personal responses and be able to make choices about how to use them.
(Etherington, 2004, p.19)

In order to be reflexive we need to be aware and critical of the socio-cultural conditions surrounding us, how these affect the way we interpret the world and our position amongst them. In our everyday lives we take into account our surroundings and are more or less reflexive depending on how important the issues we are contemplating are to us; this includes our interaction with people. As a consequence of this, it should follow that this natural reflexivity could be extended to the study of people in qualitative psychology. However, due to the positivist nature of science and the trends toward psychology emulating science, this is not the natural progression. Positivist training in psychology objectifies the people and behaviours under study and quantifies them, training researchers to become objective bystanders and to eliminate their personal biases from the data. As quantitative psychology has many uses, to obtain an all round experience of research

methods the researcher will train in both qualitative and quantitative methods. These methods are contradictory in praxis as far as reflexivity is concerned. As Bolam and Chamberlain (2003) observe:

Reflexivity involves recognising the situatedness of knowledge and practice, and works to redefine the detached, objective technician of the scientist-practitioner model into a reflexive, engaged and invested social actor.

(Bolam and Chamberlain, 2003, p.215)

The development of research reflexivity in this study involved attaining a feminist approach to the study by diffusing the power dynamics of the interview context and using a non-hierarchical approach (Oakley, 1981). This was achieved by recognizing multiple voices in the research, and by creating a balance between an objective, professional stance as a health professional and a subjective, relational stance as a woman. As the research progressed, the women who took part in the study reverted to a more relational discourse and this enabled the collection of information-rich accounts. In addition to this, changes were made to the participant pack to make the language less academic and more accessible to the co-researcher, hoping that this would diffuse the perceived hierarchy between us. Oakley comments that:

It becomes clear that, in most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship.

(Oakley, 1981, p.273)

Larson's work on the narrative enquiry process suggests that in order to achieve a rapport with the participants, the researcher must 'take part' in the interview in an empathetic way.

By failing to engage in deliberative dialogue and inquiry, researchers put themselves at greater risk of not seeing, not understanding and misinterpreting people whose lives and life experiences differ from their own.

(Larson, 1997, p.459)

To facilitate a rapport and empathetic approach to the study, an initial meeting with each co-researcher was arranged to discuss the study and to reassure them. Field notes of these meetings were recorded and some of the points raised by the women were very helpful in exposing how they perceived the study and allowed for the power balance to be redressed. For example, Claire found the prospect of an interview daunting due to the personal nature of the information she was about to disclose.

So what will this involve then? It seemed OK when I agreed to do it but now I've thought about it a bit more it's a bit scary. Do I have to tell you everything about women's problems and stuff? You said that you were going to tape it, well there are some things that I don't want to say on tape, you know I don't want a permanent record of it with my voice on it, some bad things ...?

(Claire - initial meeting)

Claire's reluctance about being taped was obvious and she was asked if she would rather not do the interview. She said that she would feel more comfortable if notes were taken at certain points. Claire was given the transcript of the recorded interview and the notes and she said:

I was really sort of worried that I would have to say things on the tape I didn't want to. If we hadn't had that chat beforehand you would probably have only got half a story. I think you've got everything there and I'm happy for you to use it as long as you don't put my real name on it.

(Claire - after the interview)

Narrative Themes, Tones and Images

The narrative accounts were analysed for overarching themes of health along with images of health which illustrated the implicit nature of institutionalised health, as detailed below. Pervasive tones in the narrative accounts were determined by consideration of the dialectics of the optimism/pessimism axis (McAdams, 1993). The tone of the interview is an important aspect of the analysis in that it provides a backdrop of understanding to the main themes of the narrative and in this study the pervasive tones of the narrative accounts were of 'stoicism in the face of adversity'. This reflects the difficult social and economic situation of the women in this study and emphasises the need for awareness and inclusion of these variables in qualitative health research in order to expose the societal and cultural variables which impact on the assumed power dialectics of health.

Personal Themes of Health

All the co-researchers represented health in terms of their personal feelings about their own health at some point during the narrative. This personal representation of health was grounded in their own representation of their health at the time of the interview and often did not relate to the sometimes serious health problems experienced in the past, or future expectations of health. The main themes of personal health in this study were those of reproductive health. However, in addition to natural reproductive health such as menstruation, childbirth and the menopause, other major reproductive themes included medical interventions such as abortion, sterilization and

hysterectomy. The decision to intervene in their reproductive health in such drastic ways was often not a matter of personal choice, but of social or economic circumstances. Sarah talked about a pregnancy which she described as the result of “legal rape” at a party, and had decided to terminate the pregnancy due to no family support and shame.

S: I went for an abortion, was in the hospital with a woman next to me who had a stillborn baby, and I haemorrhaged, they put me in a bed beside a woman who had just lost a baby. So she knew why I was there and I know she knew and felt bad about why I was there, it was pretty horrible actually because as I say I haemorrhaged. They needed my bed so I was sent to a nursing home for a week, my parents knew what was going on but didn't talk about it. (Sarah)

Interpersonal Themes of Health

The personal perspective of health discussed above represents the reflective and reflexive health identity of the women in the study. However, experiences of an interpersonal nature are inherent in the health experience. In this study these interpersonal aspects of the narrative account represent the embodiment of the health identity in the world, and underline the meaning-making process of the health encounter. Many of the women in the study told harrowing stories about this and the negative effects on their interpersonal relationships. Holly talked about the effect of her PMS and eventual depression as a result of this on her family:

H: And with my circumstance being difficult at the time I think that spiralled me down into depression where I became erm depressed and dysfunctional not all the time but just a few weeks of the month so it just But I think the root cause of it was PMT. And just the feeling of you don't like yourself because of it and you can't see any way out of it and you know you are having an effect on people who are dear to you. So that I think was the main trigger. You know going downhill with depression and it was quite a long episode then. I was trying to fight depression. (Holly)

Positional and Situated Themes of Health

The women in this study were recruited by a newspaper advertisement that appeared in the town's free newspaper and was therefore distributed to everyone in the town. During the initial meeting, the interviews, debriefing interviews and the diary study, none of the women stated that they were feminist or spoke about feminist ideals. However, the fact that women responded to an advertisement that appealed for women's voices about health indicates that, on an implicit level, feminism is at work. Despite the lack of previous person-centred studies focused on women's whole-life health

including the personal perspectives of the women themselves, and the objectification of women in the medical model, the women took action to make their voices heard and invested time in this action which is a premise of turning a feminist epistemology to feminist ontology. It is on this basis that this study has empowered these women. This was clearly stated in the following comments:

The study has made me conscious of all health issues on a day to day basis. It has been a good thing as we are making changes to our daily lives now to improve health - especially where the kids are concerned. (Sandra, Diary Study)

And

This study has made me realise just how relaxed and possibly carefree I have been about my health - I don't have many worries, but it's highlighted the need to care for myself better, especially regarding exercise. This will help me a lot in a few years in a positive way. (Laura, Diary Study)

This is an example of implicitly feminist action which has led to positive changes in the health identity of the woman concerned. The narrative accounts exposed influences from institutionalised power which, whilst the women were aware of the existence of a power dynamic, often framed this in terms of a crisis and became confused about the source of the power dynamic. This was illustrated in the narrative account by instances of images of situations where the power dynamic was clearly present in the narrative, but presented as mystical or perplexing to the co-researcher as to who or what was responsible for their dissatisfaction. In these cases there were no clear interpersonal images, but more feelings or instincts accompanied by metaphorical phrases in an attempt to explain how this dynamic was out of their control; in most cases the scenario was of 'us and them' with 'them' as a source of unidentified external control. Susan, for example, expressed frustration with her GP:

No not at all. I think they was useless at the doctors erm but as I say on those couple of occasions where I do go, cos I don't like going to the doctors, but when I was going with headaches they started saying, "Oooo how you feeling? And what about anti-depressants?" and I said, "No I don't want to go down that road. No I don't feel like I need to do that." Erm so basically I think they are rubbish. Erm and not helpful at all. (Susan, 81 – 85)

Concluding Comments

The information rich data and the depth of the narrative accounts in this study suggests that narratives of health are, under appropriate reflexive conditions, empowering opportunities for women to express their personal, interpersonal and positioned health situation. This study has underlined the fluid and flexible

nature of identity construction and reconstruction and the narrative approach used has allowed for an exploration of the emplotment of the health identity of perimenopausal women outside chronological time towards a time line based on women's reproductive health.

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