MIDDLE-AGED ICELANDIC-CANADIAN WOMEN'S PERCEPTIONS OF HEALTH, THEIR HEALTH NEEDS AND FACTORS THAT INFLUENCE HEALTH

by

Susan Jane Gudmundson

A thesis
submitted to the University of Manitoba
in partial fulfillment of the
requirements for the degree of
Master of Nursing

ISBN 0-315-76892-4

MIDDLE-AGED ICELANDIC-CANADIAN WOMEN'S PERCEPTIONS OF HEALTH, THEIR HEALTH NEEDS AND FACTORS THAT INFLUENCE HEALTH

BY

SUSAN JANE GUDMUNDSON

A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF NURSING

ABSTRACT

Health promotion and illness prevention programs are often designed using a definition of health that is not sensitive to gender, age, or culture. Yet, the Canadian government recognizes that effective health programs must have thoughtful regard for such variables.

Women's definitions of health, spoken by and for women from their own experience, have not been systematically explored. Most women's health-related research is designed to depict women's health in terms of performance of social roles, from a biomedical perspective, and is usually focused on young women in the childbearing years. This narrow conceptualization of women's health precludes older, healthy women from articulating a vision of health based on their own experience.

Women have been acknowledged as the primary guardians of health for their families and communities. The Icelandic-Canadian community has successfully sustained itself within Manitoba mosaic, therefore we must assume the Icelandic-Canadian women were, and continue to be, instrumental in the survival of the Icelandic-Canadian culture.

This study explored and described Icelandic-Canadian middle-aged women's perceptions of health, their health needs and factors that influenced their health through their own experience with health. Twelve informants were interviewed and through a qualitative feminist analysis three themes emerged that enhance understanding of health from a middle-aged women's perspective. The three themes are: (a) health as the power of positive thinking, (b) health as autonomy, and (c) health as caring for the self and others.

The informants advanced multi-dimensional definitions of health accentuating the minor role biological health plays in their health perceptions. The informants also experienced the phenomenon of the double-bind and other-centeredness that encouraged them to assume personal responsibility for their own health, and the health and happiness of others. However, through resourceful adaptation and subversion, the informants achieved a level of self-determination.

ACKNOWLEDGEMENTS

When I first thought about my thesis two years ago, I sensed I would require solid academic advice, large doses of encouragement, and some opportunity to be single-minded. The difference between wishing for circumstances not within your control, and experiencing them, usually rest with the goodwill of your surrounding community. My community of friends, family, and academic advisors faithfully provided solid advice, encouragement and private time that transformed a wish into reality.

I thank Dr. Theresa George for introducing me to the qualitative paradigm and to feminist research. I knew when I requested Dr. George as my committee chairperson I was choosing someone with exceptional critical thinking abilities. I also understood from the beginning that research was not entered into lightly, rather it was the moral obligation of the researcher to explore all possibilities with thoughtful resolve. I truly thank Dr. George for her faith in my ability to meet my obligations as a beginning researcher.

Dr. Linda Kristjanson, my committee member from the Nursing Faculty, scrupulously read and reflected on every draft of each chapter. I thank Dr. Kristjanson for asking those fundamental questions for which I needed to examine my motives, my ideas and my intentions.

I thank Dr. Keith Louise Fulton, Margaret Laurence Chair of Women's Studies, for serving as my external committee member. Dr. Fulton steadfastly shared her knowledge and expertise of feminist theory and creative writing. I was encouraged by Dr. Fulton to explore society's assumptions and to apply my experience and my voice to research.

Sincere thanks is also extended to Marie Edwards; the person I could always count on to tell me how close I was to finishing. I recall making many self-indulgent phone calls to Marie under the pretence of inquiring about a methodological point.

My sister-in-law Anne Gudmundson deserves a special acknowledgement. I thank Anne for her interest and support throughout the thesis process. If Anne was not caring for my children to give me some quiet time, she was baking muffins for my family and simultaneously reading my second draft. A testament to what women can do in one day!

I would especially like to thank the participants in this study. The women in this study shared personal and intimate details of their lives with me with the intention that their words and experiences might help someone else. I absorbed profound lessons about survival and caring from the participants and I thank them for this privilege.

Thanks are extended to my family members, especially my mother Doris Henry for her support and encouragement. To my children, Stefan and Carla, thank you for regularly reminding me, "It is just a thesis; what are you worried about?" I appreciated your ideas and patience.

Finally, to my husband Bruce, thank you for your concern and generous interest.

To

Palina Lulu Gudmundson and Donna Leigh Lightfoot

for their fortitude and tenacity

A PARTICULAR STYLE OF WRITING

My thesis is written in the first person to acknowledge my research product as inseparable from my values and beliefs as a person. Feminist scholars insist, and I agree, that knowledge is not produced in a vacuum, rather it is produced by humans that are vulnerable to opinion and influence. Instead of acknowledging the who, why, and where of research, most of the valued scientific writing denies the relevance of time, place, social context, and authorship. Somehow a depersonalized style of writing is supposed to convince us of the researcher's objectivity and promote the results of the research as "facts of nature" separate from human interference. As Ruth Hubbard writes, "Our world of facts is contextual not only in that it depends on who we are and where and when, but also in that it is shaped by where we want our facts to take us" (1990, p.16).

Many scientific opinions, and their obscurity as natural facts, have subordinated women by hoarding and enforcing definitional power (MacKinnon, 1987). From the beginning science was created by and for men from

the educated upper classes in Europe and the United States. These scientists effectively used a depersonalized writing style to at least partially disguise their personal and political role in the research process. Therefore, some academic men and their objective scientific writings enacted a powerful role in defining and enforcing what is normal and abnormal for women. Once parochial views of womanhood were accepted as true "objective" fact, they defined and shaped women's options and future potential. This is the power of science.

The preceding claims demand that I offer the reader some sense of my social and political context as author of this thesis. I am a white, married, middle-class woman with a formal nursing education. My middle-class and race privileges have allowed me to pursue skills, education and respect within traditional institutions.

My interest in the Icelandic-Canadian culture partially springs from my personal connections with the culture. My biological mother, although through misfortune her life is somewhat unknown to me, belonged

to a first generation Icelandic-Canadian family from Manitoba's interlake. My marriage partner was raised in an Icelandic-Canadian family which further entrenched my interest in the culture. The foregoing description of myself should offer the reader the notion that, although I have some ties to the Icelandic-Canadian culture, I am part of the larger Canadian culture with its own values and beliefs that are somewhat more difficult to define.

The audience must remember that what I perceived, questioned, and recorded were all choices influenced by my location in a particular place at a particular time. Although researchers are unable to purge themselves of their values and beliefs during the research process, they can consciously examine their biases and speculate about their influence on the results of the research.

The audience for this research may now appreciate and evaluate my perspective in this thesis and the context from which it springs; in this way I claim my findings and myself as inseparable. I assert that acknowledging the self adds to, not detracts from, the rigour of research.

TABLE OF CONTENTS

CHAPTER 1

STATEMENT OF THE PROBLEM

Introduction

Nursing is an art and a science with a distinct domain of intellectual inquiry that is centrally concerned with the concepts of nurse, person, environment and health. Nursing research and theory seek to describe and understand these major concepts and the relationships among them.

The concept of health, in particular, is fundamental to nursing research, theory and practice. The nursing profession exists to preserve and promote the public's health and in accepting the responsibility, must acknowledge health as a political, multi-dimensional notion that varies depending on who is defining it, and for what purpose (Keller, 1981; Payne, 1983).

Nurses are consistently involved in promoting health and preventing illness within a diverse Canadian society. Logically, before health professionals can promote health, they must understand the meaning of health from a variety of perspectives. A comprehensive

definition of health must be created by, and for, the groups representative of Canadian society before health professionals can effectively and thoughtfully promote health.

The power to define health for women is analogous with the power to define what is "woman". Women who challenge conventional definitions of womanhood (i.e., those women that do not make nurturing, protecting, and facilitating the centre of their lives) may automatically challenge our notions of what constitutes a healthy woman. These women will surely be accused of insensitivity, but perhaps more dangerously they run the risk of being labelled as "sick" or unhealthy. Once the label "sick" is systematically applied by the health care system, the educational system and other patriarchal authorities, a woman may internalize the belief that she is sick. If women accept the imposed definition of "sick" the potential then exists for others to arrogate women's authority to speak and act in behalf of themselves.

Health promotion and illness prevention programs are often designed using a definition of health that is not sensitive to age, gender or culture. Yet, the

Canadian government recognizes that effective health programs must have thoughtful regard for such variables (Epp, 1986; Lalonde, 1974; Pender, 1982). Therefore, health research, that informs program planners and guides health policy, must account for diverse meanings of health.

Age and Gender

The meanings women give to health have not been explored (Ashley, 1980; Rose, 1990). Yet, women's health problems, and subsequent treatments, appear frequently in nursing, medical and allied health literature.

Nursing has been particularly interested in researching the health of child-bearing women. From 1970 to 1980, four major nursing journals published twice as many research articles on childrearing and childbearing women than on women in general (Dunbar, Patterson, Burton, & Struckert, 1981). From 1980 to 1985, eight major nursing journals published a total of 83 articles on women's health. Only 15% dealt with women in the middle years, while 69% dealt with young women (Woods, 1988). The exaggerated focus on maternal and child health, to the exclusion of middle-aged and

older women, reflects a society enamoured with youth and the maternal role. In a political and economic sense, these images serve to remind women of their responsibility in producing the next workforce (Burt, Code & Dorney, 1988; Duffy, 1985; Gordon, 1976).

The research questions asked of women and the methods used to collect data often represent normal life events as disease, and quantify human responses (male and female) as representative of women in general (Duffy, 1985; MacPherson, 1981). Research done in this manner is termed androcentric research because it is biased towards men's perspective, both in the selection of study problems and in the design and analysis of the research (Rosser, 1989). Androcentric research contributes to social control of the female population by helping to shape the health options and social roles of all women (Allen, 1985; Baruch & Brooks-Gunn, 1984; DeLorey, 1982; Dunbar et al, 1981; Ehrenreich & English, 1973).

Unfortunately, illness is the framework within which most women have been studied. Primarily, women's health research has been based on the disease-oriented, or biological-deficit model, where normal life events

like menopause are treated as medical conditions (Begin, 1990; Woods, 1981). The medicalization of normal, healthy events in a middle-aged woman's life may account for the statistics which show that women use medical services almost twice as often than men (Clement, 1987). Common focuses for research on middle-aged women's health include sexual dysfunction, coping after breast surgery, mental health problems associated with aging and loss of children, menopause as disease, gynaecological surgical interventions, and altered body image (Lapierre, 1984). The illness model is inherently reductionist (McBride & McBride, 1981). A reductionist approach reduces the understanding of women and women's health to biological functions, or to a set of social roles and functions, separate from a political, cultural or historical context (Duffy, 1985; Fausto-Sterling, 1986; Voda & George, 1986). Most health-related studies focus on women as marriage partners, mothers, and childbearers; social roles fundamental to the western economic system of capitalism (Dunbar et al, 1981; Gatz, 1983; Rotberg, 1987; Stevenson, 1979).

Traditionally, women have been gazed upon as

"other"; as different from men's bodies that are considered the norm against which women's bodies are judged (De Beauvoir, 1953; Ehrenreich & English, 1973; Mitchinson, 1988). Before the late eighteenth century, North European men topped the hierarchical model of biology, depicting women as inferior derivatives of men. For instance, female reproductive organs were construed as underdeveloped parallels to those of males. During the nineteenth century, most arguments supporting men's superiority included a presumption of biological difference. The medical community endorsed the "biological difference" argument in order to assign women appropriate (i.e., expedient) social roles according to class status. They suggested the female cycle, from menarche to menopause, was debilitating, if not disabling, and made middle-class and upper-class women unfit for wider social roles. Men's reproductive systems exercised no parallel control (Clarke, 1990). "The view that women are sick, or defective versions of men is as old as Eden" (Ehrenreich & English, 1973, p.6). This view may partially explain why women receive medical intervention more often than men. Females seek medical help twice as often as males, receive twice as

many prescriptions for minor tranquillizers and anti-depressants, and are subject to unneeded surgery: 35 to 45% of hysterectomies are thought to be unnecessary (Doress & Seigal, 1987; Lapierre, 1984; Mitchinson; 1988).

During the 1960s, the women's movement prompted some individuals to re-examine the status of women's health within the medical system (Boston Women's Health Book Collective, 1984; Daly, 1978; Ehrenreich & English, 1973, 1978; Fee, 1982; Kirkpatrick, 1982). Learning from this re-examination, today's current women's health movement emphasizes the need for women to know and gain control of their own bodies, and in doing so, to understand the normal and healthy processes individually and collectively experienced. Consequently, women articulating their own perceived needs and notions of health can serve to empower a group that has, in the past, had the male biomedical notion of health imposed on them.

The Canadian government recognizes that women's status in Canadian society has been, and continues to be, subordinate to that of men's (Canadian Advisory Council on the Status of Women [CACSW], 1989). Yet

women's labour within the home is crucial to the health and survival of the Canadian family. The CACSW's study in 1986 (Heller) reaffirms women as the primary guardians of health within Canadian families. In fact, between 54 and 74% of middle-aged women carry out three-quarters of the health care tasks within families without help (Heller, 1986). Notwithstanding that 65% of middle-aged women are in the paid labour force, the unpaid domestic work of women accounts for 37% of the total working hours of all Canadians (Meissner, 1985).

Existing research describes women's health in terms of social roles, from a biomedical perspective, that precludes healthy women articulating a vision of health from their own experience. Although exploration into women's images of health has begun using a qualitative approach, the study subjects have been invariably between the ages of 18 and 45 years, which excludes the middle-aged woman's perspective (Calnan & Johnson, 1985; Woods, Laffrey, Duffy, Lentz, Mitchell & Taylor, 1988). The systematic social forces that shape the experience of health for women are rendered invisible when debased choices are marketed as something any healthy woman would naturally want and

freely choose. Therefore, women's personal experiences with health are not personal at all, but political. Women's personal experiences of health must be moved from the private, personal realm to the more powerful public realm to urge political action and secure social change.

Culture

Nursing has emphasized the need for culturally sensitive or ethnically competent care (Clinton, 1982; Leininger, 1978). However, few studies have sought to incorporate a cultural variable in understanding women's health. Studying individual cultures provides a foundation of culturally sensitive questions by which trends and similarities of other cultures can be compared and used to inform culture-bound theories (Spradley, 1979). Ultimately this leads to a broader and culturally more sensitive health care system (Leininger, 1975; 1978).

Why study Icelandic-Canadian women?

The Canadian federal government endorses and supports multi-culturalism as a distinct feature of Canadian life. Implicitly, the notion of multi-culturalism suggests that our differences can be the

foundation for a strong, unified country. Audre Lorde (1984, p.111) discusses academic arrogance that, by not exploring cultural differences between women, we assume women of different cultural backgrounds have nothing to say. She continues to suggest that difference "must not be merely tolerated, but seen as a fund of necessary polarities" (p.112) to spark our creativity in finding power and courage for all women. By acknowledging our differences and sources for interdependence, we build a community that can be a force for social change.

One of the enduring cultures in Manitoba is Icelandic. In fact, Manitoba is home to the largest Icelandic population living outside of Iceland (Simundsson, 1981). The preservation of the Icelandic language, through Icelandic Studies at the University of Manitoba, weekly newspaper publications, plus speciality foods and celebrations provided by the Icelandic population, attest to a thriving culture within the multicultural setting of Manitoba. In May, 1990 the Canadian federal government bestowed a $300,000 grant on the University of Manitoba to create a Canadian Icelandic Studies Program in conjunction with the University's existing Chair in Icelandic

Language and Literature ("Icelandic studies grow", 1990). Many Icelandic-Canadians living in Manitoba, particularly those of middle-age and older, have maintained their cultural identity.

The Icelandic-Canadians, like many other immigrants, faced serious threats to their survival; both physically and conceptually as a distinct community within a dominant Anglo-Saxon culture. Despite this, they have survived and flourished as an ethnic group in Manitoba. If we acknowledge women as the primary guardians of health for their families and communities, we must assume that women were, and continue to be, instrumental in the survival of the Icelandic-Canadian culture. Some health beliefs and behaviours learned within families often remain unchanged throughout generations (Leininger, 1975). Besides accepting this notion as a research finding, I sense the validity of entrenched familial health beliefs because I have been, through a network of friends and relatives, consistently exposed to the health beliefs and practices of Icelandic-Canadians.

For the reasons of embracing possible difference and acknowledging and giving voice to successful

survival, I assume Icelandic-Canadian women have something to say about their personal experiences with health. This study seeks to avoid the paternalistic notion of "what can we do for them?", to acknowledging what they do for themselves.

Summary

Middle-aged women's perceptions of health, their health needs and factors impinging on their health have not been systematically articulated, therefore they require exploration and description. Women must define their own needs and desires in the realm of health care or face the grim prospect of having medically manufactured ones substituted (Ehrenreich & English, 1978). Dependence on medicine for defining women's health and health needs makes the medical system all the more powerful as a tool of social control. Self-knowledge and articulation of that knowledge will promote woman-centered health care (Begin, 1990). Future health care and health policy that accounts for culture, age and gender stands to be more efficient and effective (Epp, 1986).

PURPOSE

This study accounts for culture, age and gender

when defining health, health needs and factors that impinge on health. The goal was to make middle-aged women's lives visible and to articulate their personal experiences and desires to facilitate the design of woman-centered health care. Nurse researchers must explore what women from various cultures and age groups have to contribute, from their own experiences with health, to the goal of woman-centered health care.

Middle-aged Icelandic-Canadian women's own words, derived from their personal experiences, were used to define health. Health needs and factors influencing their achievement of health were also explored and described. These concepts were derived from a self-identified "healthy" middle-aged woman's perspective.

RESEARCH QUESTIONS

1. How do middle-aged Icelandic-Canadian women, from their own experience, define "health"?
2. What do middle-aged Icelandic-Canadian women perceive as their health needs?
3. What factors do middle-aged Icelandic-Canadian women perceive as influencing, either positively or negatively, their achievement of health?

DEFINITION OF TERMS

Icelandic-Canadians implies Icelandic-Manitobans for the purposes of this study (see eligibility criteria, p.78).

First generation Icelandic-Canadians are those people belonging to the generation that was first born in Canada, not those that immigrated to Canada. A combination of first, second and third generation Icelandic-Canadian women participated in this study.

Middle-age is between, and inclusive of, 45 and 65 years old.

Perception is insight, meaning, or personal understanding an individual gives to any object or event (Pender, 1982; Webster's, 1984).

ASSUMPTIONS

1. Icelandic-Canadian women have beliefs about health that are partially culturally bound.
2. Both explicit and tacit meanings are revealed through speech and non-verbal behaviour.
3. Reality is a multiple set of mental constructs made by humans and is inseparable from the meaning humans give to events and experience. Women's words reflect their experienced reality.

4. Reality for women is situated within a patriarchal power structure. Women are oppressed, both materially and conceptually, when they are denied control of their bodies and their health.

CONCEPTUAL FRAMEWORK

A feminist conceptual framework acknowledges, and is part of, the naturalistic paradigm shift in the scientific world (Chinn, 1985; Duffy, 1985; Kirby & McKenna, 1989). Yet, it demands to be more than a philosophical perspective in the feminist commitment to analyzing the conditions of women's lives, to understanding them, and to delineating the causes and consequences of women's oppression. Fundamental to feminist research is praxis: acting and creating change out of concern for improving women's lives (Allen, Benner & Diekelmann, 1986; Kirby & McKenna, 1989; MacPherson, 1981).

Feminist research is a method of exploration and discovery that may contribute to the goal of women's liberation. It questions male-dominated intellectual traditions, including ideas about the basic nature of human beings, social life and the world view of traditional science. Some researchers propose that

individual experience is embedded within a set of social relationships which produce both possibilities and limitations of that experience (Acker, Barry, & Esseveld, 1983).

The conventional or present view of scientific rationality is an extremely limited one with irrationalities and inconsistencies of which academics and the public need to be aware (Benston, 1982). Feminists challenge the conventional paradigm's claim to objectivity and neutrality and offer evidence for the importance of subjective and ideological factors in science (Allen et all, 1986; Chinn, 1985; Stanley & Wise, 1983). The implication is that conventional science is not only the dominant paradigm for knowledge, but a paradigm almost entirely controlled by males.

The conventional paradigm assumes an orderly "objective" material reality separate from, and independent of, the observer. The paradigm also assumes that the material world is knowable through rational inquiry and that quantification and measurement of natural phenomena is possible through reductionism with the ultimate goal of prediction and control (Benston,

1982; Chinn, 1985; Harding, 1986). These assumptions are transferred onto the social sciences in their attempt to model themselves on the physical sciences.

This process has been called "impoverishment of reality" and has been consistently rejected by humanists and feminists who point out the range of important aspects of human culture which cannot be reduced to quantification and measurement. The naturalistic paradigm accepts the notion that the inquirer/observer, and the "object" of inquiry, interact to influence one another; the knower (the mind) and knowable (nature) are inseparable (Lincoln & Guba, 1985). Reductionism is suspect within a naturalistic paradigm because it assumes a whole is nothing more than the sum of its parts. The new paradigm is acutely aware of context, and the complex interrelationships among the parts that produce a whole greater than the parts. Many of the traditional research questions and resulting methodologies surrounding women's health issues are fashioned on the reductionist approach. The biological model, for instance, isolates and fragments the experience of many female health issues into "hormonal deficiencies" (Voda

& George, 1986). Although some level of understanding can be achieved within reductionism, it is assumed that multiple inter-related factors exist that serve to make prediction and control of human experience impossible (Lincoln & Guba, 1985).

Feminist researchers aspire to develop knowledge and theories from women's experience. If part of the problem of female subordination lies in the invisibility and repression of female experiences and values within the present social system, the solution lies in the nurturance and rehabilitation of these values, and the creation of woman-centered systems. The development of woman-centered systems, thought and culture is essential to ending female oppression (Chinn, 1985).

Summary

A feminist conceptual framework senses the limits of reductionism. It debunks the myth that a segmented analysis of the parts will yield the whole (Duffy, 1985). Feminist science recognizes the importance of considering context within research findings and analysis. The social context within which traditional science developed accounts for its practice as a male

enterprise. "The claim that science is value-free, objective and purely rational is ideology and not reality" (Benston, 1982, p.6).

Feminist theory creates a vision of woman-defined systems. The strategies to obtain this vision include asking women to articulate in their own words, for themselves, their thoughts and experiences (Bunch, 1987; Gilligan, 1982). Once women's thoughts and experiences have been spoken and heard, they can be analyzed in context to discover, the differences and the common ground of women's reality (Belenky, Clinchy, Goldberger & Tarule, 1986; Donovan, 1988). Woman-defined health concepts can then be made visible and used to lay the foundation for woman-centered health care. New descriptions of reality change people's perceptions of the world. Changed perceptions are necessary to alter the existing reality (Bunch, 1987).

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

It was difficult to narrow and circumscribe my literature review. Empirical studies existed, yet because my research strove to honour the everyday experience of women I sensed reviewing only empirical studies might be inadequate. After discussions with my thesis committee, we mutually agreed to include both the lay literature and academic empirical research publications in the literature review. Therefore, both the professional and lay literature were reviewed in the following areas of: (a) definitions of health, (b) middle-aged women's health needs, (c) factors that influence the achievement of health, and (d) Icelandic-Canadians. Relevant research in Nursing, Medicine, Psychology, Anthropology, Sociology, and Women's Studies was reviewed to provide a comprehensive background to the topic.

Mass media, such as magazines and newspapers, provide the public with an abundance of health-related information. In order to appreciate the media's

portrayal of health, I evaluated each monthly issue of two major Canadian magazines that deal with women's issues and women's health, Chatelaine and Canadian Living (1989 and 1990 issues), for health-related articles. As well, examination of the daily newspaper, Winnipeg Free Press and the Manitoba Icelandic weekly paper, Loberg Heimskringla, from 1989 to 1990, produced articles pertaining to the research area

Conceptions of Health

Early Notions of Health

Health appeared as a word around the year 1000. At that time, it denoted the state of being sound or whole (Dolfman, 1973). During the last part of the nineteenth century and the early part of the twentieth century, the prevalent mechanistic view of the world influenced Western medicine and the conception of health. The experimental, laboratory approach to solving the world's problems was widely accepted (Sells, 1968). Scientists believed a whole (i.e., a human) could be broken into parts, independently treated, reassembled, and returned to a healthy, whole state. The body was viewed as a system functioning according to only biological and chemical laws, with a

distinct separation from the mind. Social, economic and political factors were not seen as health determinates (Torrance, 1981).

Eventually, Western medicine recognized that treating the whole person and accounting for context and the environment were crucial to health (Torrance, 1981). During the late nineteenth century, changes in agriculture made improved food supplies possible. Incomes rose, nutrition and housing improved, and public health measures resulted in improved sanitation. These social and environmental changes, rather than new medical treatments, led to improved morbidity and mortality rates (McKeown, Record, & Turner, 1975). Hippocrates' early writings in the late fifth century, trace disease to an imbalance between the whole person and the environment (Sells, 1968).

Three broad philosophies of health influenced present day conceptions of health: the asymptotic, the elastic, and the open-ended philosophy (Sells, 1968).

The asymptotic philosophy has two components. The first component defines health as a collection of distinct elements harmoniously working together. The concept of harmony, or balance, is representative of

health. The significance of harmony is evident in the "ying and yang" of Chinese philosophy, and the Western notion of homeostasis. The healer's primary goal is to restore balance.

The second component embedded within the asymptotic philosophy is a belief in "backward looking romanticism" (Sells, 1968, p.332). Rousseau (1712-1778) associated the Western world's ills with the results of civilization. The process of civilization, according to Rousseau, separated us from a perfect state of harmony with nature. Freud (1856-1939) agreed with Rousseau's "back to nature" beliefs speculating that uncivilized "man" did not suffer from modern "man's" neurosis, since the uncivilized did not inhibit the innate sexual and aggressive drives so necessary for "man's" well-being.

The elastic concept of health begins to discuss and acknowledge preventive health care practises. The elastic concept claims that potential danger or threat can be averted or altered by an accumulation of resistance. Experience, an understanding of basic anatomy and physiology, and learning to cope with hardship, will furnish an individual with resistance. A

present day example of an accumulation of resistance is the mental and physical preparation women receive before childbirth.

The open-ended philosophy of health regards death as an absolute zero, and knows no upper limit for human functioning and health. Health promotion ideals of growth, creativity, and self-actualization are possible within the open-ended philosophy. Preventive medicine is bypassed in search for goals which are independent of disease.

The three philosophies in general, and the open-ended in particular, influenced the World Health Organization's [WHO], 1958 definition of health: "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". A concern for social well-being was now entrenched in the holistic WHO's definition of health. Callahan (1973), a philosopher, opposed including "social well-being" in the WHO definition because, as he expressed it, "not all human problems are reducible to matters of health". The danger, according to Callahan, lay in increasing the medical profession's domain to treat social conditions such as unemployment.

Although medicine knows little of solving unemployment, the WHO definition also promotes a constant escalation of unmet needs. However, Callahan fails to account for culture and class because he speaks from a Western, professional, middle-class perspective. He implies medicine is the only profession involved with the working concept of health. Callahan may also write from an androcentric base, judging from the sexist language, and references, contained in his article.

A Canadian Federal Government definition states:

> Health is not something that comes about merely as a result of treating and curing illness and injuries. It is a basic and dynamic force in our daily lives influenced by our beliefs, our culture and our social, economic and physical environments.
>
> (Epp, 1986, p2)

Although Epp's definition implicates the broader social system as an influence on the health of our daily lives, the definition needs to be validated and operationalized by women across the life span and from different cultures.

Nursing Theorists and the Concept of Health

Nursing theorists from 1950 to 1970 can be classified into three schools of thought. Each school of thought theorized about the concepts of human, nurse

and health, although the underlying assumptions about each concept were quite different. Needs theorists Abdellah, Henderson, and Orem, (cited in Marriner, 1986) focused on health problems and the respective nursing functions. They broke away from the medical model by encouraging independent nursing judgements, yet their theories were still based on disease and illness. The perception of the client and importance of the environment were not clearly addressed (Meleis, 1985).

Interaction theorists King, Orlando, and Peplau (cited in Marriner, 1986; Meleis, 1985) contributed to the second school of thought in nursing theory. Interactionism, phenomenology, and existentialist philosophy guided these theorists to study the concept and the process of caring. Interactionists specifically studied the interaction between nurses and clients. The patient perspective was valued, and context was earnestly implicated in the health of the client. However, context was limited to the immediate physical and psychological environment. The larger issues of culture, gender, and systemic barriers to health were not questioned.

Outcome theorists such as Rogers and Roy (cited in Meleis, 1985) conceptualized health as balance, preservation of energy and a state of harmony between the individual and the environment (Marriner, 1986; Meleis, 1985). Notions of health developed by outcome theorists vary in their degree of abstraction, although some research has been undertaken to operationalize health, further research is needed to ground health in everyday experience.

Nursing theorists, regardless of school of thought, claim health as part of the domain of nursing. Understanding and conceptualizing health were central goals of Florence Nightingale's nursing philosophy in the mid-1800s. More recently, Carper (1978) reviewed nursing texts and journals from 1964 to 1974 and found that health was repeatedly referred to as a basic nursing concept.

Newman (1982), Parse (1985), and Smith (1986), are three contemporary nurse theorists particularly interested in explicating the notion of health. Newman (1982) states health encompasses pathology and should be considered a manifestation of the total pattern of the individual. For Newman (1982), health is the

condition, or the process, in which all parts and subparts (variables) are in harmony with the whole of the person; disharmony reduces the wellness state.

Nurse theorists, both historical and contemporary, have sought to operationalize the concept of health. Although some theorists (e.g., Sister Callista Roy) have produced more complete definitions than others, health requires further grounding in everyday experience.

Empirical Work Related to the Concept of Health

Recent health research is acknowledging the significance of the lay person's notion of health in effectively delivering quality health care (Parse, 1985; Shaver, 1985; Smith, 1986; Tripp-Reimer, 1984). The health research discussed in this section is primarily derived from a lay person's perspective. However not all the studies allow the subjects to speak in their own words, for themselves.

Parse (1985) interviewed 400 subjects about their "feeling of health" from a phenomenological perspective. The subjects were divided according to age groups. One hundred subjects (50 women and 50 men) between the ages of 45 and 65 provided 169 descriptive

expressions about health. Three specific elements associated with health emerged: exhilarating potency, creating triumphs, and serene unity. The hypothetical definition read, "health is serene unity lived in exhilarated potency toward creating triumphs" (Parse, 1985, p.33). Parse's definition is ambiguous and not gender specific. There is no evidence that the final definition was confirmed by the subjects.

Smith (1986) extensively reviewed and critically analyzed the health literature to conclude most definitions of health fit into four general conceptions: clinical, in which health is viewed as the absence of disease; role performance, where health is the ability to perform socially defined roles; adaptive, where health is viewed as flexible adjustment; and eudaemonistic, where health is described as exuberant well-being. These four conceptions are mutually exclusive, but form a progressive scale where one has to meet the standards of the clinical model as a prerequisite to all other levels. Later, Smith suggested a nationwide survey be done of various ethnic and racial groups to secure some reliability and validity for the scale.

Building on Smith's (1986) work, Laffrey (1986) developed a health conception scale with 28 items (seven items for each of Smith's four dimensions) which were scored using a Likert format. Tested with a group of (N=11) female student nurses with a mean age of 32.2 years, the results supported Smith's four dimensions of health. Alpha coefficients, using Cronbach's alpha, ranged from .87 to .88, providing evidence of the instrument's internal consistency. Factor analysis of the 28 items validated the four dimensions of health. For an item to be retained, a loading of .5 or greater was required. The research did not support the claim that the four models form a progressive scale from clinical to eudaemonistic, with each model subsuming the concerns of the previous one. The instrument also has not been validated by midlife women from different cultural backgrounds.

Recently, researchers have examined women's images of health. Several authors (Woods et al, 1988) elaborated on Laffrey's (1986) work by describing the meaning of health for a population of Pacific Northwestern American women. The women represented multiple ethnic groups. A sample of 528 women between

18 and 45 years were interviewed and responded to the question, "What does being healthy mean to you?" Content analysis, with high inter-rater reliability (.88), confirmed images of health consistent with Smith's (1986) and Laffrey's (1986) four conceptions of health. The most frequently cited health images were associated with the clinical and eudaemonistic categories. The eudaemonistic category was expanded to contain nine additional dimensions and these new additions accounted for an 88% frequency of report. The nine new eudaemonistic categories were: actualizing self, practising healthy lifeways, self-concept, body image, social involvement, fitness, cognitive function, positive mood and harmony. Of the nine, positive affect, fitness, practising healthy lifeways and harmony (i.e., spiritual wholeness, centered) were most commonly acknowledged as images of health for these women. The authors stated "clearly, women's images reflected a strong emphasis on exuberant well-being, not merely the absence of symptoms, role performance, or management of their environments" (p.42). The women's ages did not influence the variety of images they reported, but those closer to 45 years reported

more role performance ($p<.05$) and adaptive health images ($p<.05$), and fewer eudaemonistic health images ($p<.05$) than younger women. The non-parametric statistics provided superficial data analysis which resulted in rank ordering of the responses.

Rose (1990) studied nine women, five of whom were between 47 and 53 years old, to discover what constituted women's inner strength. The nine women were self-selected on the basis of their subjective experience with inner strength. Purposive sampling was used to select women of diverse educational backgrounds and different occupations. Rose (1990) chose the participants from women in literature and the media and from clients, colleagues and friends. In-depth, open-ended interviews produced themes depicting the meanings and qualities of inner strength. The themes expressing inner strength were, "embracing vulnerability, intimate authentic interrelating, using humour, being true to themselves, centering and balancing, becoming self-aware, being quiet and calm, and finally, seeing and understanding the whole of situations while remaining cognizant of compounding factors" (p.68). The research findings from this phenomenological study produce

beginning knowledge about women's inner strength from a healthy women's perspective.

Colantonio (1988) interviewed 100 adults about their conceptions of health. The subjects were stratified into four age/sex groups representative of the study population. A content analysis performed on the one interview performed with each subject, found the most recurrent concepts of health refer to being fit with reference to fulfilling necessary and desired activities. The data did not show differences in perceptions of health between men and women or across age groups.

The influence of social class on health has been broadly documented (Epp, 1986). Only recently have researchers explored the relationship of social class to personal definitions of health. Calnan and Johnson (1985) explored the relationship among occupational social class, health and the perceived vulnerability to disease. Working class women were found to more frequently use the dimension of health described as "function" and "absence of symptoms", while professional counterparts elicited more multidimensional definitions such as "being fit".

Although these findings suggest that social class may influence women's definition of health, the sample was confined to women of 25 to 55 years and does not allow for variations in conceptions of health between women from different generations and cultures.

Morse's (1987) research with Canadian inner city, low-income people produced similar statements about health as did the working class subjects in Calanan and Johnson's 1985 study. The informants in Morse's qualitative study specifically included aspects of sleep, nutrition, and work in their definitions of health. Health was associated with physical well-being and definitely with the ability to move about and accomplish work.

Summary

The three basic philosophies of health suggesting harmony and balance, an accumulation of resistance, and self-actualization have been historically associated with the notion of health.

The relationship between health and social factors influenced the WHO and the Canadian federal government's definitions' of health. The most encompassing and viable definition comes from the

Canadian federal government (Epp, 1986), yet it remains to be validated and operationalized from a women's perspective.

Nurse theorists, over time, have rejected the view of health as the absence of disease, but more research is required to ground the abstraction in everyday experience. Because most nursing theory is informed by traditional medical and social science paradigms, concepts such as health may be rooted in an androcentric bias. Smith's (1986) four conceptions of health were confirmed and expanded by researchers studying women's images of health (Laffrey, 1986; Woods et al, 1988). Some research has explored the relationship of social class and gender to health images (Calnan & Johnson, 1985; Morse, 1987; Woods et al, 1988) but has not specifically focused on middle-aged women.

Women's Health Needs

Health needs of midlife women, from their perspective, have not been studied extensively. Griffith (1983) completed a descriptive research study of 579 women between the ages of 25 and 65 years. Forty-two percent were between the ages of 25 and 35

years. A self-administered questionnaire, with undetermined validity and reliability, was used to elicit demographic data, health history, coping styles, personal goals and satisfactions, and physical and emotional symptoms. Twenty-five percent of the women reported dissatisfaction with physical health factors. For instance, a lack of exercise and physical activity, and poor nutrition and eating patterns were major stressors for women between 25 and 55 years of age. Personal success stressors were highest for younger women, and decreased with increasing age.

A vast amount of literature has been written about the needs of women during menopause (Edinburg, 1982; Flint, 1975; Frey, 1981; Kaufert, 1985; MacPherson, 1981; 1985; Notman, 1982; Voda, Dinnerstein & O'Donnell, 1982). Dickson (1990) reviewed research perspectives on menopause and discovered most research falls into one dominant perspective, the biomedical; and two marginal perspectives; the sociocultural and feminist. The biomedical view promotes menopause as nothing more than the relationship of hormones to symptoms. The stereotypic midlife woman who is irritable, asexual, and depressed because of her

biological processes manifests the biomedical perspective. The biomedical perspective ignores women's own experiences with menopause and accentuates the individual response to menopause, rather than incriminating society's attitudes assigned to aging women. The sociocultural perspective emphasizes, in response to the biomedical view, that menopause has little effect on a woman; role changes and societal attitudes toward aging are the real culprits (Dickson, 1990). Dickson estimates that 12 nursing focused studies on menopause from these two perspectives have been published. However, both the biomedical and sociocultural view suffer from a reductionist stance (Dickson, 1990; Voda & George, 1986) because the first view reduces women to biological processes, and the latter attends to only social and cultural factors.

A feminist view of menopause seeks to uncover the power relationship that has successfully shrouded menopause in secrecy and silence. Posner (1979) and Delaney, Lupton and Toth (1988) provide accounts of several studies from this perspective.

Although some studies recognize menopause as a normal process, many studies use clinical populations

and represent the illness or disease- oriented perspective. Present day medical and scientific theories claim menopause to be a normal event in a woman's life, yet powerful hormones are still commonly prescribed to menopausal women (Ford, 1986). A female wellness perspective on menopause and midlife sexual needs is gaining attention, but requires more investigation (Boston Women's Health Book Collective, 1984; George, 1986: MacPherson, 1981). Middle-aged women's personal accounts of their health needs have not been widely researched. Physical health factors such as a lack of exercise and poor nutrition may be major stressors for some women. Menopause, although researched extensively, is overwhelmingly presented from a biomedical perspective.

Review of Canadian Women's Magazines

Lay literature often underscores society's prevalent beliefs and desires. The researcher assumed that popular magazine articles pertaining to women's health issues reflected society's beliefs and desires for women. Miller, Sliepcevich and Vitello (1981) state, "the majority of the public obtain virtually all of its health information from outside the context of

planned educational settings" (p.257). Chatelaine and Canadian Living are two popular Canadian magazines that are primarily targeted for female readership. Each magazine is inundated with advertising for the cosmetic and fashion industries, weight reduction plans, feminine hygiene products and the latest pharmaceutical products. Health advice for women and their families is scattered throughout both magazines.

All 1989 and 1990 monthly issues for both magazines were reviewed; a total of 48 issues producing 245 health-related articles. The researcher read each health-related article of five sentences or more, and recorded its major focus. Health-related articles were distinguished by their focus on any social, economic, political, or biological factors that influenced physical, or mental well-being. Any writing within the magazines, other than advertising, that related to health education, health promotion, and illness prevention was examined. Particular attention was given to the choice and frequency of the words used within the article. Eventually, after re-reading the articles and comparing my notes on the articles with the article itself, some consistency of theme emerged from both

magazines. A list of articles and descriptions of theme letter-codes can be found in Appendix A.

The Canadian Living's health-related articles were written within a disease or illness paradigm and primarily directed to the middle-aged or older female. The major focus of the articles was amelioration of physical health problems. General information on how to cope, and what foods to eat regarding a medically diagnosed health problem, accounted for 50% of Canadian Living's health-related articles (theme C, G and N2). Often diseases such as arthritis, diabetes, or pneumonia were physiologically described and appropriate medical treatment discussed ("Health and well-fare," 1989; "Six diseases your doctor may miss," 1990). Basic information on how to fill a prescription, store medicines safely, bladder infection symptoms and cure, and how to take antibiotics ("Medicine do's and don'ts," 1989) were common.

An equally common theme for all issues of Canadian Living was diet, nutrition and food preparation related to reducing fat intake, cholesterol, and alcohol consumption (theme N). Forty percent of Canadian Living's health-related articles focused on nutrition

(theme N and N2). About one-third of the nutrition articles detailed foods that should be eaten to improve a chronic medical disease such as heart or kidney disease ("Calcium and fiber for celiacs," 1989; "Ease up on meat and dairy products," 1989) The rest of the nutrition articles were preventive in focus with an underlying clinical component ("All fiber is not created equal," 1989; "Low-cal, low-fat desserts," 1990). This publication devotes at least five pages per issue to low-fat, low-cholesterol recipes and lists of recommended, or nutritious, brand-name foodstuffs to prevent heart, kidney, and vascular disease.

Reproductive issues, again from a biomedical perspective, was the second most common theme. However, only 6% of all Canadian Living issues discussed reproductive issues (theme R and R2). Some examples included the latest drugs to prevent miscarriage, an update on birth control pills, osteoporosis related to menopause, and promoting hormonal replacement therapy during menopause ("Miscarriages..autoimmune drugs," 1989; "Osteoporosis," 1990).

Chatelaine magazine centered its attention on reproductive issues, problems, and diseases (theme R

and R2). A full 40% of Chatelaine's health-related articles addressed reproductive issues for the young to middle-aged woman. Almost half of the reproductive articles were devoted to contraceptive concerns such as the latest contraceptive implant, latex contraceptives, the pill and viruses, and cervical caps (Michaels, 1989; 1990). The other half of reproductive-oriented articles discussed physical health problems associated with women's reproductive organs (theme R). Cervical, ovarian, and breast cancer were most common, although post-menopausal osteoporosis, premenstrual problems, and vaginal infectious diseases were also prominent (Katz, 1989; Michaels, 1990).

The second most common theme, accounting for 25% of Chatelaine's articles, centered on women's mental and physical health concerns (theme C and G). Sixty percent of these articles were disease-oriented and offered advice on coping with chronic disease or improving individuals' emotional response to disease ("Assessing your lifestyle," 1990; Michaels, 1990; Katz, 1989,1990; Webb, 1989). Chatelaine devoted 15% of their total health-related articles to women's mental health promotion, yet invariably the content of the

articles suggested that women should be responsible for improving their own mental health (theme MP). Three articles suggest women should engage in volunteer activity to improve their self-esteem, while another five articles encouraged women to be less cynical and hostile in order to improve their mental health (Jungkind, 1989; "Loneliness," 1990;).

Nutrition and diet themes occurred in 15% of Chatelaine's health-related articles (themes N and N2). The nutrition articles' core concern was reducing fat intake and lowering cholesterol levels to prevent heart disease. ("Fat free foods," 1990; Katz, 1989, 1990; Phillips, 1989). However, half of Chatelaine's nutrition articles' rationale for losing weight was to increase physical attractiveness.

Both magazines reflect the belief that individuals are responsible for their own health and in a woman's case, the health of others. Most health-related articles are biologically and disease-oriented with a clear reductionistic stance. Regardless of the issue, 65% of all health-related articles for both magazines used the words "hormones", "chemistry", and "biology" in discussing health concerns, treatment, or preventive

health practices. Some preventive suggestions do appear but they are clinically focused. For instance, how to prevent a urinary tract infection, pain reliever precautions, and prenatal blood tests, are examples of medically-driven preventive health practices. Few articles emphasized health promotion or building on healthy women's strengths. Both magazines, because of the preponderance of reproductive and nutrition articles, depicted women as wombs, then mothers and finally wives. The nutrition articles specifically targeted women that prepare food for families. The assumption is that women need to know how to reduce fat and cholesterol intake so the whole family can be at less risk for heart disease.

None of the health-related articles referred to women of colour. Both magazines encourage women to exercise more, create leisure time, eat fat free foods, and to understand their own and their husband's sexual needs, suggesting a middle-class, heterosexual bias.

Factors Influencing Health

The Canadian government recognizes that biological, environmental and lifestyle factors affect the pursuit of health (Lalonde, 1974; Epp, 1986).

Barbara McDougall (1989), the past Minister Responsible for the Status of Women, stated, "Any discussion related to women's well-being must delve into the underlying factors of women's social and economic inequality" (p.9).

Income and Employment

Women continue to earn, on average, only 66 cents for every dollar earned by men (Young, 1990). Eighty - four percent of women remain in the service sector and their net wages dropped ten percent between 1981-1987 (CACSW, 1990). Low income has been shown to not only reduce access to health services, but also to have a bearing on lifestyle, education, disability and occupation. Low income people suffer more health problems than others and tend to have shorter life expectancies (Health and Welfare Canada, 1990). Although women make up 51% of the population, 57% of the low income people in Canada are women. Single parent women are five times as likely to be poor than are men who head their own households. In 1984, one in three women heading a household had an income below the poverty line (Perales & Young, 1988). Women of colour are five times more likely to be poor than white women.

The results of Canada's Health Promotion Survey in 1985 (cited in Health and Welfare Canada, 1990) demonstrated that the number of women reporting their health as fair, or poor, decreased as income increased. When the analysis was limited to women under 65 years, 82% of high income women rated their health as very good or excellent, compared with only 52% of poor and 62% of very poor women. This study was a telephone survey that used random digit dialing to contact households across the country. The response rate was 80% and resulted in over 11,000 Canadians, 15 years and older, answering 109 questions covering 250 items. The survey excluded those Canadians without phones, and certain topics such as occupational health, violence, and family responsibilities were not included. The criteria for income categorization was unclear in this study as was the method for race representation.

Women are concentrated into a narrow range of occupations as a result of gender segregation. "Many female job ghettos in offices, stores, and factories have stressors typical of any low-status, poorly rewarded, routine job" (Lowe, 1989, p.12). Women are at risk for the harmful effects of occupational stress

because at least 80% of women's paid employment reflect job ghetto status (CACSW, 1990). Even in situations where men and women are performing the same work, women face unique stressors. Some of these occupational stressors include 75% of the responsibility for childrearing and household work once women return home from a day at the "office", sexual harassment, inequities in employment opportunities and rewards, and the pressure of token status in non-traditional jobs (Lowe, 1989).

In 1983, the Canadian Human Rights Commission researched sexual harassment by surveying 2,004 women and men. The results indicated 4% of men and 15% of women had received unwanted sexual attention at some point in their life. Most incidents (36%) occurred in the workplace. Emotional stress develops over fear of reprisals or of losing one's job if a complaint of sexual harassment is formally lodged. Despite this, some researchers state that paid employment outside of the home has a positive effect on an individual's health. Regardless of sex, when compared to the effect of unpaid domestic labour in the home, outside paid employment is associated with higher levels of self-

esteem and health (Baruch et al, 1984).

The state of the national economy has historically played a role in women's health. Women's domestic tasks are increased and intensified during times of recession. Tasks such as preparing non-convenience foods, bargain hunting, repairing clothes and household appliances, stretch the family budget by adding considerable invisible domestic work to a woman's agenda (Armstrong & Armstrong, 1987).

Family Relationships and Responsibilities

Marriage and the quality of relationships within the family have shown either a positive or negative effect on the health of women. A non-communicative, emotionally unsupportive marriage partner contributes to depression among women (Brown & Harris, 1978). Yet, partners that share household and family responsibilities can ameliorate women's health by increasing women's personal time. Lack of personal time has been perceived as a major source of stress for women (Heller, 1986).

With the increasing emphasis on community and home health care, families, and women in particular, are assuming health care responsibilities for family

members (Heller, 1986). Heller (1986) interviewed 165 women from across Canada. The purposive sample allowed a variety of women from varying backgrounds to tell their stories about home health care. Some of the variables included regional and economic diversity, young to old women, and a variety of ethnic origins. Seven different interviewers posed open-ended and multiple choice questions to the women. Although pre-testing of the questionnaire allowed refinement, there was no mention of inter-rater reliability. Middle-age was not defined in years, however the study concluded "54% of middle-aged women carry out more than three quarters of the health care tasks within the family without help and 86% look after more than half the health maintenance activities unaided" (p.33). Accessing health services was cited as somewhat difficult for 19% of the middle-aged sample and 33% were less than fully satisfied with the care they received. The most common complaint at all stages was, "Doctors don't listen to mothers and don't recognize the knowledge gained by mothers in raising a child" (p. 35).

The middle years for Heller's sample of women was

not a time of peace and contentment with "everything coming together". Rather, a strong sense of family responsibility, increased attention to their husband's mid-life physical changes, and health care needs of children and older parents, produced a time of "everything coming at once" (Heller, 1986). In the United States, Glazer (1988) estimates "the average American woman will spend 17 years raising children and 18 years helping aging parents and parents-in-law".

Heller (1986) identified that 50% of middle-aged women did something positive for their emotional health. The most frequent activity associated with maintaining emotional health was a "good social life...going out and seeing people...entertaining and talking to friends" (p.37).

Anderson (1985) researched the experience of health and health-seeking behaviour of East Indian Canadian and Greek Canadian women. Subjects (N=144) ranged in age from their early twenties to mid-fifties. Content analysis, from qualitative data gained from in-depth interviews, revealed factors that shaped these women's subjective experiences with health and health care systems. The findings suggest that factors that

impinge on health go beyond the health system itself to social, economic and political forces. For instance, the loneliness, tension and isolation many of these women experienced, took precedence over any physical or biological factors. Anderson's(1985) study accounted for gender and culture in its broad analysis of forces that impinge on health. Although it was from a woman's perspective, it did not specifically target middle-aged women.

Violence and Exploitation

Many pharmaceutical and medical treatments have both contributed to and detracted from women's health. Certainly advances in diagnosis, the discovery and use of antibiotics, and some surgical procedures have enhanced women's lives. However, some of the pharmaceutical assaults on women's bodies have recently gained social and political attention. The teratogenic sedative Thalidomide, which produced limb defects, was given to mothers who complained about fatigue and overwhelming responsibility. In 1971, diesthystilbestrol [DES], widely used as a synthetic estrogen replacement, was discovered as a transplacental carcinogen. Harvard researchers provided

evidence of increased cases of vaginal cancer among daughters of mothers who had taken DES (Bale, 1990; Hynes, 1989). The Dalkon Shield, an intrauterine contraceptive device, was launched in 1971 and removed from the market in 1974 after many reports of uterine infection and puncture, resulting in hundreds of hysterectomies (Hynes, 1989). In 1981, a ten million dollar lawsuit was successfully launched against Johnson & Johnson and International Playtex, the producers of high absorbency tampons. The companies were accused and charged with failing to test properly their products even after evidence was clear on the tampon's adverse affects (Bale, 1990).

Violence against women is a reality for Canadian women and a serious threat to their health and their lives. From January to November, 1990, 14 Manitoba women died due of domestic violence ("Roots of domestic abuse", November 6, 1990). It is not surprising that the CACSW (1989) reported that 56% of Canadian women living in the city feel unsafe walking alone at night in their own neighbourhoods.

Summary

Women's social and economic inequalities impinge

on women's opportunities to achieve and maintain their health. The Canadian Health Promotion Study of 1985 (cited in Health and Welfare Canada, 1990) demonstrated the effects of income and employment disparities on women's health with only one-half of poor women rating their health as "very good". Since 57% of the poor in Canada are women, we can project that approximately four million women rate their health as less than very good in Canada.

Marriage influences women's health. Some research suggests the impact of marriage on women's health is directly related to the communication style employed by the marriage partner (Brown and Harris, 1978). Middle-aged women are most often entirely responsible for the health care tasks within the immediate and extended families (Heller, 1986). The demands of raising children and caring for aging parents can produce emotional and physical exhaustion.

Without overstating the fact, abuse is killing women. Abuse of women by unsafe pharmaceutical practices and physical violence is not uncommon.

Achieving health for women is profoundly affected by their economic status, social role responsibility,

quality of family relationships, and the environment.

Icelandic-Canadians

Iceland is an island located in the North Atlantic between Norway and Greenland whose economic and social survival depends, to a great extent, on a successful agricultural and fishing enterprise. Unfortunately, from 1850 to 1873, the Icelandic people were afflicted by catastrophes that targeted both these Icelandic mainstays. The death of thousands of sheep from infectious diseases, volcanic eruption covering large areas of land, and worsening glacial conditions made fishing and farming almost impossible. These calamities prompted emigration to various locations in North America and in the fall of 1875, about 270 Icelandic people arrived in Winnipeg, with another 1200 arriving in 1876 (Simundsson, 1981).

C. Matthiasson (1977) documented the early, and present day, history of Icelandic-Canadian women's involvement with voluntary organizations. Matthiasson's research does not include a description of her sample or methodology, however she does refer to "informants" that seem to be second and third generation Icelandic-Canadian women.

She states that the Icelanders, and the women in particular, began to form voluntary associations for charitable, political and social reasons almost immediately after they immigrated to Canada. Because the pioneer immigrants experienced many adversities in the economic and social adjustments to their new country, voluntary organizations "first tended to focus on providing mutual assistance, education of the young and medical care" (Matthiasson, 1977, p.27). Matthiasson concludes that women played a strong role as fund raisers, executive board members, and elected officials in the social welfare activities of the Icelandic-Canadian community. Her results further suggest that the pioneer women were regarded by the informants in her study as, "a special group of individuals who were more than ordinarily hard working and capable" (1977, p.29). The study informants also perceived themselves as capable and strong-minded, although not as tough physically as the pioneer women. It was the pioneer women that continued to affect Manitoba's history.

Icelandic-Canadian women were instrumental in securing women's right to vote in Manitoba. The first

women's suffrage association in Manitoba was established by Margaret Benedictsson from Gimli, Manitoba who also wrote and published "Freyja", the only women's suffrage magazine in Canada (Newman, R., April 19, 1991, p.4). While insisting that women should have the right to vote, the Gimli suffragettes maintained that the well-being of the home was of prime importance, in fact the home was women's separate sphere and her prime responsibility. The notion of women's obligation to home and hearth is reflected in the legendary persona of the Fjallkona.

The Fjallkona is a mountain woman that represents to the Icelandic people, the mother and protector of the Icelandic nation (Bjornsdottir, 1989). A Fjallkona, from the Icelandic-Canadian community, is named and presides over the Gimli Icelandic festival each year. The Fjallkona as David Arnason describes, "rules over us, the maid of the mountain, not some young girl celebrated solely for her physical beauty, but an older woman, earth mother, celebrated for her contribution to the community as a whole" (cited in Islendingadagurinn, 1988). Women are seen as the very embodiment of the culture by the symbol of the Fjallkona. Although an

explicit display of such ethnicity is acceptable to a certain extent today, this was not always the case.

J. Matthiasson (1989) acted as a participant observer within the Icelandic-Canadian Winnipeg community; a sociocultural environment of which he had also been a native. Matthiasson (1989) discusses the contempt with which the Icelanders held the term "ethnic". He states the Icelanders would have avoided, at all cost, any ethnic self-presentation had it not been for the highly ethnicized environment in which they found themselves in Winnipeg.

Matthiasson (1989) relates that Icelanders were given the opportunity, on their arrival to Canada, to create their own republic north of the keystone province of Manitoba when "none of the other ethnic populations had received the gift of autonomy that the Icelanders had received" (p. 160). This difference heralded a prestige and power distinction the Icelanders still enjoy today compared with other ethnic populations. A honoured place within the ethnic hierarchy had long-range consequences for the Icelanders even though the Icelandic community refused to consider themselves ethnic. Perhaps one of the

reasons the Icelanders enjoyed such favoured status was because of their willingness to denounce their ethnic ties and become structurally identified with the Anglo-Saxon majority. Matthiasson states "in a self-conscious manner they sought to become, not hyphenated Canadians, as in Icelandic-Canadian, but Canadians in the fullest sense" (p.163). Matthiasson discusses two postures the Icelanders employed: one for presentation to the outside world, and the other for community use; one very English and one very Icelandic. However, with the changing Canadian ideological perspective on ethnicity that values multi-culturalism, the Icelanders are, over the last 15 years, finally ready to display and discuss their ethnicity (Matthiasson, 1989).

Although the foregoing articles describe psychological, anthropological and behavioral traits of Icelandic-Canadians, there were no studies located that specifically discussed Icelandic-Canadian women's perceptions of health, health needs or factors that influence their health.

Summary of Literature Review

The notion of health first appeared around the year 1000. Since that time, numerous disciplines have

offered their version of the meaning of health.

Nurse researchers have, over time, rejected the view of health as the absence of disease. Many are now beginning to ground the concept in the everyday experience of humans, but only two studies have specifically researched middle-aged women's perceptions of health and their health needs. There were no studies located that studied Icelandic-Canadian women's health.

A review of two popular Canadian magazines dealing with women's issues and women's health, primarily describe women and their health according to social roles, from a biomedical perspective with a middle-class stance. Women's health is profoundly affected by economic status, social role responsibility, quality of family relationships, and the environment, yet this is not always communicated in the popular literature or the empirical research on women.

Some research has been published regarding the personality and behavioral traits of Icelandic-Canadian people in general. Although the first and second generation Icelandic-Canadian women expedited suffrage for the women of Manitoba, they did so because they believed home-life would be strengthened with an

active, astute mother and wife. The Icelanders were positively stereotyped because of their close association with the dominant Anglo-Saxon majority. The close association however, required the Icelanders to deny their ethnicity and assimilate into the Canadian culture.

Little knowledge exists about women's personal perceptions of health developed from their own experience with health. This research may provide insights into healthy middle-aged Icelandic-Canadian women's own experiences with health, thereby adding knowledge to the nursing profession's paradigm.

CHAPTER 3

METHODOLOGY

Design

This research project was designed and implemented as an exploratory-descriptive study. The purpose of the design was to explore and describe phenomenon in order to become familiar with them, and gain new insights (Wilson, 1985). The design was appropriate because little knowledge had been developed on middle-aged women's perceptions of health, their health needs and factors affecting their health.

The research was philosophically directed by the naturalistic paradigm previously described in the feminist conceptual framework. Lincoln and Guba (1985) impose two requirements on researchers who wish to label their work as naturalistic. The first of the two requirements, is to honour the five naturalistic axioms throughout the research process (Lincoln & Guba, 1985, p. 37).

> Axiom 1: there are multiple constructed realities so prediction and control are unlikely, although some understanding of the phenomenon can be achieved.
> Axiom 2: the inquirer and object of inquiry

interact to influence one another.
Axiom 3: generalization is not a goal of the naturalistic method. The aim is to develop a body of knowledge that is context dependent.
Axiom 4: it is impossible to determine cause and effect because all entities are in a state of mutual and simultaneous shaping
Axiom 5: research is value bound.

Throughout this study the five naturalistic axioms were honoured to the best my ability.

The second requirement demanded that I develop a level of interpersonal skill to ward off criticism of the human as instrument. An acceptable level of interpersonal skill includes sensing and responding to environmental cues, collecting information about multiple factors simultaneously, summarizing data "on the spot" and confirming it with informants, and possessing a knowledge base to function competently with the concepts under study (Lincoln & Guba, 1985, p.194). I feel confident in my interpersonal skills partly because I practised competent bedside nursing for 15 years. As well, instructing nursing students at the undergraduate level for several years demanded adept communication skills. Therefore, one can be relatively assured the interpersonal skills developed as a successful registered nurse can be transferred into the naturalistic researcher's repertoire of

interpersonal skills.

A naturalistic inquiry is always carried out in a natural setting, "since context is so heavily implicated in meaning" (Lincoln & Guba, 1985, p.187). Naturalistic inquiry implicates qualitative methods because they are more adaptable in dealing with multiple realities and expose more directly the essences, values, and contextual meanings of human beings. Naturalistic inquiry elects to use humans as the primary data-gathering instrument because only a human is capable of grasping, evaluating, and adapting to the realities that will be encountered (Lincoln & Guba, 1985). The human instrument uses methods such as indepth interviews to begin to account for context and the complexity of human beings. However, if the human instrument is not trustworthy, the findings are meaningless.

Trustworthiness

Trustworthiness of qualitative research refers to the degree to which the findings of the study are worth considering. The conventional scientific paradigm establishes rigor by employing the criteria of internal and external validity, reliability, and objectivity.

Criteria from the conventional paradigm are not appropriate for judging actions in the naturalistic paradigm (Burns, 1990; Kirby & McKenna, 1989; Lincoln & Guba, 1985; Sandelowski, 1986). Trustworthiness within the naturalistic paradigm can be established by credibility (internal validity), transferability (external validity), dependability (reliability) and confirmability (objectivity).

Credibility

Credibility is truth value. I, or any naturalistic researcher, must demonstrate that the analysis arrived at is credible to the informants or constructors of the reality (Kirby & McKenna, 1989; Lincoln & Guba, 1985). Prolonged engagement, persistent observation, use of a reflexive journal, and member checks were the techniques I used in this study to establish credibility.

Prolonged engagement is the investment of sufficient time with the informants and their context to learn the culture and build trust to "test for misinformation introduced by distortion either of the self or the respondents" (Lincoln & Guba, 1985). I have attempted to meet the requirements of prolonged

engagement through my own life experiences with the culture and by investing sufficient time with the informants over the course of this research.

Prolonged engagement with the study informants occurred through three to four, one hour face-to-face interviews. Each informant also spoke with me over the phone before the first interview to establish a place and time convenient for reviewing the informed consent. This preliminary phone call answered the informants' questions and allowed a more trusting environment for the first interview.

Over my lifetime I have been exposed to the subtleties of the Icelandic Canadian culture. My biological mother was of Icelandic-Canadian heritage and consequently this gave me frequent opportunities for contact and participation with extended family, and other members of the Icelandic Canadian community. Informal contact with the community continues with occasions such as reunions, christenings, weddings, funerals and attending the annual Icelandic celebration in Gimli, Manitoba each year.

My formal contact with the Icelandic-Canadian community is retained by receiving The Loberg-

Heimskringla, a weekly Icelandic Manitoba paper. This informative paper was reviewed weekly during the research process and contained opinion editorials, news items from Iceland, announcements of community events, and fiction, poetry, and non-fiction written by Icelandic Canadians. I have also attended biannual fundraising events established to secure a future for the annual Icelandic festival in Gimli; the Islendingadagurinn. These combined activities alerted me, and provided beginning understanding, to the study informants' context.

As a woman, although not of middle age, I have an understanding and involvement with women's culture through the lived experience. I have had prolonged engagement with women's culture from a white, married, middle-class perspective.

Persistent observation, another criteria I used to secure credibility, allowed me to tentatively label presumed salient factors and explore them in detail "where either the initial assessment is seen to be erroneous, or the factors are understood in a nonsuperficial way" (Lincoln & Guba, 1985, p.304). The first, non tape-recorded, interview allowed me to

observe the informants' surroundings and gain a first impression of the informants' verbal and non-verbal style. The impressions from the first interview were recorded in my reflexive journal in order that subsequent impressions could be compared and analyzed. The next two recorded interviews supplemented the initial observations and were used to validate or dispute original observations.

My use of a reflexive journal was instrumental in building credibility. The journal allowed me to name and explore my biases about the research. After each interview I wrote, in the journal, my impressions of the interview. The first journal entry described the interview environment, discussed possible outside factors impacting on my interpretations of the interview, and tentatively analyzed the informant's answers. Although as naturalistic inquiry postulates, it is impossible to divest one's self of values, it is possible to develop a consciousness of the role they play. The journal was also an opportunity for me to clear my mind of the emotions and feelings that confounded my thinking processes. Clear thinking and appropriate judgements about the research process was

aided by this opportunity for reflection.

Member checks, whereby data and conclusions of the research are tested with members, is a most critical technique to ensure credibility. Member checks were routinely accomplished by referring the data and interpretations back to the informants for correction and validation. I initiated each informant interview by informally reviewing that particular informant's previous interview, thereby encouraging the informant to clarify the data by adding more detail, or refuting other details. Once semi-final themes were determined, I formally presented the themes to four representative members of the sample for validation. All four women concurred with the semi-final themes, and assisted the researcher in further refining the themes. My reconstructions were considered credible to the constructors.

Transferability

Transferability is the power to transfer conclusions or descriptions drawn from the study onto another context or situation. Transferability depends on the degree of similarity between contexts. A "thick description" (Lincoln & Guba, 1985) of the contexts was

provided by a clear description of the sampling procedure, the informants, and the context of the research. This "thick description" can be found in subsequent pages of the methodology chapter. Detailed observations and impressions of the open-ended, in-depth interviews, were recorded in my personal reflexive journal that could be accessed by interested parties (Appendix B). Lincoln and Guba (1985) suggest transferability is the responsibility of the person seeking to make the application, as long as the original researcher has provided enough descriptive data to make the judgement.

Dependability

Dependability is the process of outside verification of the accuracy and consistency of the process and product. During data collection and analysis the thesis committee discussed with me, the process of coding and organizing the data into categories. My early tentative conclusions about the data received approval from committee members.

I was the only person involved in data collection, therefore a relatively consistent style was used in all interviews. The interviews were accurately audio-taped.

All coding notes are preserved and personal analytical choices are recorded.

My thesis committee ensured dependability by reviewing the coding process and emergent themes for consistency and accuracy. I secured dependability by audio-recording each interview, collecting data single-handedly, and developing an audit trail of coding notes and personal analytical choices.

Confirmability

Confirmability parallels the notion of objectivity. Although not pursued, my personal journal, and original audio-tapes and transcripts studied concurrently with the research conclusions, could provide an audit trail for those interested in establishing confirmability. Also, throughout the interviews, the informants words determined the course of data collection. Each question posed to the informant was derived from the phrases or words the informant had previously used. In this manner, there was less opportunity to pursue my preconceived notions and biases with the informants.

The criteria of credibility, transferability, dependability and confirmability are essential to

establish trustworthiness in qualitative research (Lincoln & Guba, 1985; Sandelowski, 1986). Rigor for this study was secured using qualitative criteria.

Informants

The study sample was drawn from the Manitoba Icelandic population. It is estimated that 20,000 people of Icelandic descent live in Manitoba (Bardal, personal communication, October 13, 1988). Manitoba Icelanders have been resolute in their determination to maintain and preserve the Icelandic culture. Many Manitoba-Icelanders of middle age acquired Icelandic as their first language, and today continue to converse in Icelandic with friends and family. The Icelandic Celebration, held annually in August, is the second oldest continuous festival in North America and continues to draw a few hundred native Icelanders each year (Kristjanson, 1989). Sorofman (1986) suggests if certain pockets of a population retain their language, religion, and food specialities, and participate in ethnically specific events, ethnicity can be used as a reliable measure.

A convenience sample of 12 middle-aged Icelandic-Canadian women living in Winnipeg, Manitoba was

obtained. Convenience sampling allows the use of any available group of research subjects. My personal experience and knowledge of Icelandic-Canadians in Winnipeg, allowed uncomplicated entry into this community.

Informant eligibility limitations are listed below.

1. Middle-age requirements insisted informants be between 45 and 65 years of age.
2. Informants were born to Icelandic or Icelandic Canadian parents (both parents are/were exclusively of Icelandic or Icelandic Canadian descent).
3. All informants self-identified as Icelandic-Canadians.
4. The majority of the informant's life was spent living in rural Manitoba or Winnipeg.
5. Informants spoke Icelandic as children and continue to understand and occasionally use the language.
6. Informants were in self described "good health".

The eligibility limitations were created to ensure some measure of ethnic homogeneity, both genetically and socially. As Sorofman (1986) suggests, ethnicity is legitimately established in this sample, however this

is not a study of the Icelandic-Canadian culture. The study seeks to understand women's definitions of health, incorporating an age and cultural element. However, precise description of sample members allows for a more accurate thick description for future research and enhances transferability.

Instrument

The instrument of choice in naturalistic inquiry is the human, or more precisely "the researcher". The human instrument's special properties of responsiveness, adaptability and a knowledge base, allows clarification and exploration of responses (Lincoln & Guba, 1985). The "human as instrument" is apt to choose methods of data collection that are extensions of human activity. Interviewing (e.g., speaking, looking and listening) was an appropriate method for this study and me as the human instrument.

Non-verbal components of the interviews were captured by field notes entered in my reflexive journal promptly following each interview. The field notes cultivated deeper understanding of the concepts under study.

The Ethnographic Interview

Open-ended, in-depth interviews, using the ethnographic interview guide (Green & Leigh, 1989; Spradley, 1979) as a reference, were conducted to elicit data in relation to the three research questions. Open-ended questions encouraged the informants to respond in their own words, therefore the conversation was primarily determined by the informants.

The ethnographic interview is a particular type of speech event. This speech event contains not only language, but "functions as a means of communication, it also functions to create and express a cultural reality" (Spradley, 1979, p.20). Using the ethnographic interview format allowed me to learn the meaning of the phenomenon from the people themselves (Spradley, 1979).

The interview approach that is suggested by Spradley is word oriented and assumes that language, and in particular words and phrases, are windows into the reality experienced by other people (Green & Leigh, 1989). The three specific skills used in the ethnographic interview were (a) preparing and asking global questions, (b) identifying cover terms, (c)

eliciting descriptors for the cover terms.

Global questions

Global questions were open-ended and general in nature (Spradley, 1979). These qualities contributed to a non-threatening beginning for both the informants and myself and therefore all interviews began with a global question. Often the question involved phrases such as "could you tell me about...; or "can you give me an example of...?" The initial global question explored something personally or professionally intriguing to me that was ultimately related to the research questions. Although much of the concern was with establishing rapport, my lead questions were primarily intended to generate conversation about the informant's experiences with the concepts. Global questions form the basis of all ethnographic interviewing and aim to elicit large samples of speech about the informant's context.

Cover terms

Cover terms were key words or phrases usually used by the informants in response to a global question, that labelled an important aspect of the individual's experience. These verbal expressions suggested areas of great symbolic meaning and helped to identify themes or

patterns in the individual's background. Green and Leigh (1989) state that cover terms literally "cover some given range of culturally significant meaning and experience; they are windows onto the reality of the interviewee and of others he or she knows about" (p.9). Included terms are words that belong to the category of knowledge named by the cover term (Spradley, 1975). For example, tree is a cover term, yet oak, elm, and cherry are included terms. By asking questions such as "Are there different kinds of health?..; What is included under feeling good?"; I could draw out included terms for each cover term.

Descriptors

Descriptors are bundles of descriptive information derived from the cover terms. Descriptors are sometimes referred to as the attributes or properties of the cover terms and once put with other bundles of descriptors, a composite picture of certain cultural characteristics was built (Green & Leigh, 1989).

Descriptors were uncovered by asking contrast questions such as "What is the difference between feeling in control and feeling independent?" Descriptors clearly enunciate the fine distinctions

between concepts like control versus independence. For example, in this study, control included descriptors such as information, power, and choice; whereas independence produced attributes of physical mobility and financial security.

Many cover terms became the core of follow-up global questions. The entire process was circular where the cover terms eventually lead to descriptors, and where those descriptors triggered new global questions (Refer to appendix C for examples of global questions, cover terms and descriptors).

Method of Data Collection

The research proposal was submitted to the ethical review committee at the School of Nursing, University of Manitoba before informant recruitment. The ethical review committee is a 10 member multi-disciplinary panel. The research proposal received ethical approval and I proceeded with informant recruitment. (Refer to appendix D for ethical approval form).

Informant Recruitment

Informants for the study responded to a small advertisement in an Icelandic-Manitoban newspaper. Advertisements (refer to Appendix E) placed in the

local Icelandic-Manitoba weekly newspaper "Loberg Heimskringla", explained the purpose of the study, benefits, time involved, expectations and specific criteria for inclusion in the study. My phone number was listed so interested women could call me for more information. Seven interested women responded over a two week period. On receiving the calls, I answered all questions posed by the potential informants and reviewed the purpose, benefits and expectations of the study (refer to Appendix F). When the informant agreed to be part of the study, a place and time for reviewing and clarifying the explanation of the study (refer to Appendix G), signing the informed consent (refer to Appendix H), and building rapport, was established. I emphasized to the informant, both on the telephone and in person, that they were under no obligation to sign or proceed with the study if, at any point in the study, they decided not to do so. I also stressed there was no obligation to answer questions they did not choose to.

The informants received verbal and written assurances of confidentiality and anonymity. I explained that their name would be matched with a code-

number to which only I had access. Only the number, throughout the research process and possible subsequent publications, would be used to identify the informants. Each informant received my telephone number and my thesis advisor's telephone number to access if they had further concerns or questions about the study.

The newspaper advertisements produced seven of the twelve women in the study. All seven women agreed to the conditions of the study and proceeded to sign the informed consent.

Because the desired sample number of 10-12 women was not obtained through the advertisement, I instituted a snowball sampling method. This was done by asking four of the informants, those that had signed the consent form and were willing to participate in the study, to suggest possible other informants. I asked the four women to speak with the potential new informants and seek their permission to release their name and telephone number to me. When verbal permission from the four confirmed informants was received, I phoned the potential informants and repeated the process as described above to obtain an informed consent.

The snow ball sampling method recruited an additional five women into the study. Therefore, twelve women in total participated in this study.

Implementing the Interview

During the interview process with the informants, I endeavoured to create an atmosphere of equality and trust. I confirmed with the informants during the first meeting, that their personal experience and thoughts were valued and respected, and I referred to the informants as "experts on their experiences". This particular interview style encouraged the informant to teach me about her concepts of health. In accordance with feminist philosophy of research, an atmosphere of reciprocal sharing and trust was valued as a prerequisite to a conscientious interview (Kirby & McKenna, 1989; Oakley, 1981).

All interviews, except two, occurred in the informants' living rooms in mid-afternoon. Most informants provided coffee, cakes and cookies at some point during the first interview. I gently reminded the informants that such hospitality was above and beyond any requirement for the study. However, without hesitation, the coffee, cakes and cookies appeared

again for subsequent interviews.

Two interviews were not implemented in the informants' homes. Instead, the interviews occurred in a private area at the informant's place of work. Although there were more interruptions, these two interviews were not qualitatively different from the other interviews.

The first interview for each informant involved reviewing the explanation of the study, obtaining informed consent and lasted for approximately one hour. During the first interview, the informants invariably asked me to share my family tree and family history. This was done in an informal manner, yet generated considerable cordial conversation and "broke the ice" for further conversation. I noted the informants genuine interest in knowing my genealogy and I began to sense this as a "right of passage" before any more intimate questions could be asked of the informants.

The first interview was not audio-taped. However, I wrote my impressions and beginning analyses of the initial interview in my reflexive journal. Following the first interview, two more interviews of one, to one and a half, hours over a three to four week period were

carried out with each informant. After the first interview, all interviews were audio-taped.

Role of the Reflexive Journal

My personal computer contained a file for my reflexive journal. Usually within 48 to 72 hours of an interview, I expressed in the journal my own thoughts, feelings and speculations about the particular interview (see Appendix B). The bulk of my entries revolved around general observations, impressions, and reflections about what meanings were being expressed. My first entry for each interview described the interview setting, the informants' reactions to the researcher, and the general atmosphere. I recorded, from my perspective, interview questions that posed difficulty for the informants to answer, and those that provided rich data. The more difficult questions were redesigned or discarded within the context of the reflexive journal. I consistently wrote in the journal throughout the data collection and analysis phase.

The feminist researcher espouses the influence of context on the findings of the research (Duffy, 1985; Kirby & McKenna, 1989). By acknowledging the existence of context and using reflexive thinking in a journal

form, I could interpret the influence of the context on the study phenomenon. Reflexive thinking involved reflecting on my own values and interests and the impact they may have had on the study, as well as speculating about growing insights into the research. These features combined to alert me to shared meanings, the significance of context, and the more salient features of a woman's social world (Collins, 1989; Guba & Lincoln, 1985; MacPherson, 1981). The journal entries repeatedly enhanced the written transcripts during data collection and analysis.

Data Analysis

Data analysis was not a distinct and separate phase from my data collection. The two processes occurred concurrently, each shaping the other (Kirby & McKenna, 1989; Lincoln & Guba, 1985).

I transcribed, on a personal computer, the entire audio-tape from each interview. Transcribing was done as soon as possible after the interview to identify cover terms, included terms and descriptors.

I was the only person involved in analyzing and coding the data. Coding was whereby I systematically assigned raw data into categories which then allowed

precise description of content characteristics. Decisions about coding, of which data chunks to code, which to pull out, which patterns summarize several chunks, and what the evolving story was, were all analytical choices.

The contents of my reflexive journal were read concurrently with the interview transcriptions during the data collection and analysis phases. The contents of the interviews and my journal were compared and contrasted in an attempt to gain new insights into the evolving story. The reflexive journal always imbued a deeper understanding of the transcripts. Sometimes my journal corroborated with the transcripts and other times the disparity between my journal entry and transcript alerted me to a complex relationship.

From the beginning, I decided in a loose sense, what meanings were being expressed. As each transcript was read, I underlined cover terms which were then explored with that particular informant at the next interview. After several informants had completed their two audio-taped interviews, I transferred all cover terms from all transcripts on to three by five blank cards. Each card represented one cover term. The card

was structured with the cover term written at the top, and all the included terms for that cover term listed below. Included terms are word or phrases that are part of the cover term or literally covered by the cover term . The cards were constructed in this manner for all cover terms discovered during the research. This amounted to 425 cover term cards. All the cover term cards were then placed into piles according to concepts they defined (e.g., health, health needs, factors affecting health).

Seeking descriptors, or attributes, of the cover terms was the next task. Attributes were dimensions that defined and gave meaning to the included terms. Spradley (1975) designed "paradigm sheets" to discover descriptors, which I constructed and used (see Appendix I). The paradigm sheet was nothing more than a box grid. Along the left vertical axis all included terms for a particular cover term were written. The top horizontal axis contained blank spaces that, after careful deliberation, yielded attributes or characteristics of the included terms. The grid demonstrated how common each attribute was to each included term and therefore created more preciseness

for the cover term. Each cover term card was transferred onto a paradigm sheet and analyzed in this manner.

All paradigm sheets were simultaneously reviewed with particular attention to the horizontal axis that contained the attributes of the cover terms. In essence, I pooled all the cover terms and completed a comprehensive analysis of all pooled attributes. Some attributes recurred frequently while others were contradictory; at this point I was alerted to the potential relationships among the concepts under study. Rereading the transcripts and reflexive journal encouraged initial formulation of themes. Eventually, themes, or general assertions about the data, emerged that connected and gave insight into the different concepts.

During the data collection and analysis phase my thesis committee read some transcripts and discussed with me, possible trends or emerging themes. I chose four representative sample members to clarify and validate the final three themes. These four informants were chosen because of their previous detailed accounts during the interviews and because of the

representativeness of their thoughts and experiences. All four informants, after slight adjustment, agreed the three themes represented their views. Therefore, I offer three themes that are relatively confirmable and dependable.

Protection of the Rights of the Informants

The research proposal was submitted to the Ethical Review Committee at the University of Manitoba School of Nursing and I received ethical approval before seeking informant participation (see Appendix D). Permission to proceed with data collection was received early in February, 1990.

The informants, seeking to be part of the study, telephoned me in response to a newspaper advertisement. Upon receiving a phone call, during informant recruitment, a verbal explanation of the study was shared with the potential informants. Questions, concerns, or ambiguities were clarified to the potential informant's satisfaction. A written explanation of the study and informed consent (Appendix G, Appendix H) were offered, reviewed, agreed to and signed, before the first interview.

The psychological and physical comfort of the

sample informants was carefully monitored during the interviews by observing their non-verbal and verbal cues. None of the informants, to the best of my knowledge, became tired or uninterested, therefore no interview was ended prematurely or rescheduled for this reason. Often personal and sensitive information was shared with me, however none of the informants' reactions or statements alerted me to a possible unstable emotional state. I expressed a sincere interest and concern for the informants' experiences by creating opportunities for them to share their thoughts and feelings. Two informants shared private information about their health that had not been shared with anyone else but their husbands. After offering the information, the informants remarked how helpful it was to have someone listen to their story.

The informants were advised, verbally and in writing, they may withdraw at any point from the study. No informants chose to do this. The interviews took place at a time and place convenient for the informants and myself. Throughout the research process, I explained there were no right or wrong answers to any of the questions posed. It was emphasized to the

informants that their own experiences made them the experts in the area.

All interview information was kept confidential. Audio-tapes and transcripts were coded with a number only. Name-number combinations were designed by me and the list of combinations were kept separately in my personal locked filing cabinet. Only I had, and continue to have, access to the name-number combinations.

Accessibility to the number-coded transcripts was restricted to my thesis committee and myself. The researcher has retained the audio-tapes and transcripts on completion of the study. Confidentiality and anonymity will continue to be maintained by the measures described above.

Limitations of the Study

The application of research findings are limited for every study, primarily as a result of the research questions asked, and the researcher's choice of methodology. This study has five limitations that the audience needs to consider.

First, only Icelandic-Manitoba women from Winnipeg were involved, therefore the findings reflect concepts

indigenous to this group. Second, the sample is biased towards those women that made a deliberate attempt to participate in research by responding to an advertisement in a local Icelandic-Canadian newspaper. Third, the impact of the Icelandic-Canadian culture on the findings cannot be determined with accuracy. The study design did not include a comparison group with which to contrast and compare the findings. There was no intention, on my part, to suggest the findings are typical of Icelandic-Canadian women. The fourth limitation recognizes the sample informants as white, married, middle-class women. Therefore, the results of data analysis cannot be applied to women in general. Finally, premature closure may be another limitation of the study. Premature closure indicates the researcher in a study may end speculating on the results prematurely and come to conclusions too soon due to time constraints, financial restriction or "the intolerance of ambiguity so characteristic of the human species" (Lincoln and Guba, 1985, p. 305). Time constraints and the pressing demands of completing graduate education may have influenced me to engage in premature closure.

Acknowledging the limitations of every study is necessary to alert the audience to the rigour of the study and to offer the audience a sense of the researcher's integrity.

CHAPTER 4

FINDINGS

Introduction

Within this chapter I present the findings of a qualitative study examining middle-aged Icelandic-Canadian women's definitions of health, their health needs, and factors that influence their health as women.

Interview Informants and the Setting

Twelve women participated in the interviews. No other family members were present during the interviews, although four of the informants' husbands sat in the kitchen while the interview took place in the living room.

The women ranged in age from 48 to 68 years. One woman was a widow, one was divorced and living alone, and the ten remaining women were married and living with their husbands. All the women had children; the fewest were two children, and the most were six children, for a total of 37 children. More than half of the sample had either teenage, or young adult children, living with them. None of the sample had parents living

with them, however five informants had cared for their parents in the home at some point.

All women were born to an Icelandic or an Icelandic-Canadian mother and father. Four women had at least one parent born and raised in Iceland who either, as a child or young adult, immigrated to Canada. Therefore, these four informants would be considered first generation Icelandic-Canadians according to my definition of terms because they were the first generation born in Canada.

Seven of the twelve women were born and raised in rural Manitoba and later moved to Winnipeg as young women. The remaining five women were born and raised in Winnipeg.

Eight women could speak Icelandic comfortably, while the other four could understand some of the language, but were not proficient in speaking it. Icelandic language retention and proficiency was not related to the urban/rural split. All the women, as children, had heard Icelandic spoken in the home.

All women described themselves as examples of healthy people. Four of the women had some major health problems in the past (e.g., high blood pressure,

nervous breakdown, cancer, or major abdominal surgery), but stated their past health problems were irrelevant to their present health status.

The Emergence of the Themes

Three major themes resulted from this qualitative data analysis. Themes are assertions about a group that have a great degree of generality. As Spradley (1975), concludes, "a theme is any cognitive principle, tacit or explicit, recurrent in several domains and serving as a relationship among subsystems of cultural meaning" (p.186).

Each theme contains several categories, and each category is explained and described by its attributes or descriptors. An attribute is any element of information that is regularly associated with the category (Spradley, 1975). The attributes from each category were pooled to enable the researcher to study the contrasts and similarities among the entire attribute population. This led to defining relationships among the categories, which resulted in the development of three themes. Most themes are at the tacit level, although members of the group know and use the principle to organize their behaviour and interpret

their experience (Spradley, 1975).

Each theme will be presented and supported by their respective categories and attributes. The three research questions guiding this study are answered within the theme description.

The three themes and their respective categories and subcategories are described below. Subcategories are subsumed by the larger category, but are large and distinct enough to be described separately.

Theme A: The Power of Positive Thinking

Category (1): making the best of it
Category (2): accept it and carry on
Category (3): I don't think about it...I just expect things to go well.

Theme B: Health as Autonomy

Category (4): freedom to enjoy life
Subcategory (4-1) mobility and happiness
Subcategory (4-2) being emotionally unconstrained
Subcategory (4-3) choice
Category (5): self-determination
Subcategory (5-1) speaking and acting on one's own thoughts
Subcategory (5-2) separate identity from one's family

Theme C: Health as Caring for the Self and Others

Category (6): possessing and preserving energy through self-discipline
Category (7) committed involvement with others

Theme A: The Power of Positive Thinking

The power of positive thinking has three categories associated with it. The three categories are (1) making the best of it, (2) accepting it, and (3) I don't think about it..I just expect things to go well.

The power of positive thinking is a valued philosophy of life for the subjects. All subjects consistently applied the power of positive thinking to the tasks of everyday living as well as when faced with health problems. The theme asserts that people can control their reactions to any situation, and influence the outcome by cultivating a positive, optimistic attitude toward whatever life may bring. The power of positive thinking is an indicator of health, and its use facilitates the acquisition of health.

Category (1): Making the Best of It

Making the best of it includes the ability to rise to a challenge and take some action to ameliorate a less than perfect situation. People who make the best of it have the ability to problem solve and actively alter the outcome for the better. Sheer determination and willpower are personal attributes required to make the best of it. Ten of the twelve subjects identified

properties associated with this category as indicators of health.

...I guess whatever happens to you is an opportunity to overcome... rather than looking at it being a terrible block that you can't do anything about. [case 11]

...it is the block of I can't do this or that...For instance my husband has arthritis and it could keep him down...but no... he is very active because of his positive attitude. [case 04]

Getting in there and doing something...to help things along... you can still have problems...but that can be overcome by believing you can change things for the better. A healthy person has a personality that...just shines through their adversity. [case 12]

Healthy people think clearly and can problem solve. They create options and make effective decisions that contribute to making the best of it.

...with unhealthy people there seems to be no ability to go after an answer or solution to things..they lack a sense of insight..whereas healthy people can solve problems and are perceptive..I think healthy people can use their resources better. [case 04]

You see ways of doing things...you have the ability to do something if presented with a problem. Healthy people might encounter an illness and they would handle it much better than someone who is unhealthy. [case 07]

People who could make the best of it displayed the ability to boost their own morale and motivate themselves to carry on and cope with whatever life

brought their way. Talking to themselves, and convincing themselves the situation would improve with time, was an effective method seven women identified.

> You might feel...oh, I am not feeling so good today..I think I will just take it easy and stay in bed...but if you give yourself a pep talk and say...hey! what is wrong with me...I don't feel so good today but it will pass..and get up and moving about and before long you say..hey...I am fine... You have a good outlook and give yourself a pep talk. [case 10]

> Usually unhealthy people don't have the ability to push themselves forward...or motivate themselves to do something for themselves. [case 12]

Several women recalled their mothers or other family members using this same technique of "giving yourself a pep talk".

> I talk to myself when I am confused...I talk it out with my mind...I am determined to make the best of a bad situation. Like my mother was always fine even if she wasn't...never...never complained even when she was sick...she made up her mind...okay...I can manage this...like if anybody asked her how she was...she was always fine...And so even in her later life when she got sicker and was in a nursing home...she was still always fine!..It went a long way to her staying as healthy as she did. [case 06]

The majority of women stated maintaining a stoic resolve is a crucial attribute of making the best of it. Several subjects described unhealthy people they knew as "becoming the illness", or giving in to the unhealthy state.

Unhealthy people don't handle an illness very well...they can't deal with things and overcome them...for instance my mother in law...she would have lived a lot longer had she not had this feeling...oh! I have this illness...it took her over. She became the illness. [case 10]

Part of maintaining a stoic resolve includes resisting the temptation to give in to oneself. All the study subjects described healthy people as having an inner strength and willpower that sustained them through most life experiences. Although many subjects admitted to feeling sorry for themselves from time to time, they also recognized this as a threat to their wellbeing. In most instances mothers, or friends, were cited as examples of inner strength and willpower.

...even when she was so ill...she forced herself to eat...she didn't let the cancer and nausea get her down...[case 07]

...my sister was a great example to me...she lost a son and her husband when she was quite young and had problems with alcoholism ...she had a lot of bad things happen to her...but she just rose above the tragedy and kept going..she just rose above the tragedy and kept going. [case 02]

You hear this comment all the time...oh, I want to quit smoking but I can't...I don't believe that...every one has will power...use that willpower! Don't sit there and feel sorry for yourself. [case 10]

"Making the best of it", the first category of Theme A, emphasizes the individual's power to

ameliorate a situation through creative problem solving and personal willpower.

Category (2): Accept It and Carry On

The second category defining the power of positive thinking suggests accepting conditions for what they are, whether the circumstances can be improved on or not, is a healthy practice. Ten of the twelve women identified acceptance as a quality associated with their well being and a device consistently used to maintain their health. Gathering candid information about a situation is a prerequisite for acceptance. All the informants insisted on the need to receive straightforward information from health professionals.

> My parents...they both had a good attitude...they both died from cancer and even when that was diagnosed...they accepted it and went on. They said ... okay!.. this is what we are dealing with and there was not a moment of wavering...accepted it and that was it! [case 10]

> I can handle things if I know what it is...just tell me...I want to know so I can accept. The health professionals must be asked to put all the cards on the table. [case 06]

> Look at the situation...say trying to get ahead or to a certain place at work... change things if you can...if you can't...well then accept the thing you can't change and carry on. Accept that you are not going to get it (job)..and start something else. But people need to be honest with you. [case 05]

Many subjects felt that the greater the capacity

to accept ideas other than your own, the greater the potential benefits for self-understanding and health. Healthy people were characterized as being open to change and accepting of new ideas. Health could be detrimentally affected if women did not remain open to change and new ideas. The informants berated those that refused to accept the good with the bad that life brings.

> Being open to change...they have a willingness to change and accept or at least try new things. Unhealthy people are often full of anger and fighting between each other instead of being open to things. [case 08]

One subject reluctantly described personal strife in her life that she accepted as "part of the whole". The informant's husband, at an early age, became chronically ill and could no longer work. This woman assumed financial, household and child rearing responsibilities, besides caring for her ill husband when she returned home from work.

> In my own case I just accepted it...just accepted it as something I had to do...it came my way and it just happened. Through all this I consider myself very lucky. [case 07]

Accepting things is a method of making life easier and more tolerable for women. If you accept things, and

make the best of it, then you are preserving your health and preventing unhealthy situations. One subject recalled the mental turmoil she experienced during her marriage separation. After personal introspection, she accepted the marriage was over and separated.

> ...make it easy on yourself, don't be too hard on yourself. Often there is nothing you can do to change the situation and if you don't accept things you can really make yourself sick with worry. If I had not separated I would have been in Selkirk [psychiatric institution]...my children know this. [case 08]

> ...it is important to accept...if you are fighting a situation then you can really wear yourself down... don't waste those negative vibes...put them into positive ones. [case 12]

> I maintain my health by trying not to argue with people...it is easier just to accept it and ignore it...because you only upset yourself. [case 03]

The category of "accepting it" describes the ability to receive and assess relevant information about a situation and from there accepting those conditions one has little control over.

Category (3): I Don't Think About It...I Just Expect Things to Go Well

Nine of the twelve women spoke of their ability to have a nonchalant faith about their life and their health. Nonchalant faith implied an unspoken expectation that most experiences in life will have

positive results. This nonchalance was a tool many women used to influence situations. Although this action appeared unplanned and natural, a crucial part of implementing nonchalant faith was deliberately focusing on something, or someone, other than the self or the problem at hand. Many of the subjects referred to their pregnancies, or their children's health, as examples of their nonchalant expectation of health and wellbeing.

> I didn't think about being healthy or getting sick...I had good pregnancies and everything was normal...because I had expected it to be that way. [case 12]

> ...just figuring I should feel good...I had all these children and never gave it a thought that something might be wrong...even during menopause when I was bleeding heavy...I never went to the doctor...I just expected it to take care of itself and it did. [case 03]

Several women spoke of a lack of faith as a sign of an unhealthy person.

> ...some people expect that once they get sick they are going to stay that way. [case 06]

> ...like some people...if they have a problem or had a problem they are so afraid that it might flair up again. [case 07]

One respondent's husband underwent open heart surgery at a relatively young age. She recalled the

stress of the waiting period for surgery, but felt she controlled this stress by having an optimistic faith in the outcome.

I made my mind up that everything was going to be okay...and carried on...I was determined to have the expectation that things would go well. [case 10]

Eight subjects concurred with this notion by contending it was unhealthy and dangerous to think too much about yourself and your health.

...people who are unhealthy often talk about themselves...like every ache and pain...they pray too much about being sick. [case 03]

...unhealthy people are more worried about themselves than someone else...a real hypochondriac. [case 08]

One woman, with a history of cancer stated she maintained her health by not thinking about the cancer. Instead she focused on being optimistic about the future.

...I refuse to go back every six months...it was going to give me a poor mental attitude all the time. I decided I was not going to spend my life revolving around the next appointment...maybe it is all denial...but I am going to live! [case 09]

Several women deliberately compartmentalized parts of their life to preserve and maintain their health.

...if you read...get yourself into something...you can escape from tension...I read a lot so I don't dwell on things. [case 09]

I compartmentalize...I told my family when I go on a trip...I don't even think about them...I can really block. When things start crossing lines...family and work especially ..that is when you can really get stressed out and get sick. [case 12]

The healthy practice of focusing on something other than the self, or a problem, was evident when the informants responded to questions about their health needs. Initially 100% of the women stated they had no health needs. Only three women, after a great degree of probing and thought, conceded a reluctant need.

...well, nothing really...no I have no health needs...maybe I would like some information on an aging stomach and what goes on with it...but really that is all...[case 01]

Five of the remaining nine subjects that felt they had no health needs, mentioned they could do with more information related to other friends' or relatives' health conditions. This would give the study informants some understanding how they could help others.

I would like to know more about caring for the very elderly...and I would like to bring more awareness of the needs of the very elderly. [case 08]

Well, I would be interested in learning about some of the new things with Alzheimers and all of that...there are so many affected now. [case 12]

Of the nine subjects that definitely stated they had no health needs, six reiterated that it was not

healthy to think about your health too much.

...I am satisfied and have all the information I need...it isn't necessary to dwell on the state of your health or what you need. [case 02]

...too much information can be a bad thing for some people...especially when they list diseases, you could think about it too much and become a hypochondriac...or like my father-in-law...over the radio one day they gave a list of common medications and their possible side effects...well as a result he stopped taking his medication. [case 01]

This third category underscores the informants' abilities to shift their focus from themselves to someone, or something, else. This shifting of focus contributed to the informants' nonchalant, optimistic faith about life.

Summary of Theme A: The Power of Positive Thinking

All sample informants eluded to the health benefits associated with consistent use of the power of positive thinking. The first category, "making the best of it", defines health as the ability to problem solve and creatively take action to improve a situation. Healthy people efficiently use their resources to produce an outcome which is better suited to them. A valuable resource possessed by healthy people is self-motivation. Perhaps the most esteemed quality of the power of positive thinking is a stoic resolve. All the

women in the study respected and admired people who displayed unwavering willpower.

The second category, "accept it and carry on", portrays health as the capacity to accept things in life for what they are. By doing so, one preserves and protects their health. Two prerequisites for acceptance are being open to change, and having access to straightforward information. When people are open to change and exposed to new ideas, they grow in their own self-understanding. Resisting change only serves to make life more difficult for people. All informants, regardless of the nature of the situation, recognised the need for candid information before beginning to accept a possible outcome.

Finally, "I don't think about it..I just expect things to go well", is the third category explaining the power of positive thinking. The major component emerging from this category is the deliberate avoidance of reflecting on the self to promote self-health. Most women solicitously focused their energy on others to prevent themselves from dwelling too much on their own problems or on their own lives. Thinking too much about yourself is a threat to wellbeing. This was clearly

evidenced by the informants' reluctance to discuss personal health needs or desires. Healthy people have a faith that most things in life will have a positive outcome.

Theme B: Health as Autonomy

Health as autonomy contains two broad categories, (4) the freedom to enjoy life and, (5) self-determination. Three subcategories that contribute to the freedom to enjoy life are, (4-1) maintaining enjoyable activity and physical mobility, (4-2) being emotionally unconstrained, (4-3) having choice.

To realize autonomy, one needs to practice self-determination. The subcategories associated with self-determination are, (5-1) having confidence in speaking and acting on one's thoughts, and (5-2) securing an identity separate from the family.

Category 4: The Freedom to Enjoy Life

Subcategory (4-1): mobility and happiness.

Eleven of the twelve informants indicated that being relatively free from disease is fundamental to securing physical mobility and maintaining enjoyable activity. However, ten of the eleven women qualified this notion by explaining you could still experience

health while having some disease, as long as you could participate in enjoyable activities. If you had a minimum of disturbances, the probability of enjoying things was greater than if you had many afflictions.

...you have a minimum of aches and pains...and there are a minimum of things that would keep you at home...it is doing what you want to do...when you want to do it...[case 01]

...you can have some things wrong with you...but as long as you are relatively good to still enjoy. [case 04]

A substantial number of women identified physical mobility and physical activities with their freedom to enjoy life. Being physically able to move about and participate was significant to health.

...nothing is keeping you down...being physically able to do what you want to do...being able to do things...take part in physical activity. [case 11]

...I can drive and I can walk...being able to enjoy a brisk walk or a swim is really something. [case 02].

In contrast, past personal experiences with loss of health were characterized as instances when the subjects were less mobile and less free to enjoy themselves.

...when I felt unhealthy it was a number of little things that added up...a headache...arthritis...I couldn't get up and go anytime...I wasn't able to drive because of dizziness. [case 01]

...I couldn't move...I felt so unwell...my head was spinning all the time. Just to walk across the floor was unreal...I quit running...all those things I really enjoy. [case 02]

At least six of the subjects regarded spontaneity as a necessary element in the pursuit of freedom to enjoy life. Most recalled the experience of spontaneous freedom as the healthiest period of their lives.

...to be able to leave overnight...make minimum plans and just go...not having to worry if you will be well enough to go. Unhealthy people hesitate before they go anywhere or do anything...they have to plan weeks ahead of time...to anticipate all the things that might go wrong with them. [case 07]

...I remember when I felt the healthiest...we were visiting England and we just did what we wanted...when we wanted...no formal plans...if we wanted to stay all day in one place we would...other times we would just pack up and go at a moment's notice. [case 01]

Physical mobility and participation in enjoyable activities certainly influence the freedom to enjoy life. However, after some deliberation, ten of the twelve women reported that physical mobility alone was not sufficient to produce the freedom to enjoy life.

...health is really people enjoying themselves...no matter what..healthy people are usually happy people participating in things they like to do. [case 12]

...I think of my mother and all her friends being very healthy...and I guess that is because they were happy...they were always laughing and enjoying

themselves...they must have been pretty healthy. [case 06]

The freedom to enjoy life, even if one has ailments, largely depends on the ability of the individual to participate spontaneously in enjoyable activities.

Subcategory (4-2): being emotionally unconstrained.

Eleven of the twelve women expressed that many and varied family and community responsibilities was detrimental to women's health. The freedom to enjoy life is undermined by facing a myriad of responsibilities alone. These responsibilities are not only physically demanding, but to a greater degree, they are psychologically demanding.

> ...the thing I think affects my health most negatively is the emotional dependence within our family relationships. I feel totally responsible to keep the home together and happy...to be there for the kids and my husband whenever. For instance, if my kids left now to go to another city...fine; but I feel I can't be the one to leave. If my family is unhappy...I take on that responsibility. [case 11]

> My health is certainly helped by not having anyone dependent on me to a great degree. By realizing I was not totally responsible for family matters...that was such a release for me...I realized it was as much his (husband) problem as it was mine...this has also made him a much better father. Having faith and trust in

other family members helps. [case 12]

One woman recalled when she felt least healthy was when she was responsible for all family matters because her husband worked out of town for long periods. Fulfilling family obligations within a limited time frame left little opportunity for private time.

> Life was a lot to cope with...at times a little more than I thought I could cope with...there was so much to do in such a small space of time...it was the little things...the hot water tank ruptures...transporting children here, there, and everywhere...never being free from them...never being alone when you chose to be. [case 01]

Other women recalled similar time-bound family obligations during stages in their life.

> ...there was always something to do..I felt so overburdened...this constant pressure of if I don't do it...it won't get done. [case 07].

> Some barriers to health I think is trying to meet all your responsibilities within the time frame..you want to do everything and do it well but sometimes you just can't. [case 05]

Several women identified that if they attempted to remedy the constant responsibility, the remedy design and implementation would be an additional duty.

> ...it would be so unhealthy to be totally responsible for someone else...if you did manage to get away...it would be you that would have to make all the arrangements and call the babysitter...you would be so trapped by it all. [case 12]

...I would often go to a neighbour's for coffee with the kids of course...we would sit out on the front steps and visit because then the kids could play together where we could see them...You always planned around these things...I didn't move anywhere without my children...from the time my daughter was born in 1956...and the first time I ever went away for an entire day without a child or children was 1965. [case 01]

Five of the informants discussed their guilt in juggling a career and a family. All five women recounted the experience as being the most unhealthy time of their life.

I remember the time in my life when I felt really the most unhealthy...I went back to University and was working during the day. I felt fragmented. I felt guilty about my husband and children...I just felt I did not have enough time to give them. I hated it when they needed me and I couldn't provide what they needed. The house was always a mess too. Occasionally I still feel like this when I get too many things going. [case 04]

...it was not a healthy time of my life...working when I had two kids at home in an age where it was not acceptable to do this. Having colleagues...supposed to be your friends..saying things like "don't you know there is such a thing as cruelty to children?" [case 07]

Another woman recalled the fragmentation and guilt in her life when she recounted her limited contact with her parents once she started a family.

It sort of ate away at me...not spending enough time with my parents...but realistically knowing you couldn't with everything else. [case 01]

The freedom to enjoy life can definitely be reduced by facing many family responsibilities and community obligations within a limited time-frame.

Subcategory (4-3): choice.

Ten of the twelve women studied brought forward issues of choice to bear on their health. The freedom to enjoy life included having some options and opportunities about the direction of their lives. The importance of personal choice became apparent when others began determining choices for them.

> ...having a choice about most things is important for health...being able to choose what I want to do. Often a mother's choice is at the bottom of the list. [case 11]

> ...the time when I felt most stressed I guess you could say is when we were living with my in-laws. Just the pressure of not having your own kitchen...others deciding what my kids should eat and even with the T.V. I was fourth on the totem pole. [case 12]

Several respondents felt that for women to remain healthy in this society they needed not only to have options, but to carry through with actually making the choices that best suit them.

> ...having some choices...it plays a big role. I am very much for women and equality...but I am not a feminist. It is very important for women to work through and make their own choices. [case 04]

Having the freedom and opportunity to explore

where you fit in society...like the freedom to pursue the activities I decide I am interested in. [case 06]

Feeling entitled to a choice, or an opportunity, is a condition that must be present before a choice can become a reality. Several women disclosed their lack of sense of entitlement, therefore never being fully aware of their choices.

A big problem for women is not feeling you are important enough...like my mother...my mother would have put any surgery off. My sister suffered from migraines and she would never go and get help...but if it had been her children she would have. [case 07]

I have a different sense of entitlement than a lot of others. You don't feel entitled to a lot of things people take for granted. Take university... I never felt I was entitled to that rare privilege...I am an ardent feminist and more and more this feeling of entitlement comes into that...the whole idea if you are entitled to the world's goods or not...no matter how hard you have worked. [case 09]

Choices are broadened with financial security. Financial security was confirmed by all the informants as a prerequisite for health. Limited income definitely reduced your choices and eventually your freedom to enjoy life. However, many subjects regarded a low income as malleable; with some insight a low income could be handled. Poverty was the only legitimate reason women's health might suffer because of income.

...finances can really make you sick..I mean real

poverty...not just a low income because you can compensate for that...but real poverty...and an awful lot of women our age and older fall into this category. [case 06]

...having a certain level of money is important for health. I don't mean the middle-class either. There are lots of people just living off a small pension and rents are so high...they have no choice. They may not even have enough food and wouldn't have much of a chance to get out and enjoy themselves. [case 03]

Two subjects reiterated the burden of financial insecurity, and cited education as a means for women to avoid the problem.

...something that really helps women in the area of health is not having to worry about money...having some financial independence. Like single mothers who have to work and run a home...struggling to pay rent...that is why I made damn sure my daughters had an education. [case 02]

My education has allowed me more choices..because I was always able to have some level of financial independence. Also if I hadn't always worked part time...I don't think I would have had the same opportunity for independence. [case 11]

Six women felt that separation or divorce was detrimental to women's health because the potential for future income security would be limited and ultimately reduce choices.

...a separation or divorce is hard...there is now great stress finding a job...this is difficult for a woman who has never worked outside the home before. [case 11]

...heartache...like a poor financial situation

because of a marriage breakup...when a husband leaves there is usually a lifestyle change. Even if the woman did get a job it wouldn't pay much and she probably doesn't have much training for anything. [case 02]

Half of the informants recalled having the opportunity for self-development because of some choice to delegate childcare and household responsibilities to others. In each case, other women were hired, or volunteered, to provide this opportunity.

I was studying...and it was ideal because you got away from your kids and I had a wonderful woman come in. She would walk in the front door and as she is walking toward the kitchen she has already picked up the hall...and at the same time she is talking to you in a very calm and pleasant way...she was my hero...she came in once a week. [case 09]

My Mom helped me a great deal...she developed a program where she would come to town to get the mail and then would take one boy back with her...she would eventually rotate between them all...this really made it easier on me. [case 12]

Seven of the subjects were pleased with the choice they had experienced around health services.

...my health and most of all my family's health has been helped by all the medical advances...like antibiotics for instance...or the greatest benefit to me was when they were able to straighten my son's club feet without breaking them. [case 01]

...the access to physicians is great...and all the strides they have made in earlier diagnosis of things. [case 11]

Five of the informants recounted unsatisfactory experiences with the medical profession and three informants accessed alternative health services.

I had some trouble with my eyes...floaters that really interfered with what I was doing. So I went to this doctor...crabby and rude...terribly insulting. He told me I had terrific vision and I would just have to get used to it. So someone suggested Vitamin A...and it helped! I gave up on the medical profession...goes to show you they don't know everything. [case 09]

We should be taking health more into our own hands. The doctor cannot tell you how to live every day...they don't know...but read books and go to courses to find out what makes for a healthy lifestyle. We had some help from and iridologist..that was not a doctor..you have to get it yourself. [case 06]

Financial restrictions and family obligations superseded career interests for the majority of the informants. Half of the informants stated that if they had things to do over and had the opportunity, they would have pursued their careers and interests to a greater degree. However, all informants explicitly stated they were very happy and content and were reluctant to discuss what they might do differently with their lives.

Well, I don't think I would have done anything differently...maybe pursued my music a bit more...yes I wished I had done that but there were other responsibilities. [case 04]

I am very satisfied...I never thought of anything else but getting married and having my children. If we

had the money I would have liked to have studied languages. [case 03]

The informants identified, as a prerequisite to health, the opportunity to choose and control some of the direction of their lives.

Category 5: Self-determination

Self-determination incorporates two definite subcategories. The first category (5-1) includes having self-confidence in speaking and acting on one's own thoughts. The second category (5-2) accounts for securing a separate identity from your family. Both subcategories define self-determination and ultimately represent factors that may facilitate health for middle-aged women.

Subcategory (5-1): having confidence in speaking and acting on one's own thoughts.

Most informants indicated women had to have confidence and trust in their thoughts and decisions if they were ever to achieve health.

Health to me is having a sense of self esteem and self confidence in one's own thoughts. It means you can overcome that block of "I can't". [case 10]

I became healthy when I became secure about myself and I discovered my self worth. Like you have to believe in yourself and know yourself well enough...to have an awareness of making yourself sick in certain situations. [case 08]

Eleven subjects associated unhealthy people with people who were not taking control of their lives by designing their own destiny. Specifically, it is not healthy to be influenced by others due to your own lack of assertiveness. However, seven informants identified their own inability to consistently have confidence in speaking and acting on their thoughts.

> I think it is very unhealthy not to take control of your life...to let someone else take control for me...that is when I feel very badly about who I am...it bothers me. [case 11]

> I know what my problem is...I say what I really don't mean. In fact my smoking is connected with me trying to be the nice guy all the time...always trying to control my emotions. I am dependent on my smoking for my good humour. I hint as well...that is another thing...it is impossible for me to be direct with someone. [case 09]

One hundred percent of the subjects associated their own passivity and timidity with barriers to women's health.

> I placate and hold things in too much...this is terrible for women to do. There was always this feeling that if I did get mad I would regret it for days...I would be in such pain over being mean...or saying something that might hurt my children. [case 08]

> ...when there is a disagreement with my kids...I won't stick up for myself. And if someone disagrees with me at work I am more than willing to think it is my fault. [case 11]

The majority of informants were supportive of women developing self-esteem and self-confidence to enhance wellbeing. The informants personally experienced the benefits of securing some degree of self-confidence.

> You really need some very good feelings about yourself...to break out of the passivity...realizing you are able to do a lot more than you gave yourself credit for...and if you can ignore conventions that is also very good for you. You mustn't be impatient and angry with yourself. [case 08]

> I was afraid to be assertive because my husband's alcohol problems might surface...it was always...what would my parents think?...never what will happen to me if I don't stand up for myself. [case 11]

Eleven of the twelve subjects confirmed they would attempt to be more self confident if they were to live their lives over. Without reservation the eleven stated they would have been more assertive in their dealings with family and society in general. Many of the subjects attested to being more assertive now than ever before.

> I would have been more assertive. I would have gotten my degree earlier and taken my B.Ed...which I regret and always will. I let people and their thoughts affect me too much...I became more assertive after my nervous breakdown. [case 07]

> I would have been more assertive...I used to just sit and smile and I must say I am getting better...in fact obnoxious at times...but I wouldn't have gone through my whole life thinking I wasn't very good. I

would go and get my A.R.C.T...people put these ideas into your head...it has taken me years to just realize I am not so bad looking. [case 02]

I have started to make a lot of "shoulds" go out the window ...I just said I am not going to do this anymore...it was surprising and unusual for me. Authority doesn't impress me as much...I now stop and think for myself...I am beginning to challenge things. [case 11]

Other women recalled specific events in their life that still make them uneasy about their passive behaviour. They recognize passivity as a conditioned response to the norms of society.

I think I would talk more if I had it to do over again. Teach the kids those things I worried about. You don't say anything because you don't rock the boat when everything is going great...they think you are over-reacting and I started to believe it myself...I was silent hoping everything would turn out okay. [case 06]

I would be less passive...at least I would avoid smoothing everything. We had a teacher in elementary school that used to pick on this poor little Irish boy...oh, how I hated that. One day they took little Johnny by the hair and hit him up against the wall... you know I was so upset that I didn't do anything...I often think about it...things that I have conditioned myself to do. [case 09]

The informants recounted that self-determination is enhanced by the ability of individuals to speak and act on their own thoughts. However, most informants related it was still difficult for them to speak and act assertively on their own behalf.

Subcategory (5-2): Securing a separate identity from your family.

Ten subjects supported the idea of women securing and maintaining an identity separate from their family as a means to promote health. They acknowledged the importance of a separate identity for women to stay healthy, yet cautiously warned that if securing an identity jeopardized your family's wellbeing, it was an unwise thing to pursue.

> I think having an identity is important...goes a long way to feeling good about yourself. My work gave me an identity...a sense of self worth. I worked nearly full time but never admitted I worked more than two days a week...because I thought a mother should be home with her children and I felt guilty about that. Working was very good for me...but I don't know what effect it might have had on my children. [case 11]

> I think health is helped by having something of your own...that you do for yourself...something that gives you an identity and some independence...and after people saw that my children did not go to rack and ruin it was much better for me. [case 04]

> It is important to get away and be involved in something outside the home...away from the family...not that you don't take your responsibilities there seriously...you should. [case 06]

Ten of the women reported personally maintaining their health by keeping some identity for themselves outside the home.

> Having a healthy curiosity...whatever growth ...personal growth came...came because of this. When

you realize there are other ways of doing things than the way you were brought up. If I had remained passive...and not sought outside experiences...I know I would have never had the confidence I have now. [case 08]

One should not dwell on home life and those children. I have seen my friends become depressed when the kids move away...they have nothing. I have always maintained something outside the home...like choir or church related activities...that is very important. [case 10]

Many subjects cited the loss of the identity of the wife and mother role as potentially harmful to women's health.

...when a woman becomes separated she used to be someone's wife...she now has to search for her own identity...somebody's wife..entertaining and making a good home..this is difficult to lose and can make women very stressed out. [case 11]

...all the uncertainty...a lot of women don't know what to do with their lives once the kids have grown up...they feel they can't go out and knock on the door of the world...they feel they are unequal or can't do it. [case 10]

...what I think is very difficult for women is when they lose or are unsure of their role. When my husband's father was dying, my mother-in-law didn't want any help...yet she needed it so badly. It was difficult because I didn't know what I should be doing...I didn't know where I stood and I couldn't say certain things. [case 12]

The informants stated some separate identity from one's family was necessary for establishing a sense of self-determination with the assurance that the outside identity did not threaten her family's wellbeing. A

career, or job, was also perceived as a defense against future role and financial insecurity.

Summary of Theme B: Health as Autonomy

Health as autonomy is represented by the two major conceptual categories of (4) freedom to enjoy life, and (5) self-determination.

Freedom to enjoy life contains three subcategories, (4-1) maintaining pleasurable activity and physical mobility, (4-2) being emotionally unconstrained, and (4-3) choice. Health, for these women, is achieved and maintained by physically doing what they want to do, when they want to do it. In particular, healthy people engage in enjoyable activities with friends and family of their own choosing. Most informants agreed that a minimum of ailments is quite tolerable given that they could still spontaneously participate in pleasurable activity.

Women attending to many family and community obligations without the proper supports are physically and psychologically likely to experience poorer health. The informants described "proper supports" as someone to share child-care, parent-care, and household responsibilities. Several informants reported the least

healthy time of their lives was when they took responsibility for the happiness and wellbeing of dependent children or adults. Many of the women experienced guilt when unable to meet everyone's needs.

Choice is a major factor in the freedom to enjoy life. All informants reported the desire to make their own choices about the direction of their lives. However, because many informants did not have a sense of entitlement, the choices were never well understood. Securing a stable financial income was a prerequisite for accessing choices. The informants saw divorce as a threat to a woman's financial security and ultimately her health. The informants suggested women seek education and opportunities for self-development to overcome the threat of an unstable financial situation.

Self-determination is the second major conceptual category associated with health as autonomy. The first subcategory of self-determination (5-1) is having confidence in speaking and acting on one's own thoughts. All informants claimed the need to be more assertive and confident in determining their destiny. Past experiences of passivity with family members and society demonstrated to most informants their past lack

of control and confidence. The informants explicitly stated that having others determine or affect your choices and actions is harmful to health.

The second subcategory subsumed under self-determination (5-2) is securing a separate identity from your family. Nearly all informants identified health benefits associated with women pursuing interests outside the home. However, the wellbeing of the family would take precedence over a woman's outside involvements.

Theme C: Health as Caring for the Self and Others

Health is achieved and maintained by caring for others and the self. In particular, to stay healthy, people require a level of energy that allows them to carry out their work. An energy supply is achieved through a disciplined lifestyle and adherence to routine; consequently, the individual is almost entirely responsible for her energy level and her health.

Health can be enhanced and preserved by involving yourself in something external to the self because by thinking about, and doing for others, you prevent self-absorption which is threatening to wellbeing. The two

major categories subsumed under this final theme are (6) possessing and preserving energy through self discipline, and (7) committed involvement with others.

Category 6: Possessing and Preserving Energy Through Self-discipline

The majority of respondents visualized healthy women as energized people that are full of vitality. Their appearance is one of radiance and neatness.

> Robust is what I think of...full of energy with a bright and sparkling personality. They are fairly together in their appearance and are just full of vitality. [case 12]

> A healthy person is an energetic active person...glowing...good clear skin and shiny hair..they are pulled together. [case 10]

Unhealthy people were characterized by a loss of energy and an inability to function on a daily basis.

> Unhealthy people have something that decreases their energy...either mentally or physically...like I am quite sensitive if I don't get enough rest after a few days. It is also the quality of concentration you can bring to work and play...like playing with the grandchildren...take them out to things...you are able to pick them up. [case 09]

All the study informants felt the individual is almost totally responsible for her own health. Health is maintained by the deliberate work of eating nutritious food, regular exercise and enough rest. Many

subjects detailed their daily dietary intake and exercise regime to the researcher and spoke with annoyance about people who neglected eating and exercising properly. Adherence to routine is seen as absolutely necessary to consciously work toward health.

> You have to work at it...it is up to you to be healthy. So I eat properly and exercise...it takes discipline ...no luck involved...just plain hard work. I get annoyed when people say..."oh, you are so lucky to be slim." Luck has nothing to do with it. I look at these big fat people and think...what are you doing to yourself...I think they are just darn lazy. [case 02]

> Health is being responsible for yourself and your health...I tell my kids you can't blame anyone. That is why I taught them to be responsible for themselves...like how to cook and shop properly. [case 03]

> After I retired it was just too easy not to make an attempt to do anything. I realized if I wanted to see my grandchildren grow up I would have to work at it...like get some exercise and lose weight. [case 07]

Unhealthy people were described as lacking in commitment and careless with their health.

> ...they think it is their bad luck that they are in the condition they are...always sick or tired...But those people have no personal regime to stay healthy. At least they don't stick to it, then. [case 06]

> If you are sick all the time...I don't mean something like cancer...but low energy and all these aches and pains...then it is likely something of your own doing. Most people just don't care...they just let themselves go they are so darn lazy. [case 01]

Adhering to a disciplined routine encompasses

doing things in a controlled, moderate manner.

I take care of myself to a certain extent...like I recognize when my energy finishes...just do the basics...like get the meal and do the laundry. [case 01]

Moderation in all things is important..to preserve your energy. I love to serve the community but I deliberately serve only one committee now. I shift gears during the day...just to get a bit of energy back. [case 04]

Six of the twelve women did mention that genes and some environmental factors took health out of the individual's hands to a certain extent.

There is no magical way of gaining health, you have to work at the preventive things...eating properly and exercising...but I think a good start helps...like if you haven't been abused as a child and of course blessed with good genes. [case 08]

Health can run in families...it has to with genes...pick the right parents I guess. [case 01]

Barriers to women's health that were perceived as beyond the individual's control, were pollution and chemicals that might affect the food chain. Attaining health was perceived as more difficult because of changes in the environment and food production.

Air pollution and the environment...things are so terrible now and deteriorating everyday. The food is processed differently now and I think this is very bad for the health of the nation. [case 03]

...the environment...the water...it is horrifying to think what we might be taking in or breathing...we

seem to have such little control over that. The change in the way food is produced is frightening...all the things they do to livestock. [case 07]

When discussing their parents' notions about health, eleven of the twelve informants recounted that food was considered the most important ingredient in achieving and maintaining good health. This same concern with food and nutrition was offered by all twelve of the sample informants.

We were always encouraged to eat everything and if you ate properly that would help you in school and getting your work done. Of course, I don't know anyone that didn't take cod liver oil. I feel our diet is crucial to our health. [case 11]

Even when I was growing up it was...eat properly and get your rest. In our house now food seems to be part of the situation...a balanced diet...a heavy emphasis on food. [case 04]

The informants cited securing and preserving energy through a disciplined lifestyle was a method of caring for the self.

Category 7: Committed Involvement with Others

Within this category there are three distinct areas where committed involvement with others was seen as a positive influence on the health of these middle-aged women.

The first part of the category emphasizes the

healthy results of having and carrying out responsibilities outside the home. Assuming community or occupational obligations that challenge your skill and intellect is a positive influence on women's health.

The second area of commitment concerns sustaining friendships. Women's health can be maintained and enhanced by genuine committed friendships.

The final area of commitment that promotes health and wellbeing of this particular group of women is meeting your family responsibilities and, primarily, having and nurturing children.

Eleven subjects saw healthy women as people who did not hesitate to get involved in their careers or community activities. They viewed them as people who could accomplish what they set out to do as a result of personal effort and ability.

...being able to accomplish what you set out to do..not hesitating to jump in and do things...get involved...do something for your community. [case 12]

Health is maintaining a sense of community and helping out in whichever way you can. Like my mother gave 75 wedding showers...one for every friend at least. [case 06]

Other women saw healthy people as knowing the issues of the day and having intellectually formed an

opinion on the issues. This intellectual involvement was often called "keeping up with the times".

> You take everything in...it is not just you in this world...look around and see what is going on and get involved. [case 05]

> If you know the styles and what new buildings and projects the city is involved with...listen to the radio and figuring out if we are making progress or standing still...[case 03]

Community involvement to many informants meant challenge. Health was enhanced and promoted when the informants would try new things and create something that stimulated them.

> To me, women need a challenge...an interest that demands their concentration and attention. [case 09]

> Your health can really be enhanced if you forget about yourself and get involved thinking about someone else for a change. I don't mean for a night...but commit yourself to doing something...challenge yourself, not only then do you do a job but you help yourself. [case 08]

A example of an unhealthy situation includes few personal responsibilities to yourself, family or society. Several informants gave their impressions of what an unhealthy living arrangement might entail.

> ...being self engrossed is terrible...having everything too well mapped out...Like the Wellesley [elite retirement home]...so glamorous and clean...so perfect that you might as well be dead...what a killer just to be stashed away from the real world and being committed to self gratification. Many middle-age women need a challenge. [case 09]

...people that retire to almost no activity and no real interests. We should be expecting something of these people, not ghettoizing them. [case 06]

Most women identified volunteer work as one example of committed involvement with others that gives women, in particular, a challenge.

...lots of good mental health comes from volunteering. There are always agencies or groups that need the support...it really can help you as an individual and for women it fits in with a schedule that often includes children. [case 02]

Being concerned and caring for others...like doing volunteer work...care for others which means anticipating their needs...not waiting until things fall apart...this is not an unselfish thing. [case 08]

There is so much waste...just killing time...I am fed up with the waste. If you don't think about someone else then you are lost. [case 08]

The second major property of committed involvement with others was making and sustaining genuine friendships. Friendship was important to staying healthy, not only to have friends, but to be a friend. Again, doing something for others was doing something for yourself.

I really feel best when I am meeting with others of a common mind...involved with music and my groups concerned with women's issues...you are healthy and maintain your health when you are happy and enjoying the associations and friendships you have. [case 06]

My health has been positively affected by my friends that gave support...sometimes it takes nothing

more than a listening ear..someone you can talk to and get out your most inner feelings...and in turn listening to others is very important. That is the best thing we can do for each other...is to really listen...especially to your children. [case 10].

In contrast, many informants had experienced a sense of isolation because of a lack of friends and organizational involvement in the past. They recalled the experience as a stressful and unhappy time.

I remember when we first moved to this area...I really didn't have any friends yet..I had casual acquaintances...but no one of like mind to really talk to..I mean about everything. This added to my stress at the time. [case 01]

Being a housewife at home alone is a very unhealthy mode of being. You are alone too much and all your neurotic thoughts come out...everybody needs an audience...someone to approve. Isolation and lack of true friendships is lousy...living in a world of your own. [case 09]

I think I maintain my health by being with people...my job is a major source of satisfaction because it is so people-oriented. I was never in a position of being isolated...I am not sure how I would cope. [case 12]

Certainly being committed as a mother and member of an extended family was seen as necessary for everyone's happiness, including the informants' happiness. One hundred percent of the subjects stated if they had their lives to repeat the one thing they would most definitely do, ahead of getting married, would be to have children. In fact, nine of the twelve

women said they would have liked even more children. Of the three that said they were happy with the number of children they had, one had five, and another had six children. One woman, advised for medical reasons not to have another pregnancy, regretted not risking her physical health for more children.

> Definitely have my children again...it has brought me so much joy...even ahead of getting married. I remember when they were born I was so very happy. [case 11]

> Have my children...it is all I ever wanted to do. Mind you, I really wanted to get married...because I wanted a family. [case 02]

> Having a home and children...it is all I ever really thought about and I still think it is better than giving yourself to a career...[case 03]

The specific responsibility and resulting joy from being a parent contributed to the informants' health.

> ...raising and enjoying our children...they are a big responsibility but they were such a joy to have..they made our life. [case 09]

> My number one concern has always been my husband and the kids...sure it is worrisome and hard work but what do you expect...this is serious business. [case 10]

> I was brought up to look after my family...The degree to which you took care of your extended family really tells how stable and caring you are. It is almost a spiritual type of dimension...a serenity that made it possible for me to be aware not just of myself, but people around me. Open and helping others, not hurting them...especially your family...children.

[case 08]

Nine of the twelve women recounted personal stress and sacrifice with parental responsibilities. However, these women also reported the many rewards of raising children. Ultimately, responsible parenting was seen as having healthy consequences for women.

> The worry with your children can really make one sick...worry about the drug scene out there...driving around in their cars...wondering if they are safe and doing the right thing. [case 10]

> Children are your worry point...you hate to see them struggle...but you know they have to go through it. I have a tendency to tell them how I would do it...but you can't...they just have to find things out for themselves. [case 12]

> When I was younger I was always worried...was I doing the right thing with them...feeding them and talking to them. Then as I am older you worry about your worried children. [case 06]

The informants recounted the positive effects caring for others has on one's own health. In particular, community obligations, friendship responsibilities, and nurturing children were identified as examples of healthy, committed caring for others.

Summary of Theme C: Health as Caring for the Self and Others

The study informants cared for themselves by maintaining a self-disciplined lifestyle (e.g., consuming nutritious food, regular exercise) to gain and preserve energy. Securing a source of energy was important for the informants to enable them to serve community and occupational obligations, to sustain friendships, and to parent children. All the informants enunciated the exponential benefits they personally reaped by involving themselves in community issues or another's life.

CHAPTER 5

DISCUSSION AND RECOMMENDATIONS

Introduction

Culture is more than a set of unrelated pieces. An integrated larger picture of the culture of middle-aged Icelandic-Canadian women can be developed from what initially appears as separate and distinct concepts (Spradley, 1979). The analysis of the study data conducted within the qualitative paradigm resulted in the emergence of three major themes. The three themes represent broad beliefs that middle-aged Icelandic-Canadian women hold about health, their health needs and factors that impinge on their health. The three themes link smaller cultural concepts together and provide insight into the study informants' general patterns of thoughts and beliefs about health.

A theme is a "postulate or position, declared or implied, and usually controlling behaviour or stimulating activity, which is tacitly approved or openly promoted in a society" (Opler, 1945; cited in Spradley, 1979, p.185). The three themes (a) health as the power of positive thinking, (b) health as autonomy, and (c) health as caring for the self and others, are

principles that middle-aged Icelandic Canadian women identified as guiding their health beliefs, needs and self-care practices.

The themes and categories evolving from the study will be discussed, compared, and contrasted with other published research on women's health. The intention is to integrate and explain the themes and categories developed with respect to other similar women's health research. Subsequent to this, a feminist critique of the research findings is developed within the framework of feminist research. Based on the comparison of the study results with the existing women's health literature and the feminist critique of the findings, recommendations for future research, nursing education, practice and health policy are offered.

Discussion of the Findings

Theme A: Health as the Power of Positive Thinking

Theme A	Categories
Health as the Power of Positive Thinking	1. Making the best of it 2. Accept it and carry on 3. I don't think about it... I just expect things to go well

The power of positive thinking represented a philosophy of life for the study sample. Regardless of circumstance, all women in the study routinely applied the power of positive thinking to accomplish daily life tasks, to overcome stressful periods and to assist others with life's challenges.

The category of "making the best of it" referred to the ability of healthy people to rise to a challenge to ameliorate a less than perfect situation. Some personal characteristics required for "making the best of it" included a solid problem solving ability, stoic resolve, and self-motivation.

The second defining category for this theme was "accept it and carry on". The study informants reiterated that to achieve and maintain health, people needed to access information and be open to change. These women suggest that being open to change and being accepting of circumstances preserves health. This category honours determination and willpower and portrays healthy people as self-reliant.

The third category of "I don't think about it...I just expect things to go well" emphasizes the health benefits gained from having a non-chalant optimistic faith about life. This notion can be implemented by focusing on other people or activities.

The power of positive thinking, because of its emphasis on adaptation and coping, resembles the "elastic philosophy of health". The elastic philosophy contends that an individual can achieve health by developing skills and knowledge that serve to protect and preserve their health (Sells, 1968).

Smith (1986) studied the health literature in nursing, medicine, public health and philosophy and identified four central ideas of human health. Smith's four health conceptions consisted of the: (1) clinical

model, (2) role performance model, (3) adaptive model, and (4) eudaemonistic model. The attributes of "making the best of it" closely resemble Smith's adaptive model where adaptive behaviour is defined as "the creative adjustment to changing circumstances" (Smith, 1986). This model encompasses human growth and creativity which echoes the creative problem solving ability discussed within the power of positive thinking. However, Smith states that a prerequisite for admission to the adaptive model is physiological health and adequate performance of social roles. The data from this study differed from Smith's adaptive model in that the study informants reported that "making the best of it" could be applied in all situations regardless of physiological health status. Therefore, if one was ill with disease and unable to maintain social roles, the power of positive thinking was a tool used to adapt to, or alter, the situation. These results correspond with Laffrey's (1986) findings that the four models of health did not form a progressive scale, from clinical to eudaemonistic, with each model subsuming the concerns of the previous one.

Woods et al (1988) discovered nine additional

dimensions within the eudaemonistic category which establish some relevance to the power of positive thinking. Of the nine additional dimensions within the eudaemonistic category, three relate to the power of positive thinking. These are practising healthy lifeways, positive mood, and harmony. Practising healthy lifeways involves acting to promote health or prevent disease. This concept closely resembles "making the best of it" by suggesting that one can act on the environment to produce a better outcome, or to alter an existing situation. Positive mood includes being happy and feeling a sense of optimism. Harmony refers to feeling whole and content which may be conceptually similar to accepting things for what they are. Due to editorial limitations, some of models of health are contextually stripped, making it difficult to distinguish among the differences or similarities of the concepts.

Rose's (1990) research resulting in nine themes of women's inner strength most closely reflects the theme of the power of positive thinking. Specifically, Rose (1990) describes "having capacity" as the ability to solve problems, to continue in the face of pain and

adversity, and to recognize when one does not have capacity. Key attributes of the power of positive thinking include the ability to problem solve, maintain a stoic resolve, and accept and face things as they come. Many women cited being open to change, and cultivating understanding, as crucial to accepting things and carrying on. This would relate to Rose's notion of recognizing when one does not have capacity. Another theme emerging from Rose's research was "embracing vulnerability" which includes the ability to acknowledge limitations and in doing so, growing and developing as a human being. The informants in this study echoed a similar notion when they spoke of accepting others, being open to change and using any challenge as an opportunity to grow and learn.

C. Matthiasson (1977) recorded that her Icelandic-Canadian female informants perceived themselves as "strong-minded". Although a description of the sample and context of the research was unavailable, some similarities to this study's description of the power of positive thinking may be suggested.

Calnan and Johnsons' (1985) research compared middle-class women's definitions of health with

working-class women's definitions. Middle-class women gave a more multi-dimensional definition of health, yet only 15% of them referred to health as a "state of attitude of mind" or "being able to cope with life's stresses" that would be similar to the power of positive thinking. Most middle-class women in Calnan and Johnsons' study defined health as "feeling energetic" or "not getting many illnesses". All the informants in my study were middle-class and although feeling energetic and not getting many illnesses was mentioned, every woman in this study stressed, that even in the face of illness, positive thinking could create a healthy state in the individual. This difference may suggest a cultural variable, that class is not relevant, or that the determinates of class are unreliable.

However, Calnan and Johnsons' study does elude to the third category of the power of positive thinking; "I don't think about it..I just expect things to go well". The working-class women of Calnan and Johnsons' study associated thinking about illness as a form of hypochondria "which was considered unhealthy in its own right" (p.66). Similarly, Griffith (1983) examined

women's coping habits and discovered that while women under 45 years used food and alcohol consumption to cope with stress, women over 45 years coped by ignoring the problem.

Pender (1990) developed, from the literature, a classification system consisting of five dimensions expressing notions of health. The five dimensions of health are affect, attitude, activity, aspirations and accomplishments. Pender's (1990) affect and attitude dimensions most closely reflect the power of positive thinking. The affect dimension contains the subcategory of serenity. Serenity is defined as being satisfied, a sense of tranquillity or a peaceful inner state. Parse's (1985) research discusses a similar notion but refers to it as "serene unity". The informants in my study described a type of "serene unity" as the outcome of the power of positive thinking. The attitude dimension's two subcategories, optimism and competency, are also relevant to the power of positive thinking. Optimism, conceptually similar to "I don't think about it", refers to being hopeful, enthusiastic, and trustful. Competency is theoretically linked to "making the best of it" by including self-motivation,

innovation and initiating. These two dimensions imply that all will end well despite the challenges that lie ahead. The possibility for human growth exists within difficult situations.

The popular lay literature for women linked the power of positive thinking with women's health issues. Chatelaine (1989-1990) devoted 15% of their total health-related articles to women's mental health promotion. This particular magazine located "emotional problems" within women themselves, and suggested women should be responsible for improving their own mental health by being less cynical and hostile. The power of positive thinking as described by the informants also linked the solution to emotional barriers to health within women's own mental capacity. The informants insisted a woman could improve or ameliorate a situation by altering her attitude.

Summary

Researchers exploring the concept of health often discuss "the power of positive thinking" through conceptually similar notions of "adaptation", "affect", "strong-minded" or "inner strength" (Matthiasson, 1977; Pender, 1990; Rose, 1990; Smith, 1986; and Woods et al,

1988). Although some research (Smith, 1986) claims physiological health is mandatory prior to enacting "adaptation", my study and others (Laffrey, 1986) have underscored health as a state of mind rather than a physical state.

Social class has exhibited some bearing on personal health definitions, with working-class women associating self-centeredness and hypochondria with an unhealthy state (Calnan & Johnson, 1985; Griffith, 1983). Although my study informants were middle-class, they expressed the relevant notion "I don't think about things"; in contradiction to Calnan and Johnson's study, they emphatically expressed health as a state of mind.

The popular lay literature reflected the study informants' views, suggesting responsibility for health resides within the individual. Individuals can ameliorate or change most conditions if they use willpower and determination.

Theme B: Health as Autonomy

Theme B	Categories	Subcategories
Health as Autonomy	4. Freedom to enjoy life	(4-1) mobility and happiness
		(4-2) being emotionally unconstrained
		(4-3) having choice
	5. Self-determination	(5-1) having confidence in speaking and acting on one's thoughts
		(5-2) securing an identity separate from the family

Theme B: Health as Autonomy

Health as autonomy has two main categories; (4) freedom to enjoy life and (5) self-determination. The

first category, freedom to enjoy life, is characterized by several notions, the first one being "maintaining enjoyable activity and physical mobility". Within this dimension the study informants cited some basic requirements for health, such as being relatively free from disease. However, a person could still have a small number of ailments and experience health. The premise is that people need to be relatively free from disease to maintain some level of physical mobility for securing spontaneous freedom to enjoy life. Health as the absence or infrequency of ailments is analogous to Smith's (1986) and Woods' et al (1988) clinical image where health is also viewed as the absence of disease. However, being relatively free from disease was not in itself health. Healthy people use their healthy state to mobilize and enjoy activities of their choosing. If an individual can enjoy something, whether it be an activity, other people, or a book, then from the study informant's perspective, those people would be considered healthy. In this regard, clinical, role performance and social involvement are not separate entities but are integrated. The absence of disease is essential within many models of health (Laffrey, 1986;

Pender, 1990; Smith, 1986; Woods et al, 1988), as was true for this study. However, the absence of disease was identified by the informants as only one segment of health, and certainly not the most significant segment. Newman's (1982) nursing model of health clearly supports some biological illness as part of the total experience of health, depending on how that person interpretes their experience.

The second subcategory under freedom to enjoy life was "being emotionally unconstrained". Most women stated that having no one dependent on them right now was assisting them to maintain their health. The sample cited the least healthy time in their lives was when they were responsible for others' happiness and welfare with little support or understanding for themselves. The sample recalled that time-bound responsibilities like meals, laundry, and child-care activities left virtually no private time and contributed to a sense of fragmentation. Five informants presently experience fragmentation with the responsibilities of aging relatives, worries with teenage and young adult children, and community commitments. The study results suggest that women do not experience an end to

fragmentation and role responsibilities with middle-age. Most health definitions praise performance of multiple roles as an indicator of high level wellness (Laffrey, 1986; Pender, 1990). Woods et al (1988) eludes to the effects of fragmentation in discussion of what they term the "harmony" dimension. Harmony is signified by being centered, peaceful and spiritually whole, but includes the notion of "being carefree" with no worries that may be similar to "being emotionally unconstrained".

Two popular women's magazines, Chatelaine and Canadian Living (1989-1990), encourage women to develop more leisure time, yet contradict this goal by explicitly suggesting more role responsibilities for mothers, wives, neighbours, and grandmothers with an emphasis on expanding nutritional knowledge, staying fit, participating in recycling, and providing theme birthday parties to increase children's self-esteem. Heller (1986) identified a lack of personal time as a major stressor for middle-aged women.

The third subcategory under freedom to enjoy life was having a choice. Having a choice, regardless of the issue, was imperative for these women to achieve and

maintain their health, although many informants offered examples that demonstrated their limited options. Nearly half of the informants had experienced unsatisfactory health services in the past and had since accessed alternative health services such as nutritionists and iridologists. Heller (1986) identified that 33% of middle-aged women were less than fully satisfied with the health care they received.

The informants in this study emphatically stated that having financial security was fundamental to ensuring women had choices. Some women mentioned that because they had no awareness of, or sense of, entitlement to choice, they did not feel they had a choice. This is similar to the Canadian Advisory Council on the Status of Women [CACSW] findings (1989) which demonstrated that women have limited choice in job opportunities, education, and social roles.

The adaptive dimension in Woods et al's study, (1988) suggests financial adequacy and control over a person's life is part of health. However, the underlying assumption in the adaptive dimension is that a choice for women, in actuality, does exist.

The second category included under health as

autonomy is self-determination. Self-determination for these women included having confidence in speaking and acting on one's own thoughts. The informants associated timidity and passivity with unhealthy people, or at least believed that these behaviours contributed to circumstances and situations that were not healthy. All women stated that they wished they had been more assertive throughout their lives, although a majority felt they were now more assertive than they ever had been. Positive self-concept has been cited as a feature that women identify with healthy people (Woods et al, 1988). Part of this dimension included being self-confident and having high self-esteem. The study informants identified both of these characteristics as important aspects of health. However, of all dimensions Woods discusses, positive self-concept was the least acknowledged by the women in her study. This could suggest that women from different ethnic backgrounds, or different age groups, may perceive the importance of a positive self-concept differently. In the literature most definitions of health incorporate some sense of self-determination such as "speaking and acting on one's own thoughts" when they offer transcendence and

personal effectiveness as indicators of high level wellness (Pender, 1990).

Self-determination was manifested by securing an identity separate from one's family. To maintain health, women in my sample thought that it was wise for women to establish some identity outside the home. They recognized that if women lose their traditional role of wife and mother through divorce, death, or children leaving home, they risk their financial security and definition of self. Having some role outside the home is not only stimulating, but it can be a financial and emotional lifesaver in the event of death, divorce, or role change. This finding is congruent with research that links social involvement and social responsibility with health (Pender, 1990). However, most of the underlying intention of securing an identity separate from one's family for my study informants was to act as a hedge against emotional and financial insecurity. This could be theoretically congruent with the health definitions that include concepts of autonomy and independence, yet the impetus for the independence may be radically different for some groups compared to others.

Summary

An important feature of autonomy for the study informants was "being emotionally unconstrained" with multiple role responsibilities. Unfortunately, many descriptions of health include establishing and maintaining social roles, yet fail to qualify the effects multiple roles may produce (Laffrey, 1986; Pender, 1990; Smith, 1986). Researchers usually refer to "role enactment" separate from managing stress or establishing healthy lifeways.

Although articles in popular women's magazines such as Chatelaine encourage more leisure time, they paradoxically suggest more role responsibilities.

Securing a choice, often predetermined by material security, was important for health according to the study informants. Several researchers have documented the direct relationship between women's health and material security (CACSW, 1987; Woods et al, 1988).

The hidden assumption in most definitions, or models of health, is that people are aware of, and have access to, the same choices. This study revealed women do not necessarily experience "the entitlement of choice". Pender (1990) cited disadvantaged groups such

as the "poor and some ethnic/racial minorities" experience a range of limited options, but she does not include women (p. 120).

Personal effectiveness and a positive self-concept (Pender, 1990; Woods et al, 1988) may be theoretically similar to the study informants' desire to be more assertive. Although the study informants associated health with personal effectiveness, they also acknowledged their occasional personal ineffectiveness and yet emphatically described themselves as healthy. This may suggest that health definitions overlook and disregard personal consciousness of ineffectiveness or the process of self-development. Instead, most definitions honour the final product of personal effectiveness.

Some health researchers discuss social responsibility and involvement as indicators of health (Pender, 1990; Woods et al, 1988). However, the impetus for the social involvement, which in this study was protection against loss of financial security or social role, is undiscussed.

Theme C: Health as Caring for the Self and Others

Theme C	Categories
Health as Caring for the Self and Others	6. possessing and preserving energy through self-discipline 7. committed involvement with others

Two categories contribute to the establishment of this third theme. The first category is possessing and preserving energy through self-discipline. This sample of women repeatedly described healthy people as those that look and act like they have an abundance of energy. The most common reasons people may not have energy are because of eating poorly and not exercising. People who do not possess energy are lacking in self-discipline and should establish themselves in a routine of good eating habits, exercise and rest. Research has shown that women identify body image, fitness and practising healthy lifeways as representative of health or the style of a healthy person (Laffrey, 1986; Smith, 1986; Woods et al, 1988). Within the category of

"possessing and preserving energy...", the predominate notion was that healthy people are concerned and committed to eating properly, getting enough rest and avoiding too much alcohol, which all correspond to practising healthy lifeways. Griffith (1983), identified a lack of exercise and eating poorly as major stressors for women between 25 and 55 years of age. However, getting exercise and eating wisely were not stressors for the study informants, rather a healthful lifestyle was a duty and obligation to oneself.

The second strand contributing to this third theme is "committed involvement with others". The informants described responsibilities outside the home, friendships, and meeting family responsibilities as factors that contribute to and define a healthy person. These activities are an antidote to being too self-engrossed, which is potentially threatening to one's health. This may be similar to Pender's work (1990) which describes "the enhancement of global harmony" and "relevance" as indicators of high level wellness. Relevancy is analogous to involving oneself in committed caring that is useful to society.

Matthiasson's (1977) work documented the historical importance the Icelandic-Canadian women attached to involvement in voluntary organizations for the betterment of the community. Even the Fjallkona that presides over the annual Icelandic festival is chosen based on her contribution to the whole community.

The informants overwhelmingly associated their good health with having and nurturing children. They voiced an acknowledgment of the difficult job that "good parenting" can be, yet unequivocally cited their children as their raison d'etre. At least half of the informants implied that the underlying reason they sought marriage was to have children. There is little research that explicitly supports the idea that having and caring for children contributes to women's health, yet many health definitions include comparable concepts of "social contribution" and "accomplishment" (Pender, 1989).

Interestingly, the Fjallkona represents to the Icelandic-Canadian people a mother-figure that nurtures the culture and insists on its continuation. As well, a quality home-life coupled with the serious

responsibility of raising educated, socially conscious children served as an important ideological base and justification for women's suffrage in Gimli, Manitoba (Ibsen, 1988; Newman, 1991).

Summary

Healthy routine habits such as eating nutritious foods and exercising, as identified by the study informants, is clearly outlined in the health literature (Smith, 1986; Pender, 1990; Woods et al, 1988). Although some research revealed that maintaining healthy eating and exercising practices are stressful for women (Griffith, 1983), the study informants emphasized the importance and duty of a healthful routine.

Committed involvement with others closely parallels Pender's (1990) notion of "relevancy". However, the common health categories of social contribution and accomplishments ignore the nurturing of children as part of social contribution. At least from the limited description of health categories most models provide, nurturing children is not included. Yet the study informants in this study cited nurturing children as an important and necessary contribution to

society and to oneself. Some Icelandic-Canadian symbols underscore and reinforce the merit and value of motherhood.

A Feminist Critique of the Three Themes of Health

This section discusses and describes the purpose and application of feminist analysis and theory construction from women's everyday experiences. Furthermore, three main areas, the double-bind, other-centeredness, and resourceful adaptation and subversion, are specifically addressed in relation to Icelandic-Canadian middle-aged women.

Marilyn Frye (1983) in her book The Politics of Reality, compares the work of a feminist analysis to "forming charts of currents, trends and cycles of winds and storms, in that there is no implication that every single individual and item in the landscape is affected in just the same way by the same wind" (p. xii). I concur with Frye's belief that not all women are subordinated in the same way, nor do all women react to subordination in the same manner. However, I do believe all women, as a group, are subordinated to men as a group. You may not feel oppressed by your male partner, yet the systemic oppression of women as a group, by men

as a group, is undeniable. Women as a group are psychologically and physically more constrained by the double-bind phenomena, are less materially secure, less free to walk in the streets for fear of rape or assault, and have much less private time and opportunity to engage single-mindedly in leisure activity, or self-development activities.

During my analysis of the research results, I discovered the forces of oppression, and the informants' reactions to them, to be covert and complex because these women often cooperated and negotiated with the subordination when the most reasonable and logical action should have been to challenge the forces of oppression. Importantly, the results of this research suggest that what appears to be unnecessary cooperation may prove to be resourceful adaptation to the environment leading to a form of subversion. Consequently, I recognized that these women were all engaged, at some level, in building feminist theory.

Charlotte Bunch (1987) outlined a process for the creation of feminist theory. She divides the process into four parts: description, analysis, vision, and strategy. The first step, description, involves

describing what exists in a woman's world and naming it by, and for, women. This is primarily accomplished through consciousness-raising. Description allows the gathering and interpreting of facts about women to warrant feminist claims. Analysis is a complex and difficult second step that seeks to understand where women's subordination originates and how it is perpetuated. Vision is often in place before analysis because vision is determining what should exist for women, and somehow it is easier to name what should exist rather than why it does not. Thoughtful vision, however, requires thorough and careful analysis of the forms of oppression to establish values and goals for the future. The final step, among these inter-related and inter-dependent concepts is strategy: the "overall approach one takes to accomplish one's goals" (1987, p.245).

Throughout most of my findings I discovered that women had a consciousness of their subordination and were beginning to name the specific debasements on their own terms. By looking for subtle and not so subtle signs of resistance, I began to understand the complex and covert forces that perpetuate the

subordination of women. The majority of informants, at some point, criticized, rebelled or resisted definitions of themselves, and their health, imposed on them by society. During their naming of the oppressions, I heard these women describe a vision of what health could, and ought, to be. Strategies to secure their vision of health were beginning to take form.

The most perplexing piece of theory development for many women resides in the analysis of their subordination. From my perspective, the informants struggled to decipher the source of their subordination because, as with most women, much of what gave them pleasure also gave them pain. The gendered experience of the double-bind was agonizingly evident.

Double-bind

A distinguishing feature of oppressed people is the experience of the double-bind. Frye (1983) states, "one of the most characteristic and ubiquitous features of the world as experienced by oppressed people is the double-bind; situations in which options are reduced to a very few and all of them expose one to penalty, censure or deprivation" (p.2). For instance, Frye

discusses the predominately female requirement to smile and be cheerful regardless of the situation. In other words, the situation can not be that bad; put on a happy face and remember things could be much worse. If we consistently smile, we may signal our submissiveness and our acquiescence of our situation. Our smiling conveniently relieves others around us because if we smile we need not be taken note of, and as Frye points out, "we participate in our own erasure. We have become invisible and occupy no space" (p.2). Yet if we choose not to smile and therefore draw attention to ourselves; we are perceived as mean, bitter, angry and dangerous. Smiling versus not smiling may seem like an example of polarities. Many women fall somewhere between the demands of smiling and not smiling, depending to a large extent on their colour and class; nevertheless, women's freedom as a group to authentic emotional response is eclipsed by social dictates.

Mothers, as all the study informants are, may experience yet another form of the double-bind. If women step out of the role of nurturing, protecting and facilitating, sometimes regardless of the support plans in place, they are accused of insensitivity. The

contempt for universal child-care demonstrates the covert assumption that if women really cared for their children they would stay at home with them. When women do stay home with children they endure the "minor" penalty of material dependency often resulting in a shift of decisional power to the "breadwinner", to say nothing of society's unwillingness to take seriously mothers' knowledge and contribution to our social and economic well-being. Heller (1986) found the most common complaint from young mothers was the ignorance and trivialization doctors displayed towards mothers' concerns and observations. Raising children in a caring and responsible manner is an important feminist value, yet feminists are accused of despising "housewives" because they refuse to romanticize a situation wrought with material insecurity and emotional debasement.

The double-bind is a pervasive concept throughout my analysis of Icelandic-Canadian women's perception of health, their health needs and factors that affect their health. The women in this study were particularly concerned with the health and welfare of others. Theme C, "Caring for the self and others", disclosed the belief that by doing for others, you do

for yourself. Any accusation of insensitivity to another's needs would likely be intimidating, since sensitivity and caring are some of the few virtues that have been assigned to women and these women in particular. The social construction of the "healthy" woman requires women to think, act and serve the needs of others.

Because of the serious import these women gave to caring for others, I discuss, in the first section, the "other-centeredness" experienced by these women. The second section is entitled "resourceful adaptation and subversion" to acknowledge and describe the informants' reaction to, and rebellion against, the double-bind of "other-centeredness".

Other-centeredness

Other-centeredness refers to the phenomenon of putting "others" at the centre of your life and displacing your self-needs to the sidelines. Placing others at the centre means working not for yourself, but others; it means sublimating your desires for the others' desires; it means caring more about them, than you do about yourself. According to Frye (1983) it means participating in your own erasure.

Internalization of "otherness" means that one comes to identify oneself through the eyes of the dominant group in society.

We all experience degrees of other-centeredness, and to survive, we all must be able to think of others and act for others. What I intend when I use the word other-centeredness is that, regardless of circumstance, the self does not command the attention, or the respect, in the same degree or manner as "others" do. The weight or balance of attention goes to others, not to the self. Ideally, the needs of the self and others are balanced, and self-denial does not become the frequent path of least resistance, or the path to self-actualization.

The primary purpose of this research was to discover middle-aged Icelandic-Canadian women's personal thoughts about their health. However, before long it became clear to me that their talking about their children, families and communities was talking about themselves. They were unable to separate themselves from others in their lives. They were able to connect their children to themselves effortlessly, and most definitively stated they would have liked more

children. They described commitment to the community, yet clearly took pains to underscore their commitment to family relationships. The commitment to family and children was a clear-cut choice for all these women; they had never experienced conflict around this issue. The needs and desires of their families became their needs and desires. They were defined by, and for, others. One woman succinctly summarized this by recounting, "Health is being able to care for your family and maintain a sense of community...helping out in whichever way you can".

Feminist researchers (Gilligan, 1982; Ruddick, 1989), building on women's experiences, have emphasized values such as connectedness and responsibility. Connectedness serves to emphasize the similarities between oneself, and something, or someone else. Feminist researchers claim that women often perceive the people and environment around them as inseparable from them, which allows them to appreciate and respect differences. Ultimately, connectedness means that one can be other-centered without losing selfhood. However, what Gilligan refers to as "connectedness", I refer to as "other-centeredness" as depicted by Marilyn Frye.

Frye (1983, p.167) describes other-centeredness by depicting a stage scene where she states:

> A foreground figure is created by the motion of foreground figures against a static background. Foreground figures are perceptible, are defined, have identity, only in virtue of their movement against the background. The space in which the motion of the foreground figure takes place is created and defined by their movement with respect to each other, and against the background. But nothing of the background is in, or is part of, or is encompassed by, the foreground scene and space. The background is unseen by the eye which is focused on foreground figures and if anything somehow draws the eye to the background, the foreground dissolves. What would draw the eye to the background would be a sudden or well-defined motion in the background. Hence there must be no motion at all, or an unchanging buzz of small regular and repetitive motions. The background must be utterly uneventful if the foreground is to continue to hang together, if it is to endure as a space within which there are discrete objects in relation to each other.

Frye's describes the colonization by others that takes place within the self of an other-centered individual.

Icelandic-Canadians and Other-centeredness

Nine of the study informants were first and second generation Icelandic-Canadians, with three informants being third generation. The homes where the informant's first learned about the relationship between themselves and the dominant culture, were primarily first

generation Icelandic-Canadian homes.

The first and second generation Icelandic-Canadians, like other immigrants, were acutely aware of their success being dependent on their ability to appear like the dominant Anglo-Saxon population. Because they were white this made the job much easier. Within the safety of their small community the Icelandic language was preserved and revered, however their outside face was one of assimilation. The Icelandic culture did not begin to "go public" until they obtained a certain amount of political influence and proved their worth in music, literature and business (Matthiasson, 1989). Other-centeredness was necessary to watch and learn the dominant culture of Canadians so as to appear as one.

Voice of Otherness

The informants in this study voiced both the appeal and the cost of being other-centered; in other words, they had an understanding of the double-bind. The informants expressed their "other-centeredness" with desires such as, "committed involvement with others" and "having family responsibilities". However these women also recognized that "being emotionally

unconstrained", "having choice", "securing a separate identity from your family" and having "the courage to think and act on one's own thoughts" were absolutely necessary for health.

The desire for assertiveness, emotional freedom, a separate identity, and most pronounced, "the courage to think and act on one's thoughts", may be symptoms of the internalization of otherness. When you internalize otherness you "almost definitionally are unable to speak in the language of the self" (Frye, 1983, p.55). If self-definition depends on behaviours that are other-centered, you relinquish some freedom to speak authentically because speaking authentically demands you speak by, and for, yourself.

Carol Gilligan (1982) determined that women speak about morality "in a different voice" from men. Gilligan is careful not to call this a gender difference, but a difference in voice that is found mainly in women. Some researchers have since stated the "different voice" is the voice of the oppressed, not exclusively women's (Tronto, 1987). However, Gilligan states that women's moral processing is contextually dependent, with an acute awareness of the conflicting

responsibilities involved in making a moral decision. Women are more concerned with the activity of care and the maintenance of relationships with others, and she refers to this as a sense of connectedness. Gilligan claims a morality of responsibility for women that emphasizes connection, different from men's morality of rights that emphasizes separation. Men's moral reasoning centers on understanding the individual's rights and the rules involved in social participation. Yet as MacKinnon (1987, p.38) notes,

> Gilligan achieves the affirmative rather than the negative valuation of that which accurately distinguishes women from men. However, women value care and other-centeredness because men have valued us according to the care we give them. When you are powerless you don't speak differently, you really aren't speaking.

In actuality, these women did not speak in a different voice; they had the voice of conventional feminine self-effacement. In fact, one informant suggested one should forget about having a voice at all. As she stated, "a lot of good health comes from forgetting about yourself and caring for others...there is so much waste. If you don't think about someone else then you are lost".

Although "other-centeredness" was pervasive

throughout the research findings, the study informants had a consciousness of their other-centered lives. Theme B, "health as autonomy", voices a vision of health that begins to acknowledge the need for a centered self.

Object versus Subject

When people are "other-centered" they often see themselves as "objects" with their raison d'etre to please and serve others. "Others" are seen as subjects. Simone De Beauvoir's (1953) analysis contributes to understanding women's desire to no longer be an object or an "it" for someone else, but to become a subject, or an "I". These women's desire for "courage to act on their own thoughts", at first seemed obvious and somewhat trite. However, I believe these women were beginning to recognize their "object" status and to identify it as antithetical to good health. Perhaps because, "the refusal to be an object forces those who would see women as objects toward a recognition of their existence as subject" (Donovan, 1988, p.128), most informants believed in the need to assert themselves. Yet they failed to act on their beliefs: as one informant affirmed, "I know what my problem is...I

say what I really don't mean..always trying to control my emotions. I hint as well; it is impossible for me to be direct with someone."

The informants' struggle and ambivalence around assertiveness and self-determination may indicate a threatened self-definition. By putting themselves at the centre, these women would cause others to re-examine their position in society. Because the adaptive strategies of "accepting things" and "making the best of it" have successfully not created heartache or "trouble" in the past, these women may be reluctant to force others to see them as subjects. The double-bind makes women ask: What rewards might I receive if I do speak and act authentically or, perhaps more importantly, what punishment might I risk?

Men as a group throughout history, have perpetuated other-centeredness as proper modis operandi for most women (Lerner, 1986). Women's roles are so systematically reinforced and rewarded that women cannot be said to be choosing roles at all; instead they are coerced into roles.

It is assumed that unless you are physically forced to do something you are not being coerced, but

coercion can be subtle and malicious. The structure of coercion is to manipulate the situation so a woman's world presents the woman with a range of options but makes the other-centered option the most attractive. If the project of caring more for others is sold properly, it includes a promise for financial and physical protection, the assignment of the higher moral ground, and the freedom to speak in other-centered language or "a different voice". For if people don't mind doing what you want them to do, and they say that, then in a sense, you can't be making them do it.

Because of this, Daly (1978) understands that to reject "object" status would take considerable courage for women, as is expressed by these women requesting "the courage to speak and act on my own thoughts and feelings". The internalization of self as object is difficult to overcome and it presented tensions for the informants throughout the research findings.

Virginia Woolf recognized this difficulty when she wrote about her need to "overcome the angel in the house" (Woolf, 1986). Woolf had to purge the image of the self-effacing, ever-smiling female, "the angel in the house" before she could begin to authentically

speak her experience.

To accept the role of object is to deny, to some extent, the subject-self that is autonomous and creative. However, the study informants viewed these characteristics almost as polar opposites. If you became a subject yourself, the "others" suffered. As one informant explained, "When there is a disagreement with my kids or co-workers, I won't stick up for myself. I start to feel sorry for them and am more willing to think it is my fault."

The informants' reluctance to place themselves at the centre may point to women's difficulty with viewing the world as split between others and the self. Existentialism, and its subject/object split, has been criticized for its continual cultural attempt to transcend the feminine perspective of connectedness (Ruddick, 1989; Ruether, 1975). By analyzing women's lives from an existentialist theoretical view, some feminists believe we encourage moral and ecological disaster because "all the destructive antinomies that govern the present organization of society are rooted in the self-other model of consciousness" (cited in Donovan, 1988, p.132). However, there must be a better

understanding that placing oneself at the centre should not risk a woman's relationship with community, family or friends. The informants displayed the ability to respond in an integral, nurturing manner that promoted community survival or, in a split subject/object mode when discussing their bodies and other people who did not exhibit similar values and behaviours to themselves.

Self-discipline and Others

The findings of this study suggest that these women viewed the physical (i.e., the body) self as separate from the mental (i.e., the mind) self. The women regarded their bodies as something needing control and close observation, as if their bodies were strangers trying to get away with something. They did not trust their bodies, in fact they believed it required a tremendous amount of self-discipline and rigid routine to keep their body from getting out of shape or overweight.

Those women who did not practice self-discipline about their diet, money, appearance, children, or habits were seen as "darn lazy" and distanced from themselves. The problem, as the study informants

perceived it, lay within the "other women" and not within society at large. They indicated that people are almost totally responsible for their health, and those who experience frequent and varied health problems, likely did something to deserve the poor state of health, or were simply not trying hard enough to overcome it. Therefore, a separation was present between these women and others who repeatedly succumbed to ill-health. A separation was also evident within the self; they could apply self-discipline to themselves as if that part of themselves (i.e., the body) was an outside sinister entity that required close observation and rigid routine. One informant declared, "You have to work at health..it is up to you. I discipline myself...luck has nothing to do with it. I look at these big fat people and think what are you doing to yourself...I think they are just darn lazy."

During the thirty-six interviews with the informants, although the need to care for their aging bodies was discussed, their experiences with menopause or their future expectations of menopause were rarely discussed. It appears that perhaps menopause does not play the significant role in women's lives that it was

purported to have, or it was treated as a part of the whole, somehow connected to everything else in their lives that did not need special mention. Choosing not to discuss menopause could be an example of their resolve to "expect things to go well". However, it could also suggest that menopause was not socially acceptable to discuss.

Self-Knowledge and Health

Theme B, "freedom to enjoy life" and "self-determination" (i.e., having choice, spontaneous freedom, and being emotionally unconstrained) may be examples of the informants asking for autonomy on their own terms. I think these women were asking not to be annexed; instead they were appealing to the challenge and opportunity for developing self-knowledge. One study informant epitomized this when she recounted, "I became healthy when I became secure about myself and I secured self-worth. Like you have to believe in yourself and know yourself well enough to have an awareness of making yourself sick in certain situations".

The past, and present, lack of private time was evident in the study results. These women were

fragmented with wife-work, mother-work, house-work, community-work, and sometimes daughter-work, that left little private time for themselves. As one woman asserted, "there is always something to do...it is not so bad now, but I used to feel so overwhelmed...this constant pressure of so many things that need doing".

There were many examples in this study of the women's disdain for self-absorption. All twelve informants had done volunteer work, and nine continue to give their labour to at least two outside organizations each. As they viewed it, healthy women do not hesitate to get involved in the community activities because what you do for others, you do for yourself.

Of course, the real rub is that when they did not have enough time for everyone else they faced feeling guilty. It is no wonder then that although time for single-mindedness is a vision, the double-bind asks: how can I attain it when I must feel guilty for attaining it? This may explain why these women avoided private time as an evil; private time might lead to self engrossment, therefore involve yourself in something, or someone else. While they desire private

time, it is a threat to their self-definition.

Knowledge and self-development requires that an individual give time and attention to reading, reflection, listening, questioning, and conversing (Frye, 1983). I question, due to the time and effort given to family, friends and community in the past and present, the depth of self-knowledge cultivated by the informants. A lack of self-knowledge prevents women from finding points of connection and understanding among themselves. How can you acquire sufficient self-knowledge to care for yourself when there is little time, opportunity, or encouragement to do so? If the definition of "woman" does not allow for women to understand how to take care of themselves, then this is a fundamental harm. It is, as Frye suggests (1983, p.70), mayhem: a maiming which impairs a woman's ability to defend herself.

The study informants described a vision of health which emphasized autonomy (i.e., theme B). Within theme B, they also described and enacted strategies for autonomy.

Separation and Access

Themes B and C were preoccupied with "getting

out", "spontaneous freedom", and "being emotionally unconstrained". Both themes emphasized self-determination and "the freedom to do what I want when I want". Throughout my analysis I frequently asked myself, why was "getting out" so important to these women? I believe its importance is tied to a subtle realignment of identification, or separation; a reduction of access, and the desire for outside acknowledgement.

Frye (1983) states, "Access is one of the faces of power" (p.103). Denial of access to a flow of benefits has the form and full portent of assumption of power. Frye continues to suggest, "The slave who excludes the master from her hut thereby declares herself not a slave. And definition is another face of power" (p.105). These women were defining themselves as capable, autonomous and largely unavailable for domestic duty. Women do not usually do the defining, and from our position of relative powerlessness, definitions may not stick. However, if we change patterns of access and remove ourselves, we define ourselves. When women separate, break out, transcend, or just say no, we are simultaneously defining and

controlling access.

Theme A "the power of positive thinking", details additional reaction and resistance to the double-bind of "other-centeredness".

Resourceful Adaptation and Subversion

A prevailing notion implicit in these research findings proposes that women should, and must, adapt to the environment to attain and preserve their health. To adapt successfully to the environment, the informants agreed that a woman needs to utilize the power of positive thinking and experience autonomy.

The first theme, the power of positive thinking, most clearly enunciates the achievement of "health" as a result of maneuvering and reacting to conditions out of these women's control. Making the best of a situation, accepting, or not thinking about the reality of the world are all adaptation techniques that are actively employed to resist, and control, the sometimes hostile and unpredictable environment.

Rabuzzi (1982) and Ruddick (1989) invoke women's domestic experiences as mothers and wives as the context in which women learn adaptation and contingency planning. Rabuzzi (1982) suggests so much of domestic

life involves waiting, repetition and "serendipitous passivity where one flows with the waves. The passivity so induced is that of a light object thrown into water; it is not the object that determines its direction, but the movement of the water" (cited in Donovan, 1988, p. 174). The passivity Rabuzzi speaks of is conceptually similar to the power of positive thinking; making the best of it, accepting, and not thinking about things.

However, I choose to visualize the first theme as a resourceful adaptation technique leading to subversion. In this way the power of positive thinking may not be passivity at all but a deliberate action to defend oneself against a threatening event.

Ruddick (1989) understands the resourcefulness in this "passivity". Maternal thinking for Ruddick (1989) is characterized by a certain humility that emanates from women's realization that much is beyond one's control, especially salient from the experience of nurturing children. Mothers learn to appreciate that excessive control may hamper the child's development and that it may just be too hard to attempt. Therefore the mother may adopt a "waiting mode". MacMillan (1982, cited in Belenky, 1985, p.117) agrees with Ruddick and

suggests action has a "passive counterpart usually called forbearance. Forbearance can be distinguished from passivity, not acting, by being intentional passivity". Forbearance may also be employed to diffuse anger.

Reaction to Anger

The findings suggest the choice these women experienced to demonstrate anger was sublimated into "making the best of it", "accepting it" or "not thinking about it". Some women mentioned, "Unhealthy people are full of anger...they should stop it and just be open to change" and "I maintain my health by trying not to argue with people, it is easier just to accept it and ignore it because you only upset yourself." Expressing anger outright can make it difficult for a woman to carry out her expected role of maintaining harmonious relationships within the family. Marilyn Frye (1983) suggests "So long as a woman is operating squarely within a realm which is generally recognized as a woman's realm, her anger will quite likely be tolerated, at least she will not be thought crazy" (p.91).

Anger is a demand for respect that requires one to

place themselves at the centre, implicitly claiming they are worthy. However, if your anger is not taken seriously and dismissed, your anger does not receive "uptake" (Frye, 1983, p.89).

Giving uptake means meeting the anger head on and responding to the claims implicit in it. Anger that is not given uptake is dismissed. Feminists discovered that women may get angry in public about, or in behalf, of great moral causes like pollution, war, or starving children probably because it is an extension of our right to mother. As Frye poignantly states "It is safer for one to get angry about nuclear war than one's own rape, because the first one gets uptake" (p.92).

"Making the best of it", "accepting it", and "not thinking about things", may be resourceful adaptation techniques employed when silenced or not granted uptake on anger. "Making the best of it" revolved around the ability to use willpower and a stoic resolve to "control reactions to situations". While "making the best of it" included giving yourself a pep talk, a salient feature of the pep talk was denying the effect a certain situation was having on you. As well, the pep talk was always to the self; never was it voiced to

others. "Accepting things" as they are and "not thinking about things" may indicate the informant's unwillingness to express anger outwardly or acknowledge others' anger.

The study informants may appear to acquiesce, accept, and ignore so as not to give uptake to others' anger as well. By doing so, they preserve their own energy and take power away from those that used anger to gain power. "Acceptance" and "not thinking about things" is a technique of preserving autonomy when the expectation is that women will react in an "other-centered" mode. Theme 1, the power of positive thinking may ultimately be a way of saying no and subverting a power structure.

Summary

From a feminist stance, the women in this study define their health, health needs and factors that facilitate health in "other-centered" terms. The social construction of a healthy middle-aged woman demands them to think, act, and serve the needs of others. Regardless of circumstance, these women do not demand the same attention or respect for themselves that they freely give to others. This phenomenon is internalized

because society values, rewards and defines women by the degree to which they are other-centered. Any desire, or move, to place oneself at the center is a frightening threat to self-definition. Conveniently, the punishment for not being "other-centered" is then internally applied by the women themselves. These women held themselves responsible and blameworthy for almost every outcome they or their family members experienced.

The study informants, having some consciousness of their other-centeredness, spoke about autonomy and self-determination as factors that facilitate women achieving health. While they recognized that autonomy, identity and self-care were necessary for good health, they struggled with enacting the self-determination they visualized. I believe the request for autonomy underscores the past and present lack of opportunities for self-development, and subsequent self-knowledge, that is crucial for self-care.

Despite the difficulty these women experience enacting self-determination, they are not passive victims of the forces that would subordinate them. In every case, these women have reduced and redefined access to their domestic, nurturing and facilitating

skills. Ultimately they have controlled their definition to some extent. The power of positive thinking is a mechanism employed by the study informants to adapt to, and subvert, the sometimes threatening environment. Individual subversive actions, such as those described in the power of positive thinking, may never change society and may in fact facilitate our own erasure. However if women collectively name and analyze their reality, they can begin to develop political strategies to change the existing reality. If women remain isolated from the political context, their strategies to cope with their reality will be diluted and individualistic.

RECOMMENDATIONS

The following recommendations are suggestions for nursing education, practice and research based on the understanding derived from the research findings. Because all three areas of nursing are interdependent, my recommendations for one area may simultaneously apply to another area.

My suggestions are based on self-identified healthy, white, middle-class, middle-aged women;

therefore any attempt to transfer knowledge from this study to other women within different contexts, would be improper. Lincoln and Guba (1985) suggest that if the context of research, as determined by the "thick description" offered within the sample and setting descriptions are similar; then the research concepts may be transferable.

Recommendations for Nursing Education

Educators must encourage nursing students to think systematically about women's health status and the social and political relationship it has to the world by: (1) examining their own assumptions about women and women's health and insisting nursing students do the same, (2) critiquing theory and research, and (3) understanding the women's health movement.

Examination of Personal Assumptions

Any profession that claims guardianship of women's health must have a broad understanding of women's position in society and the political role science has played in defining "healthy" women. It is particularly incumbent on a predominately female profession like nursing to acknowledge and respond to the complex social and political forces that shape women, and their

health options. Therefore, as a necessary first step, nursing educators and students are obliged to examine their personal beliefs and values pertaining to women and women's health in society.

Critique of Theory and Research

All theory and research used or developed by nurses should be critically analyzed by nursing students and educators to determine the implicit and explicit theoretical assumptions regarding women. For instance, students examining the existing definitions of health may recognize that the environment is not in mutual simultaneous interaction with women (Woods et al, 1988), rather environments are things to which women must adapt. Also, because most health models and definitions refer to the end product of self-development, and not to the process of self-development, those women engaged in understanding themselves (i.e., attending self-help groups, support groups) may be labelled "at risk" or unhealthy. As well, most health definitions do not acknowledge resistance, or rebellion, as a healthy activity; instead they often refer to healthy humans as those who experience harmony. However, resistance to imposed

roles or definitions may indicate a healthy women who is aware of oppressive forces and is actively seeking to moderate them.

Health researchers that define health also presume choice, and freedom to exercise choice, as equal for everyone, except perhaps minorities (Pender, 1990). Health researchers' definitions must be sensitive to middle-aged women's lack of sense of entitlement to choice and the effect the double-bind phenomenon exerts on choice.

Critiquing existing theory and research for theoretical assumptions about women may serve to strengthen all future nursing theory and research.

Women's Health Movement

The women's health movement stresses that women gain control over their bodies through acquiring self-knowledge of their bodies and sharing health information among themselves. A women's health course, similar to the one at the University of Manitoba, should be made available to all nursing students. A women's health course, that includes the history of the women's health movement, would provide nursing students a conceptual framework for women's health care

reflective of the values in the women's health movement. Nursing students could then locate their nursing care within the present health system, understanding and learning from past accomplishments and struggles. Nursing students need to recognize the powerful and far reaching impact the women's health movement has had on Canadian women. Well respected services such as incest counselling, women's addiction counselling, counselling and shelter for battered women, and sexual assault services exist only because of the persistence of women active in the movement.

Ultimately, nursing students may understand from a historical point of view, why, although expertise is valued and recognized, women need to understand and gain control of their own bodies.

Recommendations for Nursing Practice

Four major recommendations for nursing practice include: (1) the discontinuance of the predominate use of the biomedical perspective to guide health professionals understanding of women's health (2) empowerment of women, (3) understanding the voice of other-centeredness, (4) nurses and health policy formulation.

The Predominate Biomedical Perspective

Nursing professionals should understand that women's health care has been fragmented by using the predominant biomedical perspective as the theoretical framework within which to understand all women. Practising nurses must be aware of the impact of the environment, versus biology, on the health of women. Work conditions, poverty, and less easily defined conditions dependent on one's role in society such as the double-bind phenomena and lack of status definitely impact on women's ability to achieve health. Therefore, health goes far beyond, as the study informants repeatedly stated, a strictly medical definition.

Empowerment

Nurses can empower women to discuss their health, control it, and make decisions about it. Nurses can empower women by providing information that destroys myths, prejudices and preconceived notions about women and their bodies. Nurses should have access to, and help create standards and criteria with other women's groups for a selective utilization of services referral system. In this manner nurses could refer women to woman-centered health services. Straightforward

information was a request from the informants in this study.

The benefits of being involved in a self-help group, or support group, have demonstrated positive effects on women's self-esteem and self-respect (Begin, 1988). Support groups often create a safe environment that simultaneously give women permission to speak authentically and disincentives for self-effacing behaviours. Nurses may create support groups or encourage women already involved in self-help or support groups, therefore adding a political dimension to nursing care because support groups redefine the boundaries of traditional medical authority. Small self-help groups may be particularly beneficial for rural women because of their regular lack of access to each other or to alternative services.

The popular literature describes women from a biomedical perspective and tends to hold women personally responsible for their own, and others' health. The nursing profession should be aware of, and respond to, the messages women receive through the lay literature. Nurses can write letters to the editors of magazines that insist on portraying women's health as

dependent on the level to which women perform their social roles as mothers and wives. As a professional group, nurses may boycott any literature that is deemed detrimental to the public's health.

Empowerment underlies all teaching within the women's health movement. As women become more confident in their own abilities, they are likely to assume more control of their bodies.

Understanding the Voice of Other-centeredness

Middle-aged women may have difficulty requesting or receiving attention for themselves. The women in this study held themselves almost completely responsible for their own health status and others' happiness, making them susceptible to self-blame for many situations that offered little control. Nurses involved in health promotion with middle-aged women should be aware of the difficulty with placing "self as a subject" and acknowledge that any health advice may be viewed in terms of the affects it will have on others.

Middle-aged women may also be vulnerable, because of their other-centeredness, to allowing themselves involvement in medical studies and signing consents

without receiving proper assurances of protection. Nurses, in some instances, can enact the role of advocate for women by insisting health professionals share all relevant information about personal care or involvement in research.

With health economists suggesting a shift of focus from acute care to community care, middle-aged women may be placed in the position of providing free home health care to relatives without proper supports. Quality community health supports must be in place before mobilizing community focused care or women will be assigned the home health care work without support or proper recognition.

Nurses and Health Policy

Middle-aged women, although resourceful and adaptable, may not have the opportunity to understand the structural forces that maintain their subjugation. Health policy needs to acknowledge the close connection between the opportunity for self-understanding and the ability for self-care. Women require time and opportunity to understand their strengths, desires, abilities, and vulnerabilities before they can thoughtfully discover what contributes to, or detracts

from, their health.

Nearly one half of the informants in this study had experienced some unhappiness with past health services and the explicit suggestion was to "take health more into our own hands." Women's health policy requires women's input from the grassroots. Nurses could facilitate grassroots policy-making by creating women's health policy resolutions for their own professional associations developed from attending to individual women and women as a group. The nursing profession must develop programs and services that recognize the need for the intellectual, social, and spiritual dimension of women's health.

Women from every part of society must be involved in reshaping broad community priorities including transportation and safe street policy. Particularly salient from the results of this study, women envisioned their health threatened when the freedom to walk or participate in activities, where and when they wanted, was usurped. However many Canadian city streets are unsafe and threatening for women because of the frequency of assault and rape. The nursing profession can support women's voices in policy development that

demands safe streets and safe neighbourhoods for women.

The nursing profession must continue to endorse a separate women's health directorate (e.g., The Manitoba government recently renamed the maternal-child health directorate to the women's health directorate) that locates women's health within a broader political and social context, rather than an exclusively reproductive context. The nursing profession, together with other women's groups, could be an effective lobby group demanding adequate government funding for women's health care conferences and programs.

However, nurses attempting to influence city, provincial, or federal health policy must have a healthy awareness of co-optation by powerful groups that adopt feminist health care ideals without placing real control in the hands of women themselves. Careful monitoring of the focus and underlying assumptions of proposed health policy is crucial.

Recommendations for Nursing Research

Fundamental to feminist research is praxis: acting and creating change out of concern for improving women's lives. Therefore, two broad recommendations for nursing research actions that will ultimately create

change are: (1) broadening our base for understanding women's health, (2) exploring specific unanswered questions from this study.

Broadening Our Base

Nurse researchers must integrate more about race, class, ethnicity, and other experiences that shape thoughts on health and perceived health needs, into their research agendas. In this manner, the nursing profession can more knowledgably appreciate the conditions that produce different beliefs and abilities. Nursing researchers must not get "cut off" from other women which would prevent a genuine examination of differences that could lead to change and growth all around.

Nurse researchers must develop an international awareness of women's health. For instance, many multi-national corporations (e.g., Mattel Toys and Zenith Electronics) have deliberately exploited third world women's labour and health to create their products under sweatshop conditions (Ehrenreich & Fuentes, 1981). Within Canada the health of immigrant domestic workers has been relatively unexplored. The health of these women must be explored and described to add our

understanding of women's strength and survival.

A feminist research paradigm offers nurse researchers the opportunity to explore underlying androcentric assumptions about women's health. For example, such issues as endometriosis and osteoporosis have not been studied from the perspective of women's own self-reported experiences. Feminist theory and research methods are valuable tools for nurse researchers wishing to understand women's health issues.

Also, our profession needs to learn more about the normal, healthy processes individually and collectively experienced by women of all groups. Integration of this knowledge may begin to challenge and reduce dependence on medically manufactured definitions of women's health experiences that contribute to women's social control. Furthermore, nurses need to publish their findings in both professional and popular journals so that all women can benefit.

Specific Unanswered Questions

Based on the results of this study many questions and concerns remain unanswered that require further research, such as (1) what are other health images and

messages women receive through popular literature or television? (2) what are the sources of dissatisfaction middle-aged women experience with health services? (3) what are other cites of the double-bind and why does placing "self" at the center present such a risk for these women in family, community and friendship relationships? (4) how is menopause perceived and experienced especially in view of the study informants' preoccupation with children?

Nursing education, practice and research will benefit from incorporating knowledge about women derived from women's own experiences with health. A feminist perspective permits the nursing profession to look beyond the status quo.

Summary of the Study

Middle-aged women's perceptions of health, health needs, and factors impinging on health have not been systematically explored or articulated. Women's health activists envision women defining their own health needs and desires, rather than facing the prospect of having medically manufactured ones substituted. Women are oppressed both materially, and conceptually, when they are denied control of their bodies and denied

definitional control of their health. Self-knowledge, and articulation of that knowledge, is a hedge against social control, resulting in the promotion of woman-centered health care.

The research questions petitioned in this study were: (1) How do middle-aged Icelandic-Canadian women, from their own experience, define health? (2) What do middle-aged Icelandic-Canadian women perceive as their health needs? (3) What factors do middle-aged Icelandic-Canadian women report as impinging on their health?

Open-ended, in-depth interviews yielded qualitative data that was analyzed within a feminist conceptual framework. Three major themes emerged from the data that address the research questions. The three themes were: (1) health as the power of positive thinking, (2) health as autonomy, (3) health as caring for the self and others.

A review of the relevant literature in nursing, medicine, sociology, psychology and women's studies revealed that women's images of health are beginning to be generated. However, most health models are informed by traditional medical and social science paradigms

that are reductionistic and to some degree androcentric.

Two popular lay literature magazines dealing with women's health and women's issues were reviewed and revealed a race and culture blindness that universalized the concept of health from white, middle-class experience. As well, the two magazines depicted women's health from a biomedical perspective with paradoxical goals for women. For example, women should create more leisure time but they should also assume more role responsibilities. The Canadian Advisory Council on the Status of Women has researched women's social and economic circumstances and the results suggest that women find it difficult to maintain health because of the existing inequalities such as: income disparities, job ghettoization, and the double responsibility of home and work.

A comparison of my research findings with other published women's health research exposed some similarities and differences. The main similarities are: (1) reference to "the power of positive thinking" through conceptually similar concepts of "inner strength", "affect" and "adaptation", (2) the popular

lay literature reinforcing that women are responsible for their own health and the health and happiness of others, (3) one-third to one-half of middle-aged women have expressing dissatisfaction with existing health services, (4) financial security as fundamental to women achieving health, (5) social involvement and moderate social responsibility positively influencing women's health, and (6) healthy routine habits such as eating nutritious foods, and exercising promote health.

The major differences are: (1) that most existing health definitions insist on biological health as a prerequisite to general health. The informants in this study described health as a state of mind regardless of physiological health status. (2) While many health models associate personal effectiveness with health, the study informants, acknowledging their occasional personal ineffectiveness, emphatically described themselves as healthy. This may suggest that most definitions of health honour the final product of personal effectiveness and devalue the process of self-development. (3) The study informants highlighted their nurturing of children as an important positive influence on their health. Although some health

definitions discuss social contribution, they do not explicitly include the nurturing of children. (4) Most health models do not discuss the double-bind or other-centeredness as features of a middle-aged woman's life. (5) Rebellion, or resistance to the status quo, is not valued as an indicator of health, rather adaptability to the environment is associated with health.

A feminist analysis of the findings uncovered examples of the informants' experiences with the double-bind phenomenon and the informants' orientation to other-centeredness. However, the study informants invoke resourceful adaptation techniques to cope and subvert the oppressive forces in their lives.

Icelandic-Canadians, like other immigrants, were acutely aware of their success being dependent upon their ability to appear like the dominant Anglo-Saxon population. The value of other-centeredness, possibly learned within first and second generation Icelandic-Canadian homes, may add a cultural dimension to the gendered explanation of other-centeredness. As well, medical definitions of health tend to universalize health as biological experience that these Icelandic-Canadian study informants explicitly rejected.

Cultural, age and gender specific health definitions underscore the inadequacy of universalizing the concept of health.

Recommendations for nursing education, practice and research emphasize the need for the nursing profession to broaden their definition of women's health, critique theory and other research for androcentric assumptions about women and to engage in some form of political action to initiate woman-centered health policy.

References

Acker, J., Barry, K., & Essveld, J. (1983). Objectivity and truth: Problems in doing feminist research. Women's Studies International Forum, 6(4), 423-435.

All fiber is not created equal. (1989, October), m 14(10). Canadian Living.

Allen, D. (1985). Nursing research and social control: Alternative models of science that emphasize understanding and emancipation. Image, 18(2), 58-64.

Allen, D., Benner, P. & Dieklemann, N. (1986). Three paradigms for nursing research: Methodological implications. In P. Chinn (Ed.), Nursing research methodology (pp. 23-38). Rockville, MD: Aspen.

Anderson, J. (1985). Perspectives on the health of immigrant women: A feminist analysis. Advances in Nursing Science, 8(1), 61-76.

Armstrong,P. & Armstrong, H. (1987). The conflicting demands of work and home. In K. Anderson (Ed.), Family matters: Sociology and contemporary Canadian families (pp. 113-140). Toronto: Methuen.

Ashley, J. (1980). Power in structured misogyny: Implications for the politics of care. Advances in Nursing Science

Assessing your lifestyle. (1990, July), 63(7). Chatelaine.

Bale, A. (1990). Women's toxic experience. In R. Apple (Ed.), Health and medicine in America: A historical handbook (pp. 411-439). New York: Garland Publishing

Baruch, G. & Brooks-Gunn, J. (1984). Women in midlife. New York: Plenum Press.

Begin, M. (1990). Redesigning health care for women. In V. Dhruvarajan (Ed.), Women and well-being (pp. 3-13). Kingston: McGill-Queen's University Press.

Belenky, M., Clinchy, B., Goldberger, N. & Tarule, J. (1986). Women's ways of knowing. New York: Basic Books Inc.

Benston, M. (1982). Feminism and the critique of scientific method. In G. Finn & A. Miles (Eds.) Feminism in Canada (pp. 47-65). Montreal: Black Rose Books.

Bjornsdottir, I. (1989). Public view and private voices. In E. Paul Durrenberger and G. Palsson (Eds.) The anthropology of Iceland (pp.98-117). Iowa City: University of Iowa Press.

Boston Women's Health Book Collective. (1984). The new our bodies, ourselves: A book by and for women. New York: Simon and Schuster.

Brown, W. & Harris, T. (1978). The social origins of depression. London: Tavistock.

Bunch, C. (1987). Passionate politics (pp.240-254). New York: St. Martin's Press.

Burns, N. (1990). Standards for qualitative research. Nursing Science Quarterly, 2(1), 44-53.

Burt, S., Code, L. & Dorney, L. (1988). Changing patterns: Women in Canada. Toronto: McClelland and Stewart.

Callahan, D. (1973). The WHO definition of health. In T. Mappes & J. Zembaty (Eds.), Biomedical ethics (pp.244-250). Toronto: McGraw-Hill Book Company.

Calnan, M. & Johnson, D. (1985). Health, health risks and inequalities: an exploratory study of women's perceptions. Sociology of Health and Illness, 7(1), 55-73.

Canadian Advisory Council on the Status of Women. (1989, Fall). Women and well-being. Fine balances, p.5-10.

Canadian Advisory Council on the Status of Women. (1990, Summer). Women's place in the economy. Fine Balances.

Canadian Human Rights Commission. (1983). Unwanted sexual attention and sexual harassment: Results of a survey of Canadians. Ottawa: Supply and Services Canada.

Carper, B. (1978). Fundamental patterns of knowing in nursing. Advances in Nursing Science

Calcium and fiber for celiacs. (1989, January), 14(1). Canadian Living.

Chinn, P. (1985). Feminism and nursing: Can nursing afford to remain aloof from the women's movement? Nursing Outlook, 33, 74-77.

Clarke, A. (1990). Women's health: Life-cycle issues. In R. Apple (Ed.), Women, health and medicine in America: A historical handbook. (pp. 5-39). New York: Garland Publishing.

Clement, C. (1987). Women and health: From passive to active. Health Promotion, 25(4). Ottawa: Health and Welfare Canada.

Clinton, J. (1982) Ethnicity: the development of an empirical construct fro cross-cultural research. Western Journal of Nursing Research, 4(3), 281-300.

Colantonio, A. (1988). Lay concepts of health. Health Values, 12(5), 3-7.

Collins, P. (1989). The social construction of black feminist thought. Signs: Journal of Women in Culture and Society, 14(41), 745-773.

Daly, M. (1978). Gyn/Ecology: The meta-ethics of radical feminism. Boston: Beacon Press.

De Beauvior, S. (1953). The second sex (pp. 231-301). New York: Knopf Publishers.

DeLorey, C. (1982). Health care and midlife women. In G. Baruch & J. Brooks-Gunn (Eds.), Women in Midlife (pp.250-264). New York: Plenum Press.

Delaney, J., Lupton,M. & Toth, E. (1988). The curse: A cultural history of menstruation. Chigaco: University of Illinois Press.

Dickson, G. (1990). A feminist poststructuralist analysis of the knowledge of menopause. Advances in Nursing Science, 12(3), 15-31.

Dolfman, M. L. (1973). The concept of health: An historic and analytic examination. The Journal of School Health, 43, 491-497.

Donovan, J. (1988). Feminist theory: The intellectual traditions of American feminism (pp.171-186). New York: The Continuum Publishing Company.

Doress, P. & Seigal, D. (1987). Ourselves, growing older. Toronto: Simon and Schuster.

Duffy, M. (1985). A critique of research: A feminist perspective. Health Care for Women International, (6), 341-352.

Dunbar, S., Patterson, E., Burton, C. & Struckert, G. (1981). Women's health and nursing research. Advances in Nursing Science, 3(1), 1-16.

Ease up on meat and diary products. (1989, September), 14(7). Canadian Living.

Edinberg, G. (1982). Women and aging. In C. Nadelson & M. Notman (Eds.), The woman patient: Concepts of femininity and the life cycle (Vol.1, pp. 169-184). New York: Plenum Press.

Ehrenreich, B. & English, D. (1973). Complaints and disorders: The sexual politics of sickness. Old Westbury: The Feminist Press.

Ehrenreich, B. & English, D. (1978). For her own good: 150 years of the experts advise to women. Garden City: Anchor Press/Doubleday.

Ehrenreich, B. & Fuentes, A. (1981). Life on the global assembly line. Ms. (January), 53-59.

Epp, J. (1986). Achieving health for all: A framework for health promotion. Ottawa: Minister of Supply and Services.

Fat free foods. (1990, August), 63(8). Chatelaine.

Fausto-Sterling, A. (1986). Myths of gender: Biological theories about women and men. New York: Basic Books.

Fee, E. (1982). Women and health: The politics of health in medicine (chap. 1). New York: Baywood Publishing Company.

Flint, M. (1975). The menopause: Reward or punishment? Psychosomatics, 16, 161-163.

Frey, A. (1981). Middle aged women's experience and perceptions of menopause. Women and Health, 6, 25-36.

Ford, A. (1986). In poor health. Healthsharing (Winter), 13-17.

Frye, M. (1983). The politics of reality: Essays in feminist theory. Freedom, California: The Crossing Press.

Gatz, M. (1983). Older women and mental health. Issues in mental Health Nursing, 5(1), 273-299.

George, T. (1986). Menopause: Crisis or boon: The result of a study. Unpublished paper.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge: Harvard University Press.

Glazer, N. (1988). Overlooked, overworked: Women's unpaid and paid work in the health services cost crisis. International Journal of Health Services, 18, 119-137.

Goodman, M. (1982). A critique of menopause research. In A. Voda, M. Dinnerstein, & S. O'Donnell (Eds.), Changing perspectives on menopause (pp.273-288). Austin: University of Texas Press.

Gordon, L. (1976). Woman's body, woman's right: A social history of birth control in America. New York: Grossman Publishing.

Green, R. & Leigh, J. (1989, August). Applying ethnographic interview skills. Applied Anthropology, 8-10.

Griffith, J. (1983). Women's stress responses and coping patterns according to age groups. Part II. Issues in Health Care of Women, 6, 327-340.

Harding, S. (1986). The science question in feminism. Ithaca, New York: Cornell University Press.

Health and well-fare. (1989, November), 14(11). Canadian Living.

Health and Welfare Canada. (1990). The active health report on women. Ottawa: Supply and Services.

Heller, A. (1986). Health and home: Women as health guardians. Ottawa: Canadian Advisory Council on the Status of Women.

Hubbard, R. (1990). The politics of women's biology. London: Rutgers University Press.

Hynes, P. (1989). The recurring silent spring. New York: Pergamon Press

Ibsen, T. (1988). The double implication of liberal feminism: The experience of the early women's movement in Iceland. Canadian Women's Studies, 9(2), 11-13.

Icelandic studies grows. (1990, May 2). Winnipeg Free Press.

Islendingadagurinn, Souvenir Program. Fjallkona's address 1988.

Jungkind, E. (1989, November), 62(11). Social phobias. Chatelaine.

Katz, S. (1989, April), 62(4). The pill and viruses. Chatelaine.

Katz, S. (1989, March), 62(3). How to live to be 80 years young. Chatelaine.

Katz, S. (1990, January), 63(1). Food facts and myths. Chatelaine.

Katz, S. (1990, July), 63(7). How heart disease affects women. Chatelaine.

Kaufert, P. (1985). Midlife in the midwest: Canadian women in Manitoba. In J. Brown & V. Kearns (1985). In her prime (pp. 181-197). South Hadley, Mass: Bergin and Garvey.

Keller, M. (1981). Toward a definition of health. Advances in Nursing Science, 4(1), 43-63.

Kirby, S. & McKenna, K. (1989). Methods from the margins. Toronto: Garamond Press.

Kirkpatrick, M. (1982). women's issues and wellness. Health Values, 13(2), 38-39.

Kristjanson, A. (1989). Foreword. In J. Dor & T. Tergesen Islendingadagurinn: An illustrated history (vii). Gimli: The Icelandic Festival of Manitoba.

Laffrey, S. (1986). Development of a health conception scale. Research in Nursing and Health, 9, 107-113.

LaLonde, M. (1974). A new perspective on the health of Canadians. Ottawa: Minister of Supply and Services.

Lapierre, L. (1984). Canadian women: Profile on their health. Ottawa: Minister of Supply and Services.

Leininger, M. (1975). Transcultural nursing presents an exciting challenge. American Nurse, 6, 17-21.

Leininger, M. (1978). Transcultural nursing: Concepts, theories and practices. New York: John Wiley.

Lerner, G. (1986). The creation of patriarchy. New York: Oxford University Press.

Lincoln, Y. & Guba, E. (1985). Naturalistic inquiry. London: Sage Publications Inc.

Loneliness. (1990, April), 63(4), p.38. Chatelaine.

Lorde, A. (1984). Sister outsider: Essays and speeches by Audre Lorde. Trumansburg, New York: The Crossing Press.

Low-cal, low-fat desserts. (1990, June), 15(6). Canadian Living.

Lowe, G. (1989). Women, paid/unpaid work, and stress: New directions for research. Ottawa: Canadian Advisory Council on the Status of Women.

MacDougall, B. (1989). The well-being equation. In Canadian Advisory Council on the Status of Women's Symposium Report on Women and Well-being. (Fall) (p. 9). Ottawa: Supply and Services.

MacKinnon, C. (1987). Feminism unmodified: Discourses on life and law. Cambridge, Mass: Harvard University Press.

MacPherson, K. (1981). Menopause as disease: The social construction of a metaphor. Advances in Nursing Science, 3(2), 95-110.

MacPherson, K. (1985). Osteoporosis and menopause: A feminist analysis of the social construction of a syndrome. Advances in Nursing Science, 7(4), 11-22.

Matthiasson, C. (1977). Women's roles in urban Icelandic-Canadian society as seen through voluntary associations. Papers in Anthropology, 18(2), 25-31.

Matthiasson, J. (1989). Adaptation to an ethnic structure: The urban Icelandic-Canadians of Winnipeg. In P. Durrenberger & G. Palsson (Eds.), (pp.157-175). Iowa City: University of Iowa Press.

Marriner, A. (1986). Nursing theorists and their work. Toronto: C. V. Mosby Co.

McBride, A. & McBride, W. (1981). Theoretical underpinning for women's health. Women's Health, 6(12), 37-55.

McKeown, T., Record, R. & Turner, R. (1975). An interpretation of the decline of mortality during the twentieth century. Population Studies, 29, 391-422.

Medicine do's and don'ts. (1989, October), 14(10). Canadian Living.

Meissner, M. (1985). The domestic economy-half of Canada's work: Now you see it, now you don't. In M. Safir (Ed.), Women's worlds: From the new scholarship (pp.71-83). New York: Praeger.

Meleis, A. (1985). Theoretical nursing: Development and progress. Philadelphia: J.B. Lippincott.

Michaels, E. (1989, August), 62(8). Sterilization health problems after tubal ligation. Chatelaine.

Michaels, E. (1990, January), 63(1). Contraception after a vasectomy. Chatelaine.

Michaels, E. (1990, June), 6396). Women's and men's behaviour. Chatelaine.

Michaels, E. (1990, July), 63(7). When breast cancer spreads. Chatelaine.

Miles, M. & Huberman, A. (1984). Qualitative data analysis. London: Sage Publications.

Miller, A., Sliepcevich, E. & Vitello, E. (1981). Health-related articles in six leading women's magazines. Health Values: Achieving High Level Wellness, 5(6), 257-264.

Miscarriages...autoimmune drugs. (1989, August), 15(8). Canadian Living.

Mitchinson, W. (1988). The medical treatment of women. In S. Burt, L. Code & L. Dorney (Eds.), Changing patterns: Women in Canada (pp.237-263).

Morse, J. (1987). The meaning of health in inner city community. Nursing Papers, 19(2), 27-41.

Newman, M. (1982). The meaning of health. In G. E. Lasker (Ed.), Applied systems research and cybernetics: Systems research in health care, biocybernetics and ecology. New York: Pergamon.

Newman, R. (1991, April 19). Gimli women set the pace. Loberg-Heimskringla, p.4.

Notman, M. (1982). Midlife concerns of women: Implications of menopause. In C. Nadelson & M. Notman (Eds.), Concepts of femininity and the life cycle (pp. 135-145). New York: Plenum Press.

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.). Doing feminist research. (pp.30-61). London: Routledge and Kegan Paul.

Osteoporosis. (1990, April), 15(4). Canadian Living.

Parse, R. (1985). The lived experience of health: A phenomenological study. In R. Parse, A. Coyne and M. Smith (Eds.). Nursing Research: Qualitative methods (pp.27-37). Bowie, Md: Brady Communications.

Parse, R. (1987). Nursing science: Major paradigms, theories and critiques. Philadelphia: W.B. Saunders.

Payne, L. (1983). Health: A basic concept in nursing theory. Journal of Advanced Nursing, (8), 393-395.

Pender, N. (1982). Health promotion in nursing practice. Norwalk, Conn.: Appleton-Century-Crofts.

Pender, N. (1990). Expressing health through lifestyle patterns. Nursing Science Quarterly, 2,(1).

Perales, C. & Young, L. (1988). Too little, too late: Dealing with the needs of women in poverty. New York: Basic Books.

Phillips, C. (1989, June), 62(6). An update on fats and cholesterols. Chatelaine.

Posner, J. (1979). It's all in your head: Feminist and medical models of menopause. Sex Roles, (5), 179-190.

Rabuzzi, K. (1982). The sacred and the feminine: Toward a theology of housework. New York: Seabury.

Roots of domestic abuse. (1990, November 6). Winnipeg Free Press p.6.

Rose, J. (1990). Psychologic health of women: A phenomenological study of women's inner strength. Advances in Nursing Science, 12(2), 56-70.

Rosser, S. (1989). Feminist scholarship in the sciences: Where are we now and when can we expect a theoretical breakthrough? In N. Tuana (Ed.). Feminism and science. Bloomington, Indiana: Indiana University Press.

Rotberg, A. (1987). An introduction to the study of women, aging, and sexuality. Physical and Occupational Therapy in Geriatrics, 5(3), 3-1.

Ruddick, S. (1989). Maternal thinking: Towards a politics of peace. Boston: Beacon Press Books.

Ruether, R. (1975). New woman, new earth. New York: Seabury.

Ruffing-Rahal, M. (1987). Ecological well-being: A study of community-dwelling older adults. Health Values, 13(1), 10-19.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Sells, D. (Ed.). (1968). International encyclopedia of social sciences. Boston: MacMillan and Company.

Shaver, J. (1985). A biopsychosocial view of human health. Nursing Outlook, 33, 186-191.

Simundsson, E. (1981). Icelandic settlers in America. Winnipeg: Queenston House Publishers.

Six diseases your doctor may miss. (1990, April), 15,(4). Canadian Living.

Smith, J. (1986). The idea of health: Doing foundational inquiry. In P. Munhall & C. Oiler (Eds.), Nursing research: A qualitative perspective (pp.251-262). Norwalk, Conn: Appleton-Century-Crofts.

Sorofman, B. (1986). Research in cultural diversity. Western Journal of Nursing Research, 8(4), 467-468.

Spradley, J. (1979). The ethnographic interview. New York: Holt, Rinehart and Winston.

Stanley, L. & Wise, S. (1983). Breaking out: Feminist consciousness and feminist research. Boston: Routledge and Kegan Paul.

Stevenson, C. (1979). Sexual behaviour in a group of older women. Journal of Gerontology, 20, 351-356.

Torrance, G. (1981). Socio-historical overview: The development of the Canadian health system. In D. Coburn, C. D'Arcy, P. New & G. Torrance (Eds.), Health and Canadian society (pp. 9-28). Toronto: Fitzhenry and Whiteside.

Trading places: The daughter track. (July 16, 1990). Newsweek, 48-52.

Tripp-Reimer, T. (1984). Reconceptualizing the concept of health: Integrating emic and etic perspectives. Research in Nursing and Health, 101-109.

Tronto, J. (1987). Beyond gender difference to a theory of care. Signs: A Journal of Women in Culture and Society, 12(4).

Voda, A., Dinnerstein, M. & O'Donnell, S. (1982). Changing perspectives on menopause. Austin: University of Texas Press.

Voda, A. & George, T. (1986). Menopause. In H. Werley, J. Fitzpatrick & R. Taunton (Eds.), Annual review of nursing research,4, (pp.55-73). New York: Springer Publishing Co.

Webb, M. (1989, December), 62(12). The benefits of volunteering. Chatelaine.

Webster's II New Riverside Dictionary. (1984). (p.520). Boston, Mass.: Houghton Mifflin Company.

Wilson, H. (1985). Research in nursing. Menlo Park, California: Addison-Wesley Publishing Company.

Woolfe, V. (1986). Three guineas. London: Hogarth Press.

Woods, N. (1981). Women and health. In C. Fogel & N. Woods (Eds.), (pp. 40-55). Health care of women: A nursing perspective. St. Louis, Mo: C.V. Mosby.

Woods, N. (1988). Women's health. In J. Fitzpatrick, R. Tauton & J. Benoliel (Eds.), (pp.207-237). Annual review of nursing research, 6, New York: Springer Publishing Company.

Woods, N., Laffrey, S., Duffy, M., Lentz, M., Mitchell, E. & Taylor, D. (1988). Being healthy: Women's images. Advances in Nursing Science, 11(1), 36-46.

World Health Organization. (1958). The first ten years of WHO (p.459). Geneva: Author.

Young, H. (1990, June 7). Poverty trapping women, study says. The Winnipeg Free Press, p.10.

APPENDIX A

SURVEY OF CANADIAN WOMEN'S MAGAZINES

HEALTH-RELATED ARTICLES

FOR THE YEARS 1989 AND 1990

Frequency of Themes
Canadian Living Magazines for 1989

	C	G	N	N2	R	R2	MP
Jan	0	1	2	1	0	0	0
Feb.	0	0	2	0	0	0	0
Mar.	1	1	2	1	0	0	0
Apr.	0	1	1	0	0	0	0
May	1	0	2	0	0	0	0
June	1	0	2	1	0	0	0
July	0	0	3	1	0	0	0
Aug.	2	2	2	2	1	0	0
Sept	0	0	1	1	0	0	0
Oct.	1	1	2	1	0	0	1
Nov.	1	2	2	1	1	0	0
Dec.	0	2	1	0	1	0	1
SUM	7	10	22	9	3	0	2

Note. C= coping with specific medical/emotional problem
G= general illness information
N= nutrition related to preventing illness
Total N2= nutrition related to chronic illness
53 R= treatment of reproductive problems
R2= reproductive issues related to contraception
MP= mental and physical health promotion

	C	G	N	N2	R	R2	MP
Jan.	0	0	3	0	0	0	2
Feb.	0	1	0	1	0	1	0
Mar.	0	0	1	1	0	0	0
Apr.	4	3	1	2	1	1	0
May	0	0	2	0	0	0	0
June	0	0	2	0	0	0	0
July	0	2	2	1	0	0	0
Aug.	0	1	1	0	0	0	0
Sept	0	0	2	0	0	0	3
Oct.	1	0	1	1	0	0	1
Nov.	1	2	2	0	0	0	0
Dec.	0	0	2	1	0	0	0
SUM	6	9	19	7	1	2	6

Total articles= 50

Note. C= coping with specific medical/emotional problem
G= general illness information
N= nutrition related to preventing illness
N2= nutrition related to chronic disease
R= treatment of reproductive diseases or problems
R2= reproductive issues related to contraception
MP= mental and physical health promotion

Frequency of Themes
Chatelaine Magazines for 1989

	C	G	N	N2	R	R2	MP
Jan.	0	1	1	0	2	2	1
Feb.	3	1	0	0	1	0	1
Mar.	2	0	1	0	1	3	2
Apr.	1	1	0	0	2	2	0
May	1	1	0	0	1	1	2
June	0	1	2	0	1	1	2
July	0	0	1	0	2	1	0
Aug.	0	0	1	1	1	2	1
Sept	1	2	0	0	1	0	1
Oct.	1	0	1	0	2	2	0
Nov.	1	2	1	0	1	1	0
Dec.	0	1	0	1	1	0	2
SUM	10	8	8	2	16	15	12

Total articles= 71

Note. C= coping with specific medical/emotional problem
G= general illness information
N= nutrition related to preventing illness
N2= nutrition related to chronic illness
R= treatment of reproductive diseases or problems
R2= reproductive issues related to contraception
MP= mental and physical health promotion

	C	G	N	N2	R	R2	MP
Jan.	2	1	3	0	2	1	0
Feb.	2	1	0	0	1	1	0
Mar.	1	0	1	0	1	0	1
Apr.	1	1	1	0	2	2	0
May	2	0	1	0	2	0	1
June	1	0	1	0	1	1	1
July	0	0	0	0	2	1	2
Aug.	1	1	1	0	0	1	1
Sept	0	1	1	1	2	1	0
Oct.	1	0	1	0	2	2	0
Nov.	0	0	1	0	1	2	1
Dec.	1	1	0	0	3	1	2
SUM	12	6	11	1	19	13	9

Total articles= 71

Note. C= coping with specific medical/emotional problem
G= general illness information
N= nutrition related to preventing illness
N2= nutrition related to chronic disease
R= treatment of reproductive diseases or problems
R2= reproductive issues related to contraception
MP= mental and physical health promotion

APPENDIX B

OUTLINE OF REFLEXIVE JOURNAL

REFLEXIVE JOURNAL OUTLINE

Separate parts of the reflexive journal included:

(1) the daily schedule and logistics of the study.

(2) a personal diary that allowed me to reflect on my own values and interests as the study progressed and to speculate on my growing insights into the informants' responses.

(3) a research log in which methodological decisions and accompanying rationales were recorded.

Once ethical approval for the study was received my entries were made regularly in the daily schedule and personal diary sections. Methodological log entries were made as needed.

Source: Lincoln, Y. & Guba, E. (1985). Naturalistic Inquiry. London: Sage Publication Inc.

APPENDIX C

EXAMPLES OF GLOBAL QUESTIONS, COVER TERMS AND DESCRIPTORS

EXAMPLES OF GLOBAL QUESTIONS, COVER TERMS AND DESCRIPTORS

Global question 1: I don't often get a chance to really talk to women from the Icelandic community. Because I am a nurse I am interested in health, particularly views women have about the meaning of health. Can you tell me what some Icelandic women, like yourself, perceive health to be?

Response containing cover terms: Well, I think you think about being free from disease and being able to work and carry on. Even if you are sick, if you can carry on, then you have some health.

Potential descriptors: Carry on might be a cover term for walking, talking, being able to eat meals, mere existence, or carrying out paid labour. There will be an array of descriptors for one cover term.

Global question 2: We have discussed what meaning health might have for Icelandic women like yourself. Now I am wondering what factors you feel affect your health in a positive or negative way?

Response containing cover terms: Well, I think being too responsible for the entire family and other families isn't a good thing. And the fact that everything has to go on...there is no time for relaxation.

Descriptors: too responsible might include primary care for a family member, grocery shopping, helping to make financial decisions etc.

APPENDIX D

ETHICAL REVIEW COMMITTEE APPROVAL

The University of Manitoba

SCHOOL OF NURSING

ETHICAL REVIEW COMMITTEE

Proposal Number N#90/02

Proposal Title: An exploratory descriptive study of middle-aged Icelandic Manitoban women's perceptions of health, health needs, and factors impacting on health.

Name and Title of Researcher(s): Susan Gudmundson
Master of Nursing student
University of Manitoba School of Nursing

Date of Review: February 5, 1990

Decision of Committee: Approved: Feb.12/90 Not Approved: _____

Approved upon receipt of the following changes:

APPROVED February 12, 1990 with submitted revisions and requested clarifications.

Date: February 12, 1990

Erna Schilder, RN,DNS Chairperson
Associate Professor
~~University of Manitoba~~
Position

NOTE:

Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

APPENDIX E

ADVERTISEMENT FOR STUDY INFORMANTS

ADVERTISEMENT FOR STUDY INFORMANTS

ICELANDIC WOMEN - RESEARCH SUBJECTS NEEDED

My name is Susan Gudmundson and I am a graduate student at the University of Manitoba completing my Master's degree in Nursing. I am from a Manitoba-Icelandic background and I have an interest in recording and sustaining the Icelandic culture in Canada. In particular, I wish to study the meaning Icelandic-Canadian middle-aged women give to health. If you think you fit the requirements as listed below and are interested in learning more about the study, please contact me at ph.# Susan Gudmundson, RN, Master of Nursing student, University of Manitoba

REQUIREMENTS

1. You are between 45 and 65 years of age, and female.
2. You spoke Icelandic as a child and you still occasionally use and understand the language.
3. Both of your parents are/were of full (mother and father exclusively Icelandic decent) Icelandic or Icelandic-Canadian decent.
4. Most of your life has been spent in Winnipeg or a rural Manitoba area, and you now reside in Winnipeg.
5. You have enjoyed good health.

APPENDIX F

TELEPHONE RESPONSE TO POTENTIAL INFORMANTS

TELEPHONE RESPONSE TO POTENTIAL INFORMANTS

Hello, my name is Susan Gudmundson. Thank you for responding to my advertisement. I am a graduate student at the University of Manitoba and to complete my Master's degree in Nursing I will be conducting a study of middle-aged Icelandic-Canadian women. This study is being supervised by Dr. T. George, School of Nursing, University of Manitoba.

The general purpose of the study is to explore and describe your own thoughts about the meaning of health, and what you perceive your health needs to be. I am also interested in knowing what factors you feel affect your health, both positively and negatively.

I will require between three and four interviews of one hour each, over a period of four to six weeks. The interviews will take place at a time and place convenient to both of us. The interviews (all except the first one) will be tape recorded and later transcribed on to paper to allow more accurate recording of your comments. There are no right or wrong answers to the questions I will be asking you. You are the expert because of your Icelandic-Canadian background and your experiences of middle-age.

All the information you provide me will be kept confidential. My thesis advisor, Dr. T. George and my thesis committee, may read some of the interviews but your identity will not be revealed because your name will be number-coded and only a number will identify you and be referred to in future writing or discussion. There may be some writing from this study that becomes published, but it will be written in a manner such that individual statements could not be linked to you as an individual.

Do you have any questions I may answer for you in regards to the study? Do you feel you may be interested in participating in the study? If you are interested I would like to review the requirements I listed in the newspaper with you.

If the subject is interested we will arrange a time and place for signing the informed consent and beginning the first interview.

APPENDIX G

WRITTEN EXPLANATION OF STUDY

EXPLANATION OF STUDY PRIOR TO CONSENT

You are being asked for your consent to participate in a study about the meaning of health to middle-aged Icelandic-Canadian women. I am asking you for your consent to participate because you meet the qualifications I require for a representative of the Icelandic-Canadian community. Ten to fifteen women from the Winnipeg Icelandic community will be involved.

The general purpose of the study is to explore and describe women's own thoughts about the meaning of health, their health needs and factors they see affecting their health. This information will be valuable to the nursing community for several reasons. First, middle-aged women have rarely been asked for their own thoughts and feelings on this subject. Nursing also believes that understanding the meaning different cultures hold about the term "health" will aid them in providing competent and culturally acceptable care to their clients. The benefits of the study will be that nursing will gain a better understanding of middle-aged women's beliefs about health, and therefore can plan and implement appropriate nursing practice.

If you chose to sign this form and later decide not to participate, you are under no obligation to do so. If you do decide to participate it will require three to four interviews each lasting about one hour. The interviews will take place over a four to six week interval. During this time I will be asking you questions regarding beliefs about health, health needs and factors you feel affect the health of middle-aged Icelandic-Canadian women like yourself. There are no right or wrong answers to any of my questions. I am wanting to understand and listen to your thoughts. The interview will be tape-recorded and later transcribed on to paper to allow a more accurate recording of your comments.

The inconvenience to you may be that you will be interviewed approximately four times for one hour each. The interviews will take place at a time and place convenient to both of us.

All information which you provide will be kept confidential. My thesis committee and thesis advisor, Dr. T. George, may read some of the responses but your identity will not be revealed as your name will be assigned a code number. All audio tapes and written accounts will be kept in a locked drawer identified only by this code number. If the study, or a portion thereof, is published the results will be arranged in order that the individual's anonymity is maintained.

You may call me anytime to ask questions about the study. Susan Gudmundson, , Winnipeg, ph#

APPENDIX H

INFORMED CONSENT

CONSENT FORM

Title of the study:

An exploratory-descriptive study of Icelandic-Canadian middle-aged women's perceptions of health, health needs and factors influencing health.

If I choose to sign this form it will mean:

1. I have read the explanations of the above mentioned study and have had all my questions and concerns about the study answered satisfactorily.
2. I have been offered copy of this consent form and the explanation form to keep.
3. That I am willing to participate as a subject of the study.
4. It is clear to me that I may choose to withdraw at any time from this study without fear of reprisal or harassment.
5. I have agreed to be tape-recorded during the interviews.
6. I am under no obligation to answer any questions I do not want to answer.
7. That all the information I provide to the researcher will be kept confidential.
8. That if some written result of this study is published no statements will be linked to as an individual.
9. That Susan Gudmundson, a graduate student in nursing at the University of Manitoba, is available to answer questions about the study. Her address is : 152 Wildwood Park, Winnipeg, and her phone number is 452-3757.
10. That Dr. T. George, the supervisor of Susan's study may be contacted at 474-8218.

Date..... Participant's signature.....

Date..... Participant's signature.....

If I wish to receive a copy of the results of the study I will write my name and permanent address below. A summary of the results will be mailed to me.

Name.....

Address.....

.....

APPENDIX I

EXAMPLE OF A PARADIGM SHEET

Cover term: "don't be too hard on yourself case 08

Attributes → / Included terms ↓	accept the self	Self understanding and willingness to change	empower	Self love esteem	
to be less like Hagar in Stone Angel and more open to change		yes			
Having an awareness of making yourself sick in situations you have little control over		yes		yes	
realizing you are able to do a lot more than you gave yourself credit for		yes	yes	yes	
You really need some very good feelings about yourself to break out of passivity	yes	yes	yes	yes	
Women need to develop some good feelings about themselves ... you can do anything	yes	Yes	yes	yes	