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MAINTAINING PHYSICAL ACTIVITY AS A HEALTH-PROMOTING BEHAVIOUR FOR MIDLIFE WOMEN: A FEMINIST PERSPECTIVE

JUDITH A. YARWOOD

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ABSTRACT

Whilst being physically active is linked to many health benefits, it appears maintenance of activity is both complex and poorly understood. Ten women participated in this research to explore the positive and negative factors that may influence midlife women to maintain physical activity over time. The perceived benefits of physical activity as a health-promoting behaviour have been found to be firmly located within the bio-medical discourse, with disease prevention accorded primacy by a consensus of health and social disciplines. The individualistic nature of this discourse mostly ignores contextual determinants, which has necessitated a feminist approach be taken in this research to ensure that the everyday reality of midlife women living in a gendered society was recognised.

The three discourses of physical activity taken up by the participants – disease prevention, health and well-being and the "body beautiful" – had resonance with the currently competing discourses in society. All three discourses appear to be constituted within a health imperative, which strongly motivated all participants to maintain physical activity. Whilst the desire to maintain such activity was axiomatic, the context in which this occurred was frequently problematic. The interweaving and changing life situations clearly illustrated the relevance of the social context in which these women were physically active.

Nurses' position within health promotion discourses has been located within and constrained by the individualistic bio-medical discourse. The limitations inherent in risk and lifestyle behaviours appear to have prevented examination of the contextual reality of women's lives. Within the political and health ideology currently underpinning health care there are opportunities for nurses to expand their practice to incorporate social determinants. In so doing they can claim their place as autonomous practitioners who emphasize promoting health within a contextual reality, thus acknowledging the uniqueness, diversity and complexity of women's lives.

CONTENTS

ACKNOWLEDGEMENTS i

ABSTRACT ii

CONTENTS iii

CHAPTER ONE : INTRODUCTION 1

1.1 Introduction 1

1.2 Definitions of key words 2
1.2.1 Midlife 2
1.2.2 Physical activity and exercise. 2

1.3 Aims of the study. 3

1.4 Background to the study 3

1.5 Physical activity and women 4
1.5.1 Maintaining exercise 5
1.5.2 A nursing perspective 5

1.6 Justification for this study 6

1.7 A feminist postmodern methodology 7

1.8 My position in this study 10

1.9 Review of chapters 11

1.10 Conclusion 13

CHAPTER TWO : A LITERATURE REVIEW 14

2.1 Introduction 14

2.2 Physical activity 14
2.2.1 Physical activity and disease prevention 15
2.2.2 Osteoporosis 16
2.2.3 Psychological health 17
2.2.4 The context of health 19
2.2.5 The downside of physical activity 21

2.3 Maintenance of physical activity 22

2.4 Measurement tools for physical activity 23

2.5 Gender bias in studies 25

2.6 Physical activity and midlife women 27
2.6.1 Perimenopausal years 27
2.6.2 Nursing literature 28
2.6.3 Maintenance of physical activity for midlife women 30

2.7 Health promotion 32
2.7.1 Lay theorizing and health promotion 34
2.7.2 Health promotion and women 36
2.7.3 Health promotion and nursing 36

2.8 Conclusion 38

CHAPTER THREE : THE RESEARCH METHODOLOGY AND THE RESEARCH METHOD 40

3.1 Introduction 40

3.2 Epistemology and Ontology 40

3.3 A postmodern perspective 41
3.3.1 Discourse 42
3.3.2 Language 44

3.4 Feminist methodology 45
3.4.1 Intersubjectivity 45
3.4.2 The perception of contradiction and action 46
3.4.3 The centrality of women and their experiences 46
3.4.4 Gender 47
3.4.5 Understanding of gender in this study 49
3.4.6 Rigour and validity 49
3.4.6.1 Construct validity 50
3.4.6.2 Face validity 50
3.4.6.3 Catalytic validity 51
3.4.6.4 Rigour in transcription 52
3.4.7 Feminist research in nursing 52

3.5 The research method 54
3.5.1 Participant Selection 54
3.5.2 Participants 55
3.5.3 Interviews 63
3.5.4 First interview 64

3.5.5 Second interview ... 65
3.5.6 Ethical issues. ... 66
3.5.7 Informed consent ... 67
3.5.8 Confidentiality ... 67

3.6 Method of Analysis : An overview ... 68
3.6.1 Reductionism ... 69
3.6.2 Interpretation ... 69
3.6.3 The audit trail ... 71
3.6.4 Emerging themes ... 71
3.6.5 The final four emergent themes ... 72
3.6.6 Triangulation ... 73

3.7 Conclusion ... 74

CHAPTER FOUR : EXERCISE FOR SELF ... 76

4.1 Introduction ... 76

4.2 Exercise is part of me, part of my life ... 77
4.2.1 Self concept, self esteem, and body image ... 78
4.2.2 Positive feelings related to exercise ... 83
4.2.3 Exercise and aging ... 89

4.3 The importance of being fit and healthy ... 90
4.3.1 Disease prevention ... 91
4.3.2 Mental health ... 94
4.3.3 Stress release ... 96
4.3.4 Weight control ... 98

4.4 Conclusion ... 103

CHAPTER FIVE : EXERCISE IN CONTEXT ... 104

5.1 Introduction ... 104

5.2 Exercise interweaves and changes with life situations ... 105

5.3 Participation in physical activity ... 105
5.3.1 Physical activity from childhood to adolescence ... 106
5.3.2 Childhood ... 106
5.3.3 Adolescence ... 109
5.3.4 Physical activity in adulthood and at midlife ... 111
5.3.4.1 Walking ... 111
5.3.4.2 Gym ... 113
5.3.5 Maintaining exercise ... 116

5.3.6 Healthy lifestyles 119
5.3.7 Social roles 121

5.4 Constraints and conflicts 124
5.4.1 Time, work, and family constraints 126
5.4.2 Financial constraints 128
5.4.3 Guilt 129

5.5 Conclusion 131

CHAPTER SIX: DISCUSSION AND CONCLUDING STATEMENTS 133

6.1 Introduction 133

6.2 The aim revisited 133

6.3 Health promotion discourses 134
6.3.1 Disease prevention discourse 136
6.3.2 Health and well-being discourse 138
6.3.3 The "body beautiful" 141
6.3.4 The lay discourse 143
6.3.5 Maintenance of exercise 145
6.3.6 Implications for nursing 148
6.3.7 Limitations of the study 153

6.4 Concluding statements 154

REFERENCES 156

APPENDIX A: INFORMATION SHEET FOR PARTICIPANTS 181

APPENDIX B: CONSENT FORM 183

CHAPTER ONE : Introduction

1.1 Introduction

Many health experts consider contemporary society to be increasingly sedentary. To counter this people are being encouraged to be physically active, and to exercise. However, for many people, and for a variety of reasons, becoming physically active or exercising is not an option. Ten midlife women have participated in this study to explore the factors that influence midlife women to maintain physical activity over time. This study will illuminate some of the complexities inherent in this health-promoting behaviour to benefit midlife women, nurses working with this cohort, and women of other ages.

Physical activity and exercise for many women are associated with feelings of ambivalence and guilt. Both are frequently related to western stereotypical social roles, and the "body beautiful". These feelings can emerge from the populist media's portrayal of exercise, which tends to link physical activity to such notions as weight control, and the ideal body. Added to these notions are the lifestyle messages and related risk behaviours prevalent in the dominant discourse of health promotion. Taken together these ideas and influences can make physical activity as a health-promoting behaviour for midlife women both complex and problematic.

Understanding the complexity of being physically active involves a foray into the literature of a variety of disciplines including nursing, medicine, sociology, psychology, fitness and health, leisure science, exercise and sport, and women's studies. To explore the problematic aspects, a feminist and postmodern perspective is utilised to provide insights into the knowledge/power nexus inherent in the health-promoting behaviour of physical activity for midlife women.

This chapter will define key words, set forth the aims of the study, discuss the background and justification, and introduce the philosophical assumptions underpinning the project. My position in the study will also be presented, before an overview of each chapter is provided.

1.2 Definitions of key words

1.2.1 Midlife

Midlife, the timespan between 35 and 65 years of age as defined by Gillis and Perry (1991) spans many life stages and is typified by complex and personal familial changes, as well as physical and psychological challenges (Guthrie, Dudley, Dennerstein & Hopper, 1997; Slaven & Lee, 1997). Stewart and Vandewater (1999) suggest that for some women, depending on age and life circumstances, it could be a time of review, of reflection, of looking back with or without regret.

1.2.2 Physical activity and exercise.

Physical activity is understood to be the spontaneous expenditure of physical energy, and includes walking up stairs, domestic work and gardening. Exercise can be defined as a leisure physical activity with the aim of improving physical fitness, which may well occur in a structured or supervised format (Dishman, 1991; Ebrahim & Rowland, 1996).

Although these two words will be used interchangeably throughout this thesis, as they are in the literature, Ross and Cowley (1997) believe that these terms are not synonymous. They see exercise as one form of physical activity. Ulbrich (1999, p. 66) would concur, and suggests that "while all exercise is physical activity, not all physical activity is exercise". Physical activity can become exercise, depending on the level of exertion. I will provide specific definitions if and when necessary.

1.3 Aims of the study.

The aim of this study is to explore the complex factors that influence the ability of ten midlife women to maintain physical activity/exercise for a sustained period of time. As I intend to explore physical activity as a health-promoting behaviour, the suitability of the current discourses of health promotion for exhorting midlife women to participate in such health behaviours will also be examined.

1.4 Background to the study

Although many people, both professional and lay, believe physical activity can promote health and well being, a certain number choose to remain sedentary. A physical activity survey undertaken by the Hillary Commission (1999) discovered 34% of the population remain inactive, with 35% of these being women and 31% men. New Zealand's position is not an isolated one. Lee and Paffenbarger (1996) contend that 60% of adults in America participate in little or no physical activity, with a similar picture emerging from the United Kingdom.

The positive association between physical activity, exercise and good health has been acknowledged over the centuries. The wellness focus of recent decades, with its emphasis on physical activity, can be seen as something of a renaissance from ancient times. In the late 400s BC, Hippocrates urged, amongst other behaviours, fresh air, proper nutrition, sufficient sleep, and exercise as beneficial for health maintenance (Wiest & Lyle, 1997). In the closing moments of the twentieth century few people would argue that there is a growing interest in the health benefits that can be gained from physical activity. Increased well-being, improved physical, mental and psychological health, and disease prevention are just a few of the well-documented health benefits (Bouchard, Shephard, & Stephens, 1994).

Although concurring that health benefits can be gained from being active, it appears many people, perhaps like our historical ancestors, prefer their participation to be

vicarious rather than participatory. Achieving and maintaining physical activity and physical fitness remains elusive to a large proportion of the population for a variety of complex and possibly unknown reasons. However, as Brehm and Iannotta (1998) suggest, there are many barriers to being physically active. Two-car families, increased information technology, larger numbers of sophisticated home appliances, and perceived lack of time do not encourage people to take the time to exercise. Changing health behaviours would appear to be convoluted, contradictory and challenging, and have led the retiring Surgeon General to suggest that changing physical activity behaviour presents a greater challenge than decreasing smoking (Ross & Cowley, 1997).

Currently the dominant discourse of physical activity as a health-promoting behaviour is disease prevention: a discourse that tends to focus on risk and individual behaviours. The risk factors related to cardiovascular disease, for example, smoking, high-fat diet, hypertension and inactivity, drive many health promotion programmes. These messages are invariably sanctioned by government agencies such as the recent funding announced for Green prescriptions, a project involving general practitioners prescribing physical activity rather than drugs. Like the majority of health promotion programmes, the focus of this project remains on individual behaviours, rather than on the social context in which these occur.

1.5 Physical activity and women

Despite the known health benefits of exercise, it appears women are less likely to exercise than men, particularly as they age (Felton, Parsons, & Bartoces, 1997; Romans, 1997). There are a variety of reasons offered for this. The Hillary Commission (1999) suggests that one reason why women between twenty-five and forty-nine years are less active may be due to family responsibilities. These responsibilities are inherent in many women's social roles, which have been identified as major barriers to being physically active (Bialeschki & Michener, 1994; Nies, Vollman, & Cook, 1998; Verhoef & Love,

1992). Other barriers identified include time, financial constraints, lack of motivation, and poor body image.

Peterson and Lupton (1996) believe that in our society women are constantly being urged to monitor their bodies to enhance their attractiveness and desirability. Society's preoccupation with youthfulness and with young, slim bodies, at both a covert and overt level, has also influenced women's health behaviours. This preoccupation is certainly not a twentieth-century phenomenon. Rubenesque physique and thinness have both been a cultural norm at different times. The present norm can be seen in the media on a daily basis, where the ideal healthy woman is portrayed as slim, young and attractive. Frequently this is linked to being physically fit, and to doing exercise. It is this link which Markula (1998) suggests can become problematic for women, especially for midlife and older women, who live in a culture preoccupied with youth and slimness.

1.5.1 Maintaining exercise

Being physically active is one thing; maintaining this over time is another. Although the psychosocial and environmental barriers women face appear to influence their ability to adhere to physical activity, understanding how and why some women, and not others, maintain physical activity is poorly understood (Klonoff, Annechild, & Landrine, 1994). Most of the studies regarding maintenance of physical activity have had an illness focus and have either been based on male subjects or have been gender-blind, with the majority of these studies being quantitative in nature (Hawkes & Holm, 1993). Even within this literature little appears to be known about women's ability to maintain lifestyle behaviours over time (Robison & Rogers, 1994).

1.5.2 A nursing perspective

Apart from the contribution of Nies et al. (1998) the few nursing research studies investigating physical activity are all quantitative and have frequently cited the Health Promotion Model developed by nursing scholar and researcher Nola Pender (Gillis & Perry, 1991; Duffy, 1993). The popularity of this model demonstrates nursing's

commitment to promoting health. However, the discourse within which many nurses position themselves is the medical discourse, which Kermode and Brown (1995) believe not only continues the individualistic health promotion discourse, but suppresses a radical critique of the social determinants of health. A bio-medical focus has discouraged the inclusion of the socio-political context, including the social categories of gender, class and ethnicity. Disease prevention is seen as the ultimate health benefit, and acknowledging the context of women's lives has no part in this discourse.

Although much of the critique of the medical discourse comes from the social sciences, nursing is well placed to add to this critique. Nurses, the majority of whom are women, have first hand experience of the limited relevance of the disease prevention discourse for women's health. Although many nurses may practice within the confines of the bio-medical discourse, I believe a considerable number think outside this discourse. This study may not only provide nurses with a critical insight into the limitations of the disease prevention discourse, but also add to a nursing discourse regarding health and well-being for midlife women.

Identifying and illuminating the factors which enhance midlife women's ability to maintain exercise could also provide nurses with a greater understanding of the complexities of this and other health-promoting behaviours. The benefits of up-to-date knowledge being effective in practice was found by McDowell, McKenna, and Naylor (1997) and Sourtzi, Nolan and Andrews (1996). To ensure the nursing perspective is heard, nurses need to conduct and disseminate their own research, using methodologies which can privilege people rather than the health professional, and which consider the contextual reality of people's lives.

1.6 Justification for this study

Innumerable studies regarding physical activity conclude that more research is needed to understand the determinants of physical activity (Dishman & Sallis, 1994). Much of

the research into physical and psychological benefits of physical activity has focused on men, with results being generalized to women. This can be problematic, as Blair (1996) found in a recent research project where a lack of association between inactivity and mortality in women was the unexpected finding. Although he suggested inadequate measurement as a possible cause for this unexpected finding, this does highlight the need for research specific to women. I believe it also highlights the need to look beyond objective measurement to incorporate the subjective, which can include the context in which people live. The quantitative nature of the majority of studies, with mortality and morbidity frequently cited as measures of health, are proving to be inadequate (Slattery, 1996).

The paucity of research investigating not only the physical and psychological benefits of physical activity for women, but also the reasons women have difficulty exercising, is an important challenge for researchers (Romans, 1997). Angus (1994) agrees and argues that any analysis of women's health needs to consider the social and working context, which is frequently ignored. Context, however, was attended to in the one relevant qualitative nursing study I found, which examined the themes emerging from the context of women's everyday lives (Nies et al., 1998). I hope that my qualitative study can add to this knowledge and offer a critical insight into the health promotion discourses which propel health-promoting behaviours such as physical activity.

1.7 A feminist postmodern methodology

Choosing a methodology for this study was simple, yet challenging. As one of the central ideas emerging from this study related to considering physical activity within the context of each woman's life, the choice of a feminist approach was axiomatic. Feminism as a critical philosophy offers an opportunity to redress injustice brought about by unearned privilege, and to make a difference to women's lives (Allen & Hardin, 1998). This approach provides a framework not only to challenge empirical

knowledge as "the" way of knowing, but also to consider critically how gender issues impact on women's ability to remain physically active.

Deciding to choose a postmodern perspective provided the challenge. The questions I hoped to consider contributed to the decision taken. For example, I wished to know what knowledge regarding physical activity and health promotion is taken for granted, how it came to be taken for granted, and how it retains this status (Bassett-Smith, 1998). It appeared from my reading that not only did a postmodern approach challenge empirical knowledge as to the ultimate truth, but it could also allow recognition of the multiplicity of constructed realities present when considering physical activity as a heath-promoting behaviour (Rafael, 1997).

As I read I became aware of the literary tension between the terms postmodernism and poststructuralism. Although both perspectives are complex and at times confusing, there are recognisable common features, which include a reaction to, and a questioning of modernist thinking; a rejection of the metanarrative, the grand theories; and an acceptance of multiple world views and realities (Cheek, 1998). Whilst both emanate within a postmodern genre, poststructuralism emphasises the centrality of language, of the need "to make language reflexively visible, that is, not just visible as an object, but visible as an active force shaping our bodies, shaping desire, shaping perception" (Davies, 1997, p.280). Language, therefore, can be seen as constituting, rather than representing, reality.

Whilst postmodernism and poststructuralism are intertwined and frequently used interchangeably, for the purpose of this study I have taken a postmodernist stance. This will enable me to explore a group of midlife women's experience of maintaining exercise, in relation to knowledge and power, which is central to, and congruent with, the ideas of the French philosopher, Michel Foucault. Both Cheek (1998) and McNay (1996) believe that Foucault himself resisted definitive categorising or labelling of his work, and this position is mirrored here because the meaning of language in these women's life experiences is integral to this exploration. Thus knowledge, power and

language are seen to interweave. I will explicate these ideas further in the methodology chapter.

Similarly, the notion of discourse used in this thesis will also draw on the work of Foucault. As with many postmodern abstract notions, definition is elusive, but discourse can refer to ways of thinking, of meaning, and of talking. Foucault's interest in knowledge and power, however, was analysed through discourse, and he questioned "what rules permit certain statements to be made; what rules order these statements; and what rules enable us to identify statements as true or false.... Such a set of rules constitutes a discursive formation or discourse" (Cheek & Rudge, 1994, p. 584). Although there are many competing discourses operating at a particular time, why and how one becomes ascendant and powerful while others remain silent is given primacy in Foucault's work. These ideas will also be examined in more detail in chapter three.

The combination of a feminist and a postmodern perspective therefore offers an opportunity to explore gender and health promotion beyond the bio-medical model. Within a feminist postmodern perspective, gender can be seen as socially constructed through language, cultural practices and social institutions, rather than being a biological entity (Paech, 1996). If, as Weedon (1997) contends, meaning originates from language, rather than reflects it, what does female mean without male? Answering her own question, Paech suggests "it is this process that leads to the view of maleness and femaleness as being constructed in relation to each other, rather than being biologically given" (p. 151). The sex/gender debate, which has raged within feminist thinking over the years, looks set to continue, with the postmodern perspective contributing yet another viewpoint.

By necessity, and to ensure clarity, the stance taken in this study regarding sex/gender needs to be stated at the outset. Acknowledging the risk of being accused of categorisation, sex will refer to the biological nature of being female and male, of the possession of certain bodily parts (Cheek & Rudge, 1996). This is not to accept the humanist view of sex as "natural", as a fixed entity; rather it can be seen as expedient, as

much of the literature reviewed in this study is embedded in the essentialist notion of sex as a biological given. Gender can be seen as socially constructed, incorporating both attitudes and behaviours that are inscribed on the female body (Cheek & Rudge). From a Foucauldian perspective, however, both sex and gender are social constructs which need to be viewed within a historical context, rather than as essential givens (Paech, 1996). These ideas are explored further in chapter three.

1.8 My position in this study

My interest in physical activity and exercise as a health-promoting behaviour for midlife women is at both a professional and a personal level. Although I have exercised intermittently throughout my life, there has been a more sustained effort over the last decade. As I approached midlife, exercise appeared to be a great way to keep fit and healthy. I believe being physically active has been hugely beneficial for both my physical and psychological health. Secondly, the influence of gender on one's health, and women's health in particular, has been an abiding interest of mine. Thirdly, I have an ongoing critical interest in health promotion discourses present in nursing practice and education. Therefore this thesis allows me to further develop my understanding of these complex and fascinating subject areas.

Research can never be objective and value-free; therefore the knowledge and values I bring to this study need to be acknowledged at the outset (Rafael, 1997). I would consider myself to be an emerging postmodern feminist, a position that has developed through postgraduate education. I do not see this position as fixed, but uncertain and continually evolving. From a postmodern perspective, I acknowledge gender as being socially constructed, and yet I also tend towards Lupton's (1997b) dialectical approach to the body. She "recognizes the location of bodies in nature, but also the ways in which discourses act to shape bodies, and experiences of bodies, in certain ways over which individuals have only a degree of control" (p. 5). I realise this could be considered "fence sitting"; however, my partial acceptance of either position can be seen as being

entirely congruent with the fluidity inherent in postmodernism. Having considered the background to this study, I will now give an overview of each chapter.

1.9 Review of chapters

Chapter 1 introduced the thesis topic and aims, the background, justification, and the philosophical assumptions, before my position in this study was given. The importance of being physically active and exercising can be seen to be constituted in the dominant health promotion discourse – that of disease prevention – as well as in other discourses, such as health and well-being. This chapter has also highlighted the importance of nursing research, not only to provide a nursing perspective, but also to promote the development of nursing scholarship.

Chapter 2 provides a review of the literature from a wide variety of disciplines concerned with midlife women and exercise as a health-promoting behaviour. Physical activity and health promotion are examined from a nursing, medical and social science perspective, ranging across the spectrum from the academic to the populist. Many research studies exploring physical activity and exercise have been based in epidemiology, with the participants being mostly men. Not only are women of all ages absent from many of the studies investigating physical activity, but also factors related to the social roles of women's lives are virtually ignored. Physical activity involved in housework and child-rearing, for example, is only now beginning to be acknowledged.

Chapter 3 explicates the methodology and method chosen for this study. Feminist methodology offers a framework which values each woman's life experiences, and the different social world each woman inhabits. An understanding of the multiple factors which influence the ability of midlife women to maintain physical activity over time, is possible with insights gained from each woman's experiences. A postmodern perspective is used to explore the multiple discourses available to midlife women and health professionals at any one time, and the certain positions taken up. The discussion

will continue with the method chosen for participant selection, the interviewing experience, and the relevant ethical issues. Thematic analysis, the method chosen for data analysis raises, interesting issues related to reductionism and interpretation.

Chapter 4, "Exercise for myself", is the first of two data analysis chapters. This chapter discusses the two emergent themes: "Exercise is part of me, part of my life" and "The importance of being healthy". Each theme is an amalgamation of the many dimensions which emerged during my reading, listening to and reflection of each woman's story. The importance of physical and psychological health is evident throughout this chapter, as excerpts from the participants will provide salient examples of their life experiences with exercise and physical activity.

Chapter 5, the penultimate chapter, is "Exercise in context". Here, the two remaining emergent themes, "Exercise interweaves and changes with life situations" and "Constraints and conflicts" are discussed. Physical activity levels throughout each participant's life are tracked and linked to situational influences. Maintaining exercise at midlife is explored, as is the impact of the social roles performed by each woman on a daily basis. Constraints to being physically active can not only be related to these roles, but also to the ambivalent feelings some women experience regarding physical activity. These, and other dimensions that come together in these two themes, clearly demonstrate how interwoven physical activity is in each woman's life.

The final chapter discusses the findings of this study within a framework of the current competing discourses of physical activity taken up by this group of women. The concerns and insights gathered from the critique of the dominant discourse of health promotion, evident throughout the thesis, are reflected upon and discussed. Having attempted to demonstrate the importance of considering the contextual reality of each woman's life, I consider the numerous implications for nursing practice, particularly within the primary health arena. The limitations of the study are identified and explored, before the final words are offered, with recommendations made regarding future

research possibilities in this challenging, complex and little-understood area of the human condition: being physically active.

1.10 Conclusion

This chapter has provided a synopsis of the thesis topic, which aims to illuminate how a group of ten midlife women attempt to maintain physical activity over time. I have provided both my personal and professional position, to make transparent the beliefs and values which guide this project. The underpinning feminist and postmodern philosophical assumptions have been introduced to illustrate the political nature upon which this study is predicated. The research project continues in the following chapter, reviewing the literature from a variety of disciplines, examining the numerous texts regarding the maintenance of physical activity for midlife women.

CHAPTER TWO : A literature review

2.1 Introduction

In chapter one I introduced the aims of the study and provided an overview of how I will proceed in exploring the complex nexus between midlife women and physical activity. In this chapter I will review the literature regarding participation in physical activity as it relates to people generally, then specifically to midlife women. Taking up physical activity is one thing; maintaining this behaviour over time is another, which is frequently connected to a variety of barriers. Literature exploring adherence and barriers will also be reviewed. Physical activity is frequently a component of health promotion programmes; thus finally literature related to the health promotion discourse will also be reviewed.

Rafael (1997), believes that a feminist postmodern study necessitates that the literature be "examined for evidence of who decides what counts as knowledge, how power is produced and reproduced, and what resistance to it exists" (p. 35). Knowledge and power are ubiquitous to many of the disciplines from which this literature review emanates, including nursing, medicine, sociology, human biology, leisure science, exercise and sport, psychology and health (Henderson & Bialeschki, 1991; Kimiecik & Lawson, 1996; Owen, 1996; Robison & Rogers, 1994; Wallace, 1997). The ideology of health promotion provides an example of power and knowledge relations, and this will be explicated throughout this chapter. Although not exhaustive, the review of literature will acknowledge many of the disciplines noted above.

2.2 Physical activity

In 1998 the National Health Committee (1998) published a report, *Active for life: A call for action*, conveying what the committee consider to be a new public health message. Vigorous exercise was no longer needed for health benefits. It appeared significant

benefit could be obtained from participating in moderate physical activity for about thirty minutes a day on all, or most days of the week. The committee hoped this change of emphasis from vigorous to moderate exercise may motivate people to become more active. The two central themes throughout this report, health benefits and disease prevention, are prevalent in much of the literature associated with physical activity.

Numerous health benefits that can be obtained from participating in physical activity have been well documented. These include physical fitness and health (Malina, 1996; Slattery, 1996) prevention of disease, (Blair, 1997; Garber, 1997; Karvonen, 1996), stress and anxiety reduction (Frankish, Milligan, & Reid, 1998; Morrissey, 1997) improved mental health, such as preventing and ameliorating depression (Artal & Sherman, 1998; Tkachuk & Martin, 1999) improved self concept and greater confidence (Bull, 1993; Wiest & Lyle, 1997) and relaxation and enjoyment (Felton, Parsons, & Bartoces, 1997; Wankel, 1993). However, this is not exhaustive.

2.2.1 Physical activity and disease prevention

The overwhelming majority of the research literature regarding participation in, and the maintenance of physical activity is quantitative, and embedded in the medical disease prevention discourse. D. R. Brown (1990), in an overt display of medicalisation of exercise, discusses acute and chronic exercise and "psychologically normal middle aged men" (p. 616). Mortality and morbidity related to cardiovascular disease are frequently cited as measures of health (Blair, Kohl, Gordon, & Paffenbarger, 1992; Owen, 1996; Slattery, 1996).

This emphasis can also be found in nursing articles (Gillis & Perry, 1991; Nies, Vollman & Cook, 1998; Wiest & Lyle, 1997). The populist literature, which incorporates the fitness and health industry, and women's magazines such as *The Women's Weekly* and *New Idea*, present a very similar picture (P. Brown, 1997; Robison & Rogers, 1994). In addition, the populist media implicitly, and sometimes explicitly, incorporates body image and dietary messages with physical health.

The positive influence of physical activity on morbidity and mortality in, for example, chronic diseases such as diabetes and heart disease, is considered to be clearly correlated (Arroll & Swinburn, 1994; Blair & Connelly, 1996; Blair et al., 1992). From a purely bio-medical perspective, regular physical activity has considerable value, especially when linked to the prevention and treatment of cardiovascular disease, the leading cause of premature death in New Zealand (Cox, 1997; Roos, 1997). Lowered blood pressure, raised high-density lipid cholesterol (HDL-C), and improved coagulability are a few of the ways in which physical activity improves cardiovascular health (Arrol & Swinburn, 1994; Kimiecik & Lawson, 1996). The National Heart Foundation now identifies physical inactivity as the fourth major modifiable risk factor for coronary heart disease (Arroll & Swinburn). As alluded to in the introduction, inactivity in the USA is also viewed as a public health problem, and can be seen as equal in significance to smoking, hypertension and hyperlipidaemia (Blair et al., 1992). Blair (1994) would concur with all of the above, and considers there is sufficient evidence to believe there is a causal link between inactivity and cardiovascular disease. He also considers present knowledge should be tempered with uncertainty, as doubt still remains in a number of areas, such as the causal links between physical activity and cancer. Few studies have offered a definitive answer apart from the protective effect physical activity has in preventing colon cancer (I. M. Lee, 1994; National Health Committee, 1998).

2.2.2 Osteoporosis

Research investigating the link between physical activity and the prevention of osteoporosis is contradictory. The skeletal disease osteoporosis, which causes increased risk of bone fractures, can affect both men and women, but predominantly the latter. Whilst Drinkwater (1994, p. 734) believes there is extensive evidence that people who are active have a "greater skeletal mass" than those who are inactive, she remains unclear regarding the role of regular activity in the prevention of osteoporosis. The National Health Committee (1998) believes that forty percent of women are at risk from

an osteoporotic fracture and see the maintenance of physical activity as one way to prevent falls and fractures.

While Marcus, Rakowski, and Rossi (1992) and Wiest and Lyle (1997) agree that regular weight-bearing exercise can enhance bone life and reduce the risk of osteoporosis, Slattery (1996) is more circumspect. Slattery, like Drinkwater (1994), suggests the relationship between physical activity and osteoporosis remains a little unclear as some studies show no increase in bone density from physical activity. However, Warburton (1998) contends that moderate to vigorous sustained physical activity can enhance bone density. As with many of the specific benefits to be obtained from exercise, definitive answers are not readily available.

The literature reviewed here relating physical activity to morbidity and mortality offers a representative sample of the innumerable studies and publications regarding these concepts, particularly in relation to illness, such as cardiovascular disease. The second international consensus symposium edited by Bouchard, Shephard, and Stephens (1994) offers a salient example. This symposium gathered world-leading authorities to provide an up-to-date consensus statement regarding physical activity, fitness and health. This book would be described by Rafael (1997, p. 39) as having "a strong medicocentricism", a useful phrase which acknowledges the heavy embeddedness of medicine in the text. It offers a mainly scientific, biological, and epidemiological perspective, although determinants of health and psychosocial outcomes are considered by a few of the contributing authors.

2.2.3 Psychological health

In comparison to physical health, McAuley (1994) believes the effect of physical activity on psychological health to be even less clear. He found the number of studies demonstrating no association between exercise and psychological health was matched by those finding "almost intuitive psychological benefits" (p. 551). The equivocal nature of McAuley's findings are apparent in much of the voluminous literature regarding psychological health. Although Artal and Sherman (1998) acknowledge methodological

concerns which make interpretation and applicability of findings difficult, they found, on reviewing research, that studies strongly suggest benefits can be gained for both preventing and easing depression. Similarly, Morgan (1994) found anecdotal reports suggesting reduced depression in some studies; however, he also acknowledges the inherent complexity of measuring psychological health.

Again, the literature is unclear about a definitive relationship between exercise and the prevention or reduction of depression. Whilst Morrissey (1997) found exercise promoted mood enhancement as indicated by reduced depression and anxiety scores, he remains unconvinced that exercise alone improves depression and anxiety levels. Examining the relationship between exercise and mental health, Dishman (1994), one of the more prolific writers on physical activity over the years, concluded that scientific evidence does not support substantial mental health benefits amongst the general population. Despite the absence of causal evidence, Dishman and Morrissey both suggest there are benefits to be gained from physical activity for people who are depressed or anxious.

Recent evidence, however, suggests the link between exercise and mental health maybe significant, particularly from a therapeutic perspective. Tkachuk and Martin (1999) reviewed research on the effects of exercise for people diagnosed with disorders such as depression and anxiety. They found considerable evidence "that regular exercise is a viable, cost effective treatment for mild to moderate depression" (p. 279). Interestingly, Tkachuk and Martin also found in their review, the majority of research linking exercise with mental health benefits, studied healthy college students, rather than participants experiencing depression and/or other mental health disorders.

Weyerer and Kupfer (1994) offer another perspective with their findings that the risk of depression was significantly greater for people who were physically inactive, compared to people who exercise regularly. Whichever way the causal links between exercise and mental health, particularly depression and anxiety, are approached, it appears definitive answers have yet to be found. However, Dishman's (1994) belief that moderate exercise

has never been found to cause psychological harm, and may provide protective cover for those at risk of psychological distress appear to be supported by Tkachuk and Martin's (1999) recent research review.

Similarly, J. D. Brown (1991) and Caltabiano (1995) also linked enhanced psychological well-being to exercise, and Ransford and Palisi (1996) found this particularly so in the middle to older age group. In a study examining physical fitness as a moderator of life stress, Brown demonstrated that physically fit people are less vulnerable to stress and ill-health. However, like other authors, he did sound a warning, suggesting that unequivocal causal relationships between physical activity, fitness, stress and health are not possible due to the many factors influencing people every day, such as self-esteem levels and mood states.

2.2.4 The context of health

J. D. Brown's (1991) note of caution is worth considering as very few of the studies discussed so far have acknowledged the context in which people live and exercise. Although health-related behaviour such as physical activity may, in an ideal world, lower risk factors for disease such as coronary heart disease, Tarlov (1996) contends that many of these risk factors arise from the social environment. Gauvin, Rejeski, and Norris (1996, p. 391) are also keen to incorporate what they see as the "rich social environment that accompanies daily bouts of physical activity".

A review of 12 major studies carried out post-World War 11 to examine the relationship between physical activity, health and longevity, demonstrates, I believe, the limitations of failing to consider the social context. In the overwhelming majority of these studies, the risks of coronary heart disease, namely hypertension, hyperlipadaemia, cigarette smoking and inactivity were used as measures of morbidity and mortality. The studies, reviewed by Paffenbarger and Lee (1996) used differing groups of mainly men, ranging from British civil servants, American railroad workers, Californian Day Adventists, eastern Finnish men and Harvard alumni. The diversity and wide ranging findings provided no definitive answers, and had Paffenbarger and Lee questioning the

possibility of other influences on these people's health. Whilst they did suggest that population differences could be a consideration, the socio-cultural, economic and political differences so obvious in these groups appeared to be invisible.

It has been noted that activity in childhood and adolescence may influence physical activity participation in later life. In one of the few biological articles which acknowledges the many factors beyond the physical, Malina (1996) suggests that physical activity is a bio-cultural process. He argues for physical fitness to be followed across the life span, as events in childhood could affect exercise behaviour throughout life. Ebrahim and Rowland (1996) and Warbuton (1998) join Malina in considering that activity levels in childhood and adolescence may influence participation in adulthood.

This idea is one that Dishman (1994) also identified when he reviewed the literature regarding the determinants of participation in physical activity. He established three themes: personal attributes, past and present environments and aspects of physical activity itself. Personal attributes included age, education, gender, socio-economic status, past and present behaviours, psychological traits, personality, and knowledge, attitudes, and beliefs. Environmental variables included the availability of facilities, time, and the climate. Dishman concluded that although these variables do impact on people's ability to exercise, there remain other potential determinants. He considered that behaviours related to physical activity are both complex and time consuming, and as such may be different to other health behaviours. These findings from 1994 are just as relevant today, with definitive answers remaining elusive, due perhaps to the multiple and at times very complex influences.

Although clear correlations are not evident, the literature conveys the message that physical activity offers many health benefits. However, whilst people are increasingly being urged to participate in some form of physical activity, very little is written about the risks or drawbacks of being physically active.

2.2.5 The downside of physical activity

The National Health Committee (1998) briefly acknowledges injuries and sudden cardiac events as the two major areas of risk most likely to be identified with physical activity. According to Becker (1993), recent public health data showed that thousands of people experience injuries through exercise. Whereas low intensity physical activity can be beneficial for the immune system, high levels of exercise can lead to adverse effects for the immune system (Newsholme & Parry-Billings, 1994; Ross & Cowley, 1997; Sellens, 1993). It is not uncommon to hear of professional sports people, who appear to be extremely fit and healthy, having succumbed to colds and influenza. However, Sellens argues that the circumstantial evidence linking suppressed immune system with over exercising remains just that.

Many people are committed to regular exercise. It is when that commitment becomes an addiction that exercise becomes problematic. D. R. Brown (1990) found that exercise compulsion can lead to addiction and injuries, while Nimmo (1992) asserts that psychological problems related to food and weight control are seen in gyms and fitness centres throughout New Zealand as well as overseas. Overexercising and training can have negative psychological consequences, which may lead to increased levels of anxiety and depression. (Brown; Farrell & Thompson, 1998). Physical activity can become problematic as people spend ever increasing amounts of time exercising, until the positive benefits are reversed.

Bouchard et al. (1994) maintain that the greatest perceived risk of activity versus inactivity would be musculo-skeletal injuries. In reality, these authors believe insufficient information has been gathered for definitive answers. However, the message remains that in most instances risks can be minimized, and are generally outweighed by the promised benefits of physical activity.

Participation in physical activity therefore has many implications, not only for physical and psychological well-being but for all aspects of health. Tarlov (1996) believes that

physical fitness and health are highly valued in our society, although Felton et al. (1997) believe that how health is defined and the value placed on health also play a considerable role in health behaviours. Accepting that health is valued, and acknowledging the benefits of exercise, raises the question, why are more people not physically active? Marcus, Rakowski et al. (1992) contend that although many people would like to be more active, little success has been achieved in maintaining exercise over time. The typical dropout rate of structured exercise worldwide continues to be approximately fifty percent (Dishman, 1991; Leith & Taylor, 1992).

2.3 Maintenance of physical activity

The ability some people have to maintain exercise over a sustained period of time while others falter at the first hurdle is one of the themes explored in this study. According to Botorff, Johnson, Ratner and Hayduk (1996), the factors influencing the commencement of exercise are different from those which ensure people maintain these behaviours over time. The findings from research carried out in the area of behavioural maintenance is far from conclusive, as little appears to be known in regard to people's ability to maintain lifestyle behaviours over time (Bottorff et al.; Dishman, 1991; Robison & Rogers, 1994). Marcus, Rossi, Selby, Niaura and Abrams (1992) also consider more is known about relapse than maintenance, and, as with previous sections, the research here is inconclusive and unsubstantive.

Simkin and Gross (1994), investigating how people acquire the skills for adhering to exercise, describe lack of time, boredom, illness, laziness and holidays as common barriers. Ineffective coping strategies appeared to be responsible for some relapses, although Dishman (1991) considered adherence to exercise programmes was generally poor, and the effectiveness of programmes promoting maintenance of exercise uncertain.

Marcus, Rossi, et al. (1992) chose a theoretical model for change to understand the process people undergo when changing behaviours. Although they were able to identify ten change processes adopted in this study, again definitive answers were not forthcoming. In their search for answers Robison and Rogers (1994) reviewed the literature relating to adherence to exercise from the late 1960s until the early 1990s. They found there was a need to understand the behavioural change processes required to maintain exercise over time. However, they concluded that it is also necessary to acknowledge and overcome personal, social, cultural, and environmental barriers. Identifying and acknowledging the socio-political context of women's lives could begin to address such barriers.

Much of the literature found that while short-term adherence is successful, long term maintenance remains elusive. Leith and Taylor (1992) reached similar conclusions, although their focus was on behaviour modification techniques to improve adherence. Again, the context of physical activity was not acknowledged. Many studies acknowledge the seemingly confusing picture regarding exercise and the maintenance of this health-promoting behaviour (Bottorff et al., 1996; Gillis & Perry, 1991; Robison & Rogers, 1994). Studying the relationship between physical activity and health appears to be fraught with difficulty at the definition, process and interpretation level. According to Dishman (1991, p. 372) "exercise behaviours are more complex, time consuming, and effortful than most other behaviours that are targeted for change". Such complexity is acknowledged when it comes to measuring concepts such as health and physical activity.

2.4 Measurement tools for physical activity

One of the many problems associated with measuring people's ability to exercise is the lack of precise and valid assessment tools (Blair, 1996; Blair, Kohl, & Brill, 1990; Dishman, 1991; Slattery, 1996). For example, it would appear many of the benefits linking physical activity to psychological health are anecdotal. Morrissey (1997) and

McAuley (1994) both express concern related to operational definitions and measurement tools. These concerns are also raised by Bouchard et al. (1994), who believe difficulties conceptualizing constructs such as well-being and self concept have impeded the measurement of health.

Self-reporting is one method by which levels of physical activity may be measured. Although J. D. Brown (1991) queries the reliance of self-reporting levels of physical activity and fitness, Johnson, Boyle, and Heller (1995) consider self-reporting of physical inactivity may be more robust than other variables. Whether self-reporting or answering another's questions, determining the accuracy of responses could be problematic. Who is to say which life experience is correctly or incorrectly reported? What is also not clear when measuring levels of activity and fitness is how much activity is required for physical fitness and health, what type, what intensity, for how long, and by whom it is determined (Blair & Connelly, 1996; Lee & Paffenbarger, 1996).

Inadequate measurement tools and the generalisation of these tools from studies on men to those on women have also been identified as problematic. Uncertainty in assessment and measurement has been identified by Blair, Kohl, and Barlow (1993) and Blair (1996), who suggest there may be problems identifying a causal relationship between a sedentary lifestyle and cardiovascular disease for women. Both of these reports proffer the idea of inadequate measurement for women, as do Jones, Franks, Manson, Hoffman-Goetz, and Otis (1998). Several studies have observed inconsistent results when self-reported physical activity levels were the measure. While men with low levels of self-reported physical activity had higher levels of mortality than men with medium and high levels of activity, there was no relationship found for women. Mortality risk was not increased with low levels of self-reported physical activity. Jones et al. suggest this could highlight the absence of adequate and appropriate measurement methods in research about women.

There is also a plethora of literature investigating the four lifestyle behaviours of smoking, alcohol consumption, physical inactivity, and dietary practices, with very little consistency in statistical correlations and results (Dean, Colomer & Perez-Hoyos, 1995). Ruzek (1997) suggests bad habits, which could include these four behaviours, have been redefined into risk factors for causes of death such as heart disease. Whilst I have been somewhat critical of the disease prevention discourse, I do not wish to exclude its usefulness; far from it. What I believe this discourse provides is the health professional's expert voice, based on scientific, objective research. As Smith, Masterton and Lloyd Smith (1999) contend, it is perfectly valid to want to prevent disease. What is missing, however, is the subjective: the person's experience and the context of their lives. Disease prevention does not occur in isolation, and this could be one of the reasons why contradictory and inconclusive results haunt this empirical research into physical activity.

Dean et al. (1995) are among the growing number of authors who believe an alternative approach is needed to investigate health behaviours. They argue that "Studying discrete behaviours by statistically 'controlling' for other causal factors implies simple cause and effect relationships that are not tenable" (p. 853). Williams and Calnan (1996) would agree, and provide examples such as situational influences, suggesting that "The perception of what constitutes a 'risk' is intimately bound up with people's cultural beliefs, moral values, personal feelings and the social and material circumstances of their lives" (p. 1614). Another salient feature frequently neglected is that of gender.

2.5 Gender bias in studies

I will briefly reiterate the stance taken in this study regarding gender/sex. Gender is seen as being socially constructed, with gender-blind studies ignoring the context of gender performance differentials. Excluding women on the basis of sex is biologically biased. As these terms tend to be used interchangeably, and sometimes incorrectly, in the literature, I will be explicit where necessary.

Much of the literature regarding physical activity has been either based on male physiology and behaviour being the norm, or has been sex- and gender-blind (Blair, 1996; Jones et al., 1998). Allan (1994) suggests that all too often women's health issues are considered from a male and bio-medical perspective which tends to ignore socio-political and economic factors, which have much relevance for women's health. Tarlov (1996, p. 72) identified four categories of health determinants in a population: "genes and biology; medical care; health related behaviours such as physical activity; and the social characteristics within which living takes place". Tarlov considers the latter predominates. In accepting this idea, it becomes necessary to acknowledge the different social roles women and men have, and the social discourses that support these roles. Similarly, Dean et al. (1995) believe gender is one of the fundamental determinants of health and argue that it needs to be examined within the context of life situations.

Whilst physical activity may be advocated as beneficial for everyone, Peterson and Lupton (1996) and Vertinsky (1998) suggest that in public health discourses women are also encouraged to survey their body shape and size to ensure it is sexually attractive and desirable. This raises concerns that have also been identified by Markula (1998), who believes linking physical fitness to an attractive and ideal body can be problematic for some women. Although this discourse is not prevalent in the academic literature it is implicit, if not explicit in much of the populist reading (P. Jones, 1998; Nimmo, 1992; Wallace, 1997). Therefore the complexity of physical activity behaviour increases when the notions of sex and gender are considered.

The following section looks specifically at midlife women's participation in, and adherence to, being physically active. To this point in the review and from a postmodernist perspective, both the power and the knowledge emanating from the literature can be seen to be firmly embedded within a modernist perspective. Medical knowledge has rarely, if ever, been questioned. Although answers have not been forthcoming in this empirical approach, movement to subjective experiences has yet to be seen.

2.6 Physical activity and midlife women

As already acknowledged, women at any age, despite the known health benefits, are less likely than men to exercise (Romans, 1997). Marcus and Forsyth (1998) and Pinto, Marcus and Clark (1996) hypothesize this may be the reason less research has been conducted regarding women's participation in physical activity. Midlife women's representation in the literature tends to fare even worse, as there is a real dearth of papers related to this group (Lane, Macera, Croft, & Meyer, 1996). As much of the literature already reviewed relates mostly to men, and sometimes generalises to women, this section will focus on women, and midlife women where possible.

The epidemiological focus found in much of the sex- and gender-blind literature is also present in women-specific studies, particularly risk factors related to cardiovascular disease (Brown, Lee, & Oyomopito, 1996; Garber, 1997; Guthrie, Dudley, Dennerstein, & Hopper, 1997; Wiest & Lyle, 1997). A similar picture emerged with psychological health (Brehm & Iannotta, 1998; Pinto et al., 1996; Wilcox & Storandt, 1996). Amelioration of symptoms of depression and anxiety, increased self esteem, body image, and psychological well-being are considered by these authors.

Research related to breast cancer, the most common cancer amongst women, has also been problematic due to measurement concerns (Jones et al., 1998). These authors found the very few epidemiological studies completed looking at physical activity and breast cancer to be equivocal at best, and believe this area remains contentious. The lack of research and equivocal results in these areas of women's health continue to be acknowledged.

2.6.1 Perimenopausal years

Midlife is frequently seen as synonymous with the perimenopausal years. Shangold and Sherman (1998) and Slaven and Lee (1997) suggest physical activity may be both useful and positive for physical and psychological concerns occurring at this time. Vertinsky (1998) believes most women have very little accurate information regarding

the perimenopausal years and what information they do receive is frequently based on negative stereotypical beliefs regarding this life stage. She considered the benefits that may be obtained from physical activity are often ignored in favour of a pharmaceutical approach such as hormone replacement therapy (HRT). Similarly Li, Holm, Gulanick, Lanuza & Penckofer's (1999) study found support for physical activity relieving psychosomatic symptoms such as lack of energy and irritability, which tended to lend weight to a nonpharmacological approach to perimenopausal symptoms. Slaven and Lee's (1997) also found that midlife women who exercised, experienced a significantly lower number of menopausal symptoms independent of their usage of HRT.

Guthrie et al. (1997), in a population-based study over three years, also found positive benefits for menopausal women. Although increased psychological well-being was only marginally associated with increased exercise, at least one cardiovascular risk factor, cholesterol level, was reduced with the increase in activity. Guthrie et al. did comment that, for reasons unknown, there appeared to be an increase in physical activity as women move through the menopause years. It may be that decreasing family commitments provides increasing opportunity and time for many women to be physically active at this life-stage.

Evans and Nies's (1997) study of the effects of day-to-day difficulties on exercise for perimenopausal women acknowledges the inconsistency of results. They suggested further work is required to develop a greater understanding of the effects of social roles and daily undertakings, such as family, finances, work and health. C. Lee (1993) also found constraints, both practical and societal, influenced midlife women's ability to exercise, even for those with a positive attitude towards exercising.

2.6.2 Nursing literature

A nursing perspective has not been visible in relation to physical activity and women's health until quite recently. This has coincided with the increasing societal acceptance of the benefits available to those who wish to become physically active. In the earlier nursing literature Gillis and Perry (1991) and Duffy (1988) were cited for their work

investigating women and physical activity. Gillis and Perry specifically looked at midlife women and exercise as a health-promoting activity, while Duffy's focus at that time was the determinants of health promotion for midlife women, which included exercise.

During the last ten years Duffy has continued this work, looking at employed women in (1989), employed Mexican American women with Rossow and Hernandez in (1996) and singularly in (1997). Duffy, and Gillis and Perry have all based their work on Pender's (1996) Health Promotion Model. These researchers have examined the relationship between the cognitive-perceptual factors (how people perceive themselves): health status, self esteem and health locus of control, and health-promoting behaviours such as exercise.

The findings from all these studies are similar. Although Gillis and Perry (1991) found participating in physical activity improved one's ability to manage stress, it did not appear to have significant influence on the three cognitive-perceptual factors identified above. Similarly, Botorff et al. (1996) also found these three factors contributed little to health behaviours. Duffy (1997) arrived at the same conclusion, although she argued that it appeared that midlife women with high internal health locus of control and good health status are more likely to participate in health-promoting behaviours, such as exercise.

Interestingly, Felton et al. (1997) found that women with lower educational levels had more personal control than those with higher education. These researchers chose to examine the interaction of demographic factors such as gender, race, age, and educational levels, on health-promoting behaviours. Gender was not defined, and was referred to as the biological female/male. Gender was the only factor in this study which affected exercise, relaxation and health promotion behaviour. Felton et al. recommended health messages be developed specifically for women and men, which is pertinent in light of Marcus and Forsyth's (1998) thoughts. They believe that although most studies exploring the benefits of physical activity have not used the category of

gender (meaning sex) for reporting results, there is now sufficient evidence to suggest that various correlates of exercise do differ for men and women.

All the nursing studies reviewed have been quantitative in nature, with neither the subjective experiences nor the context of participants' experiences having been explored. In comparison, one of the few recent qualitative nursing studies exploring exercise behaviours identified themes which came from the context of the women's everyday lives (Nies et al. 1998). Physical activity varied according to each woman's perception of her unique situation. For example, work or domestic situations could be seen as either a barrier or facilitator to being active. This study, Jones et al. (1998), and Wilbur, Miller, Montgomery, and Chandler (1998) were three of very few articles which believed it is necessary to acknowledge that domestic tasks involve physical activity.

Wilbur et al. (1998) suggested that women may be able to obtain the new levels of activity such as ten minutes' sustained activity, by incorporating a variety of household tasks, such as ten minutes' gardening and ten minutes' walking. Blair (1996) and Blair et al. (1993), when discussing the validity of measurement tools, allude to this idea; however, Verhoef and Love (1992) found that women who saw household work as physical activity were less inclined to exercise. Blair's finding that the failure of some empirical studies to show an association between women's inactivity and cardiovascular disease could be linked to ignoring domestic-related activity rather than inadequate measurement tools. Many women may be physically active throughout their lives without recognising this as such. The equivocal nature of this literature continues. The following section will survey the literature relating to women's ability to maintain physical activity over time.

2.6.3 Maintenance of physical activity for midlife women

Understanding related to maintenance remains like physical activity itself: complex, elusive, and poorly understood (Klonoff, Annechild & Landrine, 1994; Pinto et al.,

1996). Hawkes and Holm (1993) contend that much of the literature published regarding the maintenance of exercise is based on men and illness, with the male being the norm. The majority of studies are also quantitative in nature.

There are as many theories as there are reasons as to why women are unable to adhere to exercise. Theories identified in the literature include social cognitive theory, stages of change model, and the relapse prevention model, all of which offer behavioural strategies to maintain exercise (Lutter et al., 1998). However, women encounter barriers on a daily basis, and adherence remains poor. Klonoff et al. (1994) believe some women may cease being physically active due to their perceived body image, or changes in physical health, while others may become overwhelmed by their multiple roles and drop out because of lack of time. Barriers for women are wide-ranging, from environmental, such as work or time, to psychosocial, with examples being family obligations, social roles and lack of social support (Nies et al., 1998; Pinto et al., 1996).

Social roles appear to strongly influence women's health behaviours, particularly those involving family and children. Verhoef and Love (1992) looked at employment, marriage, parenthood, a combination of these three roles, and the obligations attached to each. Parenthood was identified as the most significant barrier to exercise participation, a not unexpected finding when considering Thomas (1997) found that for many women, the role of motherhood outweighed any other. Whilst this role was seen as the most rewarding for many women, it can also be seen as "the ultimate high demand/low control job", which can be accompanied by feelings of psychological stress and guilt (Thomas, p. 546). Although women with and those without children both valued the benefits of physical activity, mothers exercised much less (Verhoef & Love, 1994). The social roles midlife women enact are multiple, and unique to each woman's situation; however, they are frequently linked to their perception of their role in society, especially that of protector of the health of their children, partners and elderly parents (Health Funding Authority, 1998; Jackson & Henderson, 1995; Peterson & Lupton, 1996).

This section of the review has shown contradictory results from a dearth of literature regarding participation in, and maintenance of, physical activity for midlife women. Investigating the determinants of physical activity for midlife women appears to necessitate exploring the reality of daily life experiences, multiple roles, and subjective experiences, all of which have frequently been ignored. A similar picture is seen when looking at the discourse of health promotion. As I am exploring physical activity as a health-promoting behaviour, I will briefly give a critical overview of the literature emanating from this discourse. Again, this will not be exhaustive, but will provide an appreciation of traditional and contemporary approaches to health promotion.

2.7 Health promotion

Just as the literature regarding physical activity is mostly embedded in the medical disease prevention discourse, so too is much of the health promotion literature (Hartrick, Lindsey & Hills, 1994; Hills & Lindsey, 1994; Williams, 1989). The focus of the disease prevention discourse is on the individual, their lifestyle and personal health behaviours, such as physical inactivity, high-fat diet, and smoking. Within much of this literature, lifestyle and behavioural change are seen as the central themes (Arroll & Swinburn, 1994; Blair & Connelly, 1996; Paffenbarger & Lee, 1996). When exploring the concept of lifestyle, however, the main emphasis appears to be on the concept of risk (Antonovsky, 1996; Becker, 1993; Peterson & Lupton, 1996). Risk factors for coronary heart disease, such as elevated cholesterol levels and high blood pressure, propel many health promotion programmes, and yet Syme (1996) argues that consideration of all risk factors accounts for only 40% of coronary heart disease. He asks rhetorically, what then accounts for the remaining 60%?

The focus on lifestyle and health behaviours has been criticized for the tendency to consider the person as a victim of his/her behaviour (Becker, 1993; Blane, Brunner, & Wilkinson, 1996; Caraher, 1994; Ruzek, 1997). Becker suggests this "victim blaming" is the most disturbing feature of this discourse, as not only is the person seen as being

responsible for the cause of health problems, but it also absolves health professionals from any responsibility. According to Watson, Cunningham-Burley, Watson, and Milburn (1996), the importance placed on lifestyle is founded on the assumption that people have a high degree of influence regarding their lifestyle behaviours. There is also the supposition that changing personal behaviours will have a significant effect on health outcomes.

Blane et al. (1996) suggest there is a hint of morality in the "dos and don'ts" of personal behaviour, with most messages being against smoking, drinking and slothfulness. Lupton (1994) and Davison, Frankel, and Smith (1992) have also identified a moralistic stance, with Lupton suggesting that this is linked to the role medicine has in social control. The development of a new morality, in what Peterson and Lupton (1996) identify as an increasingly secular society, can be seen in a set of moral tenets based on binary opposites such as health/illness, clean/dirty, and controlled/uncontrolled. Dean and McQueen (1996) believe simplistic dichotomies are unhelpful, as they fail to recognise the complexity and diversity inherent in health behaviours. Skolbekken (1995), in investigating "the risk epidemic" in medical journals, wonders why, when life expectancy is at its highest ever for European and North American populations, more people are concerned with identifying and fighting risks than ever before. To answer, Williams and Calnan (1996) not only encapsulate why the concept of risk has become endemic in health, but also how it has become embedded in this discourse. Risk, they argue, "becomes a fundamental existential parameter of life in late modernity, structuring the way in which experts and lay people alike organize their social worlds" (p. 1614).

The central problem with the risk focus, as identified by Dean et al. (1995), is the possibility of excluding all the other potential causes, such as the social determinants of health. A lifestyle and personal behaviour focus, therefore, fails to acknowledge the context in which people live (Caraher, 1994; Dean et al.; Gott & O'Brien, 1990). Health sociologist Aaron Antonovsky also identified these concerns, believing that understanding health was not possible within an illness framework (Kickbusch, 1997), a

belief advocated by Dean and McQueen (1996). Antonovsky's (1996) development of a salutogenic model not only places health promotion within a health rather than an illness focus, but also places it in context. He believed "Health is created where people live, love, learn, work and play" (Kickbusch, p. 431).

The growing critique of the traditional disease prevention discourse of health promotion is seen in the social sciences rather than in the medical or nursing literature. It is here the power of bio-medical models are questioned, and the social and cultural context of health and associated meanings are explored (Milburn, 1996). One way of understanding these notions is the lay perspective: how people define, understand, and make sense of being healthy.

2.7.1 Lay theorizing and health promotion

Over the last decade a number of articles have emerged from the social sciences exploring the social and cultural factors which underpin health behaviours (Backett, Davison, & Mullen, 1994; Blaxter, 1997; Davison et al., 1992; Milburn, 1996). Milburn argues for a more flexible approach to health promotion theory incorporating the complexity, richness and diversity of people's everyday life experiences. Although Dean and McQueen (1996) agree with Milburn's sentiments, they urge caution regarding the terms *objective* and *subjective*, and what constitutes scientific knowledge when developing health promotion programmes.

Several studies have been carried out to explore lay people's understanding of health and healthy lifestyles (Backett et al., 1994; Clarke, Crotty, & Pearson, 1997; Davison et al., 1992). A study of the responses of three South Wales communities' responses to coronary disease prevention messages, provides a salient example. These researchers found the officially sanctioned health promotion messages frequently out of step with popular culture. Although virtually all the participants knew about the risk factors related to heart disease, these were not associated with their personal lifestyle. Nor did they see behaviours such as smoking as being irrational, because "potentially damaging

behaviours were set in a wider personal and social context" (Davison et al., p. 678). Fatalism, one of a set of beliefs identified in the study, identified that luck, chance, or God played a central part in understanding health outcomes. Blaxter (1997) and Furnham (1994) also found fate and religious beliefs were powerful predictors of health beliefs. The random and sometimes chaotic nature of illness and death was summed up by the knowledge that "some fat smokers really do live till advanced old age, and some svelte joggers really do fall down dead" (Davison et al., p. 683).

The personal attributes of people appear to contribute to lay theorising. Coronary candidacy, another lay belief expressed in Davison et al's (1992) research, was also found by Clarke et al. (1997) as they investigated people's understanding regarding cholesterol testing. A person with certain personal attributes, such as being overweight, highly stressed or sedentary in nature, is seen as a coronary candidate, with these ideas developed from personal networks and the social context. Similar findings were discussed by Backett et al. (1994), who found social, emotional, and spiritual aspects were also important when considering health.

Providing a differing perspective to the lay theorizing, Watson et al. (1996) explored lay perceptions of the body in relation to personal responsibility for health. Although the body can be seen as one of the places within which people locate health, Watson et al. believe health promotion neglects the lived experience of the body, be it healthy or unhealthy. Medicine's role in social control is revisited in this study, as Watson et al. suggest that the promotion of particular health behaviours is aimed at the body as a site of control and change (Lupton, 1994; Vertinsky, 1998). They argue that the normalizing nature of health promotion can both marginalize and problematize many people's bodies. This supports Markula's (1998) opinion that linking physical activity to a toned and ideal body can be problematic for many. Watson et al. believe that for health promotion to be of value it must recognise and respond to embodied lay experience. Clarke et al. (1997) consider the lay perspective may lead to an understanding of how people interpret health risks and behaviours. It may also illuminate lay peoples'

responses to health, which may or may not be consistent with the beliefs of health professionals.

2.7.2 Health promotion and women

The determinants of health promotion behaviours in women, which can include physical activity, have been studied by a variety of authors (Duffy, 1988, 1993, 1997; Gillis, 1994; Gillis and Perry, 1991; Redland & Stuifbergen, 1993). Cheek and Rudge (1996), Dean et al. (1995) and Ruzek (1997) consider that the dominant medical discourse of heath promotion has failed to distinguish between the health needs of women and men. Clarke (1992) believes a critique of health promotion research methods would acknowledge that women and men reside in different social worlds and their health and illness experiences are unique to each sex.

Literature from the social sciences appears to be leading the way in viewing health and the promotion of health from a wider perspective. Macran, Clarke and Joshi (1996) and Young (1996) provide examples, investigating the influence of socio-political factors on the health of women. Both articles found women's health constrained by social roles and the availability of financial and social resources. Vertinsky (1998) posits the idea that for many women being healthy may be more about feeling a greater sense of control, of being capable and belonging, than being physically active.

2.7.3 Health promotion and nursing

Although the majority of health promotion literature is medically focused, the concept of health promotion has become a desirable arena for some nurses who consider themselves ideally suited to this branch of health care, with varying degrees of success (Delany, 1994; Kermode & Brown, 1995; Maben & MacLeod Clark, 1995). The Ottawa charter for health promotion has been ubiquitous in nursing education, and many nurses have recognised the role of the World Health Organization in health promotion (Gott & O'Brien, 1990; Hartrick, 1997; Tones & Tilford, 1994). All the authors acknowledge the ideology of this organisation, which claims health is much more than the absence of

disease, and aims to reduce inequalities between countries and social groups. Delany suggests that the World Health organization's desire for health promotion to be a unifying concept appears to combine both personal choice and social responsibility.

Allan and Hall (1988) and Caraher (1994) believe that viewing health promotion at a personal level is not an issue, as long as it is seen within the context of the person's situation. Just how often this occurs is uncertain, when much of nursing education remains within the reductionist medical paradigm. Pender's Health Promotion Model is frequently cited in nursing health promotion literature (Bottorff et al., 1996, Duffy, 1993; Hills & Lindsey, 1994; Pender, Walker, Sechrist, & Frank-Stromborg, 1990). Although Pender (1996) recently revised this model, the overall design remains the same: to describe the structures that explain and predict health-promoting behaviours. Health-promoting behaviours within the model are based on individual characteristics and experiences, perception of cognitive-perceptual factors, and behavioural outcomes. Studies carried out using this framework have been both reductionist and quantitative in nature.

Kermode and Brown (1995) argue that many nurses continue to practice within the reductionist paradigm. This not only continues the individualistic health promotion discourse, but also suppresses a radical critique of the social determinants of health, and encourages victim blaming. Williams (1989) believes nurses, both as women and nurses, have experienced personal and professional choices and behaviours which are constrained by structural patriarchy. This, she argues, provides an understanding of the reality of health choices within an individualistic discourse, which could in turn enable nurses to reorientate their thinking. Parmee (1995), however, questions how nurses can be expected to emancipate and empower their clients when they themselves are victims of hegemonic medicine. Similarly Purkis (1997) asks how possible it is for nurses, who are firmly positioned within a medical discourse, to extend their practice into the socio-political arena.

There is a sense that nurses need to reclaim a position within the health promotion discourse. Lindsey and Hartrick (1996, p. 106) believe that for nurses to be successful in health promotion they must move away from the reductionist medical perspective, and adopt a "human science perspective" which they consider is dialectical, inductive, holistic and contextual. Such a paradigmatic shift could incorporate Antonovsky's (1996) concept of salutogenesis, with a focus on health rather than disease. The essential elements of such a discourse of health promotion would include empowerment, autonomy, partnership, self determination and egalitarianism (Lindsey & Hartrick). Rafael (1999) believes that for nurses to reclaim a place in health promotion, a critical approach is required to challenge structural constraints and to ensure both lay people and health professionals are aware of the unique focus nurses bring to health promotion.

The dominant discourse of health promotion embedded in the bio-medical model appears to raise more questions than answers (Becker, 1993; Ruzek, 1997). Both these authors and Blane et al. (1996) question the medicalized view of life, which reduces health to a number of risk factors. Ruzek argues that there is more to life than risk reduction, and both she and Becker (p. 5) urge the conventional wisdom of generations of mothers of "moderation in all things - and moderation in that".

2.8 Conclusion

The literature related to the participation in and the maintenance of physical activity as a health-promoting behaviour for midlife women, and the discourses of health promotion, have been reviewed from a postmodernist perspective. A strong medicocentric presence was evident throughout much of the literature, which came from a variety of disciplines including nursing, medicine, sociology, leisure science, and exercise and sport. Virtually all the research studies were quantitative in nature, and have not demonstrated any definitive answers regarding the determinants and the maintenance of physical

activity. It is evident from this review that the health-promoting behaviour of physical activity remains complex, elusive and poorly understood.

The paucity of studies investigating women and specifically midlife women highlight the inadequate manner in which the notions of sex and gender have been addressed in this field, particularly within the medical discourse. A review of the health promotion literature makes it evident that the medical discourse endures. The power inherent in this individualistic and officially sanctioned discourse is obvious, with very little critique occurring from within either medicine or nursing. However, within the social science literature there is an increasing awareness of the necessity to consider the socio-cultural, political and historical contexts of people's lives in relation to health.

Having reviewed aspects of the literature related to this study, in the following chapter I will consider the study's philosophical underpinnings, and the methods used throughout the research process.

CHAPTER THREE : The research methodology and the research method

3.1 Introduction

This chapter describes and critiques the methodology and method chosen to conduct this study, and the congruency of each to the other. The terms *methodology* and *method* are often used interchangeably and sometimes incorrectly in the literature. Although frequently intertwined, methodology refers to "a theory and analysis of how research does or should proceed" while method is "techniques for gathering evidence" (Harding, 1987, p. 2; King, 1994).

3.2 Epistemology and Ontology

Selecting both method and methodology involves acknowledging the epistemological (theories about knowledge) and ontological (our being in social life) assumptions on which this study is based (Armstrong & DuPlessis, 1998). Maynard (1994, p.18) believes that "who knows what, about whom and how is this knowledge legitimized" remains the primary feminist concern with epistemology. The epistemological foundation underpinning the development of feminism over the decades has been firmly ensconced in the era of modernity. This time period followed the theological certainties of the mediaeval epoch, and has been aligned with the rationality of Enlightenment thought of the seventeenth and eighteenth centuries.

Enlightenment thinking provided the basis for the belief that reason and rationality could provide an objective, reliable, and universal truth upon which to build knowledge. Rather than God and the church providing answers regarding truth and morality, the rationality of individual people would progress towards reality, enlightenment and freedom, based on objective, scientific evidence (Burr, 1998; Porter, 1998). Throughout this period, the masculine voice was the agent of knowledge (Porter).

The homocentricity of Enlightenment thinking is apparent in the Cartesian dualisms such as mind/body, subject/object and rational/irrational. Of primary concern for feminists is the dualism male/female, which prioritises the masculine. Privileging one side of each dualism is the Derridean notion that considers that where binary opposites exist, one term is always given primacy over the other (Cheek, Shoebridge, Willis, & Zadoroznyj, 1998). Hekman (1992) believes it is this privileging of the masculine over the feminine which is the one common challenge feminists have. The foundation for knowledge, therefore, has not only focused on individualism, but has been androcentric, which has excluded women as knowers (Harding, 1987). Feminist inquiry challenges empirical knowledge as the one way of knowing, and seeks to legitimise women's experiences as valid forms of knowledge.

3.3 A postmodern perspective

A theoretical underpinning that could encompass a multitude of possibilities was required for this study if the metanarratives, or the grand theories of modernity were to be questioned as the ultimate truth (Burr, 1998). Postmodernism not only challenges such a thesis, but values multiple and diverse ways of viewing the world. However, venturing into postmodernism can be fraught, if for no other reason than "one of the central tenets of postmodernism involves the argument that we can never pin down what anything really means" (Porter, 1998, p. 204).

In the search for an epistemology and ontology that values women's diverse experiences and voices, "feminism" is tentatively approaching this postmodern perspective. Postmodernism as an intellectual movement has often been aligned to architecture, literature, and the arts, and interrogates and rejects the tenets of modernity (Burr, 1998; Bury, 1998). The era of postmodernism is frequently seen as a time of challenge to unitary ideas, to essentialisms, to metanarratives, and to one truth. "Post" in this genre is not necessarily regarded as a time after modernism, as both eras can co-exist; rather it is a time of difference (Burr). Modernism is not entirely rejected, just displaced, and for

some, this period of time is characterised by a growing sense of unease, of uncertainty, a time of promises unrealised in modernity (Lupton, 1998).

Cheek et al. (1998) see the term postmodernism as a theory of society and culture often conflated with poststructuralism, a theory of knowledge and language. Separation of the two terms is most difficult, as culture and language are so intricately entangled (Grbich, 1999). Lupton (1998) suggests the difference should be noted, as people who embrace a poststructuralist theory may not consider themselves to be postmodern, and vice versa. Even the French philosopher Michel Foucault, whose critique of modernity permeates much of the postmodern and poststructuralist literature, had difficulty accepting the label of postmodernist (Hekman, 1992). Whilst this disclaimer hints at the complexity, precariousness and challenge inherent in a postmodern perspective, Fox (1998, p. 30) believes that "the promise of postmodernism lies in its emphasis on openness, diversity and freedom".

In taking a postmodern position in this study I am interested in drawing on the work of Foucault, of his aim of challenging the nature of knowledge, and his analysis of power and the discursive construction of health care. Foucauldian analysis is of particular use in this project as one aspect of his work focused on a critique of medical knowledge, and more recently the work of Foucault is being used in the analysis of nursing and health care (Cheek & Porter, 1997; Henneman, 1995; Lister, 1997). Much of Foucault's thinking centered on power and knowledge, with the two being seen as inseparable. Where there is knowledge there is power, and for Foucault, power is owned neither by one person or a group. It is a neutral concept which is capillary and extends everywhere and to everyone (Cheek, 1998). Knowledge and power are mutually generative, and are exercised through discourse (Bassett-Smith, 1998).

3.3.1 Discourse

The concept of discourse refers to the way in which we construct our world, our conversations, and our way of thinking of ourselves (Lupton, 1993). Foucault's interest

in the power/knowledge nexus is explored through discourse, as he asks why certain ways of thinking and talking have authority, while others remain silent (Cheek & Rudge, 1994). Whilst there are multiple discourses or discursive frameworks available at any one time, many of which are "competing, potentially contradictory ways of giving meaning to the world", certain discourses gain prominence (Brooks, 1997, p. 21). This occurs through social, political and historical influences working on discourses, which in turn influences what is socially accepted or rejected (Cheek & Rudge; Bassett-Smith, 1998). Therefore, meaning within discourse is always socially and historically located (Weedon, 1997).

The positioning of self is integral to understanding the notion of discourse, and from a feminist perspective, all women have a variety of discourses available to them, and each midlife woman takes up a certain position, both privately and publicly, within her social world. Allen and Hardin (1998) suggest that women's conversations contribute to this discursive process, and although the position of "woman" may be stable, how an individual woman positions herself over time is constantly changing. However, Davies (1992) believes the very experience of being a woman is discursively constituted and how and why each woman takes up a certain position within this and other discourses requires interrogation.

Davies (1992) also believes that although not desired, there is certain inevitability in positioning people in terms of gender. She questions to what extent this positioning arises out of the fundamental dualism, male/female. It is therefore axiomatic that power and authority can permeate each available discourse. The health promotion discourse provides a salient example, with the disease prevention discourse assuming social authority, as the scientific medical discourse maintains predominance in Western society. It is the taken-for-granted assumptions of such hegemonic power which postmodern feminist analysis questions. Such analysis explores powerful discourses, questions assumptions embedded in our understanding, and asks how categories such as female are constructed and maintained (Cheek et al., 1998).

All knowledge within a postmodernist perspective, therefore, can be viewed as socially constructed, constantly changing, having no one essential truth (Lupton, 1993). The place of language becomes apparent as we see that the subjectivity of people and the reality of their lives are constructed through this medium (Lupton). Our subjectivity, our sense of being at a conscious and unconscious level in a postmodern world, has shifted dramatically from the humanist perspective. No longer are we seen as free-thinking people, making choices and taking up positions, but as people constantly changing and being positioned within multiple discourses. We are constantly being produced and reproduced; language does not express or reflect our reality, it constitutes it (Weedon, 1997).

3.3.2 Language

Understanding language to be the foundation for the social production of experience takes us further from the modernist perspective of language as a neutral, value-free transmitter of information (Allen & Hardin, 1998). Language in a postmodern perspective is seen as playing a vital part of the process through which knowledge and our social reality is constructed (Cheek et al., 1998; Grbich, 1999). Explicating this view of language further, Allen and Hardin (1998) argue that through repeating language we become or enact our relationships and roles. For example, gender roles and associated practices are performed through repetition of language. This idea will be explored further in the methodology section; suffice to say here that such a position is critical in disrupting the modernist understanding of gender. The power of language within the postmodern perspective, therefore, can be used to disrupt discourse, particularly discourses which are presumed to be "normal" (Cheek et al.).

Just as postmodernism challenges the epistemological foundations of modernism, so too does feminism. However, unlike certain postmodernists, feminists' rejection of Enlightenment thinking is gender-based (Hekman, 1992). Postmodern feminists not only question and challenge a universal subject, but also, as already discussed, the

male/female dualism that privileges masculine thinking. The next section considers the research methodology, and will explicate these questions and challenges.

3.4 Feminist methodology

The use of feminist methodology as the philosophical underpinning of this study signals my desire to research a topic which is of interest and has pertinence to the lives of midlife women (King, 1994). Knowing how to proceed, however, in terms of doing research from a feminist perspective, is somewhat daunting for the novice researcher, a point with which Maynard (1994) concurs. Speedy (1991) simplifies matters considerably by identifying three interrelated characteristics of feminist methodology.

3.4.1 Intersubjectivity

The first, intersubjectivity, discards objectivity, the notion which posits "neutral researchers producing objective and value free facts" (Maynard, 1994, p. 13). This empirical view is rejected in favour of acknowledging people as sentient beings, and focuses on the dialectical relationship of all involved in the research process. Knowledge is not the sole prerogative of the researcher, but emanates from interaction between all participants (Horsfall, 1997). Subjectivity, a person's individual consciousness, their sense of self and experience, is not only valued, but also paramount to feminist research (King, 1994). I had no desire to distance myself from either the participants or the research topic, which is relevant and pertinent to my subjectivity at both an academic and personal level. Throughout interviewing I worked to ensure the process was dialectical and symbiotic.

Burnard (1997) questions the relevance of this process and believes issues related to subjectivity and intersubjectivity remain murky, and yet to be resolved. Maynard (1994) suggests the issue may not be so much with objectivity but with the reliability and soundness of feminist research. She believes feminist researchers need to ensure their

scholarship is rigorous if they wish others to regard it as intellectually sound and relevant.

3.4.2 The perception of contradiction and action

The second characteristic of feminist methodology, the perception of contradiction and action, looks to disclose the invisibility of women's experiences and to end women's oppression (Speedy, 1991). There is a need to make explicit existing power relations between women and men. Weedon (1997) argues that discourse, so frequently disprivileging the feminine, defines the nature and social role of women in relation to "the norm", masculinity. Acknowledging the invisibility of women's experiences can be seen as one step towards ending the inequity of women's social position, which Lather (1991, p. 71) believes to be "the overt ideological goal of feminist research".

3.4.3 The centrality of women and their experiences

The centrality of women and their experiences is the third and possibly the primary characteristic identified by Speedy (1991). This highlights the need to validate the reality of each woman's experiences. The concept of gender therefore must remain the essential category of analysis. Like most ideas within feminist research, this concept is not static. Feminist research, like feminist epistemology and feminism itself, is continually evolving. The modernist approach has failed to acknowledge the diversity and complexity of human nature, particularly the nature of gender issues. The limited nature of such an approach "presupposes a universal, homogeneous and essential 'human nature' that allows knowers to be substitutable for one another" (Code, 1993, p. 17). Within this understanding women have been viewed as a homogenised, unitary group, with each life experience being applicable to all women. A postmodern feminist approach rejects such a notion and proposes a subject which is contradictory and fragmentary and constantly changing (Brooks, 1997).

3.4.4 Gender

Our understanding of gender as "a basic organising principle, which profoundly shapes/mediates the concrete condition of our lives" is also evolving (Lather, 1991, p. 71). Three conceptions of gender are offered by Worell, (1996, p. 474). "Gender as difference", which has the female/male dichotomy as its focus; "Gender as socially constructed beliefs", which offers the perspective of gendered behaviours attributed to social and cultural situations; and thirdly, gender as "a reflection of power arrangements" (p. 475). In this conception gender emphasizes the role of position and power as defining characteristics of gender. Social resources, power and status can be seen to intersect with gender and are expressed within and between groups of both women and men (Worell).

A fourth and differing perspective, gender as performance, introduced above, suggests both women and men enact gender through language (Allen & Hardin, 1998). They contend that we all take up our gender roles through language repetition as we learn what is expected within a given position. Our enacting 'woman' or 'man' is therefore constituted through language. A. Jones (1997), drawing on the work of the philosopher Derrida, holds that not only is everything mediated by language, but there is nothing outside language. Meaning is also considered to be constantly shifting and contextual, a tenet of poststructuralist thought. This again highlights the intertwined and complex nature of postmodernist and poststructuralist thinking.

Whilst these four conceptions of gender will be able to be identified implicitly and explicitly throughout this study, my focus will remain on the fourth, a postmodern perspective. In saying this I am suggesting that each woman is "discursively, interactively, and structurally positioned as such", and it is the taking up of these discourses as one's own which constitutes one as female (Davies, 1992, p. 54). It is through these socially located discourses that Foucault argues that subjectivity is produced; therefore what it means to be a woman can be seen to be socially and historically constituted (Weedon, 1997).

Within a postmodern perspective, the idea of a fixed or essential "woman" is no longer acceptable. There is the need to acknowledge that although each woman's experience is unique, all women are subject to the range of available or possible discourses present at any one time. Most importantly, this offers exciting possibilities to problematise women's life experiences as they intersect with context and social practices. Weedon (1997) agrees, and suggests there is a need for a theory that explains why women subordinate their interests to those of men, and how particular discourses develop. Postmodern analysis not only provides the opportunity to problematise discursive practices, but offers ways of generating alternatives (Davies, 1992).

Theoretically, within the social structure women have many options open to them. However, Weedon (1997) suggests these options are only available within the context of the primary role of women, that of wife and mother. This ubiquitous message necessitates women accepting, rejecting or negotiating this position. For many there is little choice, as this primary role is seen as the natural way of things (Weedon). The naturalness of this discourse of femininity is extremely powerful, and the central role women play in maintaining the structures of a capitalist society cannot be under-estimated (Burr, 1998).

Why this discourse of "the way things are" is accepted as natural remains open to discussion. However, it is suggested that particular social discourses enjoy extensive acceptance as they are in the interests of powerful groups in society (Burr, 1998). The discourse of romantic love provides an interesting example. Constituted almost exclusively upon heterosexual attraction and seen as the foundation for marriage and family life, this discourse could be seen as concealing inequitable social arrangements (Burr, 1998). Passivity and subordination of women within such a hegemonic structure is easy to envisage. Such experiences, and the voicing of these experiences, are not a given but, as seen with this example, discursively and culturally constituted (Maynard, 1994).

The complexity of gender does not end here. Just as power and position converge with gender, so too do parenthood, age and sexual orientation. Code (1993) suggests there is a growing understanding that "gender is not an enclosed category, for it is always interwoven with such other sociopolitical-historical locations as class, race, and ethnicity" (p. 20). Gender cannot imply sameness, but is embedded with diversity, multiplicity and complexity. The position midlife women take up related to physical activity and exercise, therefore, is discursively constituted, and constantly changing.

3.4.5 Understanding of gender in this study

Gender within a feminist and postmodern perspective remains open to many interpretations. Gender as performance will, however, provide the main focus in this study. This acknowledges that each enactment of "woman" is very much part of our subjectivity, of who we are. Thus each act, like our inner self, is constantly changing, fragmented and contextual (Lupton, 1997b). Problematising the context recognises the knowledge, power, language, gender, subjectivity, discourse, and discursive practice nexus. I am mindful, therefore, of the complexities inherent in considering not only the enactment of gender for midlife women who exercise, but also the context in which this occurs. My position, I believe, corresponds to that of Cheek et al. (1998) who see feminist postmodernism presenting interesting and challenging possibilities for making transparent some ways in which each woman takes up certain subject positions.

3.4.6 Rigour and validity

Rigour and validity in qualitative research have been, and continue to be, the subject of concern and discussion, particularly from those researching within a positivist paradigm. This has arisen from the rejection of objectivity and a moving away from assuming the value-free position inherent in empirical research. Viewing a world full of paradox and uncertainty outside totality, duality, non-contradiction, and certainty does not necessitate the abandonment of rigour and validity (Lather, 1991). Within this ongoing debate, feminist researchers acknowledge the necessity for rigour and validity, and suggest there appears to be a growing consensus for the reconceptualisation of these

issues (Webb, 1993). Both Lather (1991) and Hall and Stevens (1991) have provided alternative concepts, such as credibility, relevance, and mutuality, to address concerns relevant to rigour and validity. I have chosen to use Lather's reconceptualisation, as she presents guidelines for praxis-orientated researchers, which nurse researchers seek to be. Lather also advocates a dialogically reciprocal process and the need to make the common sense problematic, which are both inherent within feminist research. Alternative concepts offered by Lather incorporate construct validity, catalytic validity, and face validity.

3.4.6.1 Construct validity

Construct validity asks the researcher to report on decisions made throughout the process, and to reflect on how influential the researcher was in relation to content and process. This construct of validity can be evaluated by way of reflexivity, a concept also discussed by Hall and Stevens (1991, p. 21), who suggest "a reflexive approach to research fosters integrative thinking, appreciation of the relativity of truth, awareness of theory as ideology, and a willingness to make values explicit". This approach asks the researcher to reflect on, examine critically, and explore analytically the nature of the research process (Maynard, 1994; Wuest, 1993). Grbich (1999) suggests reflexivity at the very least requires an awareness of how one's beliefs and values influence the research process.

3.4.6.2 Face validity

The second notion of validity considered is face validity, which Lather (1991) sees as being inextricably linked to construct validity. This involves returning emerging analysis, ideas, and conclusions to the participants for their reaction and consideration. Therefore in my study, initial themes that emerged after reading the first interviews were returned to the participants, greeted with interest, and generated further discussion. Even at this early stage many of the participants commented on the relevancy of the themes to themselves.

3.4.6.3 Catalytic validity

Acknowledgement of my personal and professional involvement in the research project implies rejection of researcher neutrality, an idea Lather (1991) posits as catalytic validity. This way of validating critical research calls for each participant to be fully involved in the research process, to ensure understanding of reality, and the prospect of self-determination. I am confident the interviewing process was collaborative, and that each participant was involved to the degree they were happy with. All participated fully, and are keen to receive a summary of findings on completion of the study.

Maynard and Purvis (1994) suggest that there are two ongoing concerns related to validity in feminist inquiry which need to be addressed. Firstly they ask whether the focus on the woman's experience is enough. Illuminating the experience provides an awareness, but is in itself limiting. They suggest there is a need to problematise the experience as they believe "there is no such thing as a 'raw' or authentic experience which is unmediated by interpretation" (p. 3). Brooks (1997) and Cheek et al. (1998) agree, and argue that there is a need to problematise not only the experience, but also the context, to explore the subject position taken. Allen and Hardin (1998) go so far as to suggest that if the context is ignored there is the possibility of pathologising the woman. I agree with Cheek et al., who assert that a feminist postmodern analysis "offers the possibility of exposing the way in which woman occupy subject positions that in large have been constructed for them by the influence of powerful discourses in society" (p. 214).

The second concern Maynard and Purvis (1994) signal relates to the process of interpretation. They suggest feminist researchers may have to accept the political and unstable nature of this activity. Burnard (1995) also raises concerns with this process, and the ongoing dialogue presently being undertaken in the literature in relation to interpretation will be discussed further in the following section of this chapter.

3.4.6.4 Rigour in transcription

An additional aspect related to rigour has been raised by Lane (1996) who considered the possibility of a typist becoming a participant of sorts while transcribing audio-tapes. Lane suggests that people who transcribe these tapes can be one of many sources of influence on women's voices. I reflected on the possibility of this, as the woman who transcribed the interview tapes (coincidentally, a fervent exerciser) found the participants' stories fascinating. After reading Lane's article I returned to my journal and reread what I had written regarding one of our telephone conversations.

> I was talking to D regarding the themes which appeared to her to be emerging, one of which is the difference between physical activity and exercise....the value women put on physical activity, or more accurately, the lack of value they place on it. Women with smalls [children] are busy all day - up and down - but don't necessarily see that as of value.

The transcriber empathised with the participants and was keen for me to be aware of this position. How did this influence my thinking, or did it? Was this something I would arrive at myself? It seems to me the only way one can avoid such influences is to talk to no-one while researching, which is impractical. Lane (1996) would suggest that acknowledging this situation provides additional aspects of rigour for feminist qualitative research.

3.4.7 Feminist research in nursing

Though nursing research is flourishing, very little has been completed from a feminist perspective. For many, feminism and nursing sit uncomfortably together. Historically, nurses have not been viewed as a powerful group and feminism, too, remains somewhat marginalised. It could be argued that the vilification feminism experiences in nursing is a result of the perceived threat to hegemonic power in health structures. Short, Sharman, and Speedy (1998) suggest the major reason feminism is rejected by many nurses is the

vicarious power they receive from identifying with the medical profession. They suggest that "A feminist perspective critically questions and challenges medical dominance over patients and health professionals, and creates the consciousness-raising essential for change" (p. 210).

However, Speedy (1991) argues that the principles of feminism, dialectical relationships, caring, advocacy and nurturing are congruent with those of nursing. There is a growing number of nursing scholars who advocate the suitability of feminist research for nursing (Seibold, Richards, & Simon, 1994; Sigsworth, 1995; Wuest, 1994). Carryer (1995), one of the few nurses in New Zealand to undertake feminist research, has called for a more creative methodology in nursing research, to incorporate the socio-political context in which women live and nurses work. Scientific quantitative research has proved inadequate in reflecting these experiences and realities. This is certainly true in the field of physical activity and exercise, where physiological measurement is the norm without reference to the context of daily life (Duffy, 1989; Duffy, Rossow, & Hernandez, 1996; Gillis & Duffy, 1991).

Using a postmodern feminist approach necessitates a critical exploration of health promotion discourses. Health promotion research has historically been carried out within the positivist paradigm, with an individual focus, and again, with no reference to context or gender issues. Lupton (1997b) believes that, in spite of new thinking in social, cultural, and political theory, very little health promotion research is carried out within a critical paradigm. Clarke (1992) contends that a feminist methodology is needed to address the differences and inequity in health between women and men. She points to the different morbidity and mortality profiles women and men have, to demonstrate the reality of contrasting health experiences. In chapter 6 the current discourses of health promotion will be considered, incorporating both gender and people's everyday thinking (lay theorizing), and the meaning related to health promotion, the most ancient of health policies.

3.5 The research method

Having considered methodological issues, I will now turn to the method used. This had to be dialectical to ensure congruency with the philosophical assumptions discussed above (King, 1994). The need to develop a collaborative relationship was uppermost in my mind as I began the process described in this next section.

3.5.1 Participant Selection.

I had intended to advertise in two local newspapers to ensure a large catchment area. One was a free weekly paper that is delivered to all households, and the other a daily Christchurch newspaper, *The Press*. My decision to advertise in *The Press* was arbitrary. This paper has a community column in which voluntary organisations and individuals may advertise. I had seen information related to research studies in this column and rang to make inquires about this. The reporter to whom I spoke was most enthusiastic and the following day this small item was published:

> **A Call To Middle-aged Women**
>
> Women aged from 35 to 60 who have indulged in regular exercise for at least one year, sometime in their lives, are needed for a Christchurch research project. Judy Yarwood wants to interview a dozen women to find links between the social roles of women and their ability to exercise regularly. The project is being undertaken as part of a Master's degree. The women, who would be interviewed during the next six months, can contact Judy at the Christchurch Polytechnic School of Nursing and Health, on 364-9074.

The response to this call was overwhelming, with at least 60 women contacting me. At this point I decided not to advertise in the local free paper and set about the task of participant selection. Although I had hoped to interview all the women before selecting the participants, this became impossible. In my research proposal I had said that I would

choose the participants on a first-come, first-served basis and decided this was the only way to proceed. As I received the first 20 or so telephone calls I was able to get each woman's age and I chose from this group of women, using age as a guide. I chose the majority of participants in their 40s. Interestingly, even though I saw the 40s as being the norm for midlife, most of the participants didn't identify with being midlife or middle-aged. However, one woman who rang in response to the newspaper item commented how delighted she was to read something for middle-aged women. This comment was reiterated several times throughout the research process.

Over the next week I spent many hours contacting all the women who had called to offer their time. I was amazed at the level of interest in the study and gratified at the support and encouragement I received. After brief telephone conversations with seven of the selected participants, giving a broad outline of the study and discussing the expectations of each woman, a time was made for an initial meeting. Two other participants joined the study during the following week and the tenth participant was the woman who volunteered to do a pilot interview. Of the ten participants, seven described themselves as New Zealanders, one identified as part Maori and two as English.

The initial visit was held at the place of choice of each participant, with the majority of women choosing to meet in their homes. Each woman was asked to read the information sheet (Appendix A), we discussed the study, and I answered any questions as they arose. I acknowledged my interest at the personal and professional level and found that all the women were most interested in both the process and topic of the study. Some participants chose to sign the consent form at this initial meeting; others signed it before the first interview commenced.

3.5.2 Participants

Before I discuss the interviews I would like to introduce the women who gave so willingly of their time. Each woman was more than happy to answer my questions and I felt extremely privileged to share certain aspects of these women's lives. Not all of the participants identified as feminist, but all were keen to participate in research that could

benefit both women and nursing practice. Several of the women spoke of their participation as enabling them to think and reflect on what they were doing at this time in their life, as Harriett demonstrates:

> H: It gives you more of an insight into a lot of the things that you perhaps um, hadn't thought too much about, you know (Harriett, Int 2: p. 16).

Tessa

Tessa is 40, married and has two preschool children. She is a registered nurse who works part time in her husband's medical practice. She describes herself as middle-class, moderately attractive and overweight. She has struggled with weight control since her late teens and has tried numerous diets.

Tessa has exercised since childhood and was involved in a variety of individual and team sports throughout her school years. This continued during her nursing training and it was not until she travelled to Europe that exercise ceased. Although she continued to walk while overseas, other exercise was not easily accessible. On returning to New Zealand, Tessa married, joined a gym, and started running with her husband. She maintained a high level of exercise until the first of her two children was born, since when exercising has been more difficult and intermittent.

At the time of the interviews Tessa was running or going to the gym about once a week and walking with the children. Tessa exercises to keep healthy; prevent disease, for example, osteoporosis; for weight control; and to be fit and healthy in old age.

Harriett

Harriett is 55 years old, and married with three adult children, two of whom are working overseas. Her married daughter, who has two pre-school children, has returned home for a year while she is studying. Apart from ten years at home when the children were young, Harriett has always worked. She was a teacher, although now she is doing

clerical work. She describes herself as tall, part Maori, and considers herself to be moderately healthy.

Harriett was physically active as a child and played netball and went swimming through her school years. After leaving school she did very little exercise apart from an occasional game of tennis. When Harriett met her husband, exercise such as rock ' n ' roll dancing, badminton, tennis, and ski-ing became very much a part of their lives until the arrival of the children. Having four children under five years was not conducive to continuing exercise out of the home; however, once the children were settled at school Harriett returned to exercise in the form of golf. Periods of illness have curtailed her exercise activities over the years.

Harriett was playing golf, attending a gym, walking, and tramping when the first two interviews were carried out. Overcoming illness and other traumatic life events, having a good marriage, and being healthy are vitally important for Harriett. "We're just so lucky" was a frequent theme in our discussions. Exercise for Harriett is related to good self-esteem, social interaction, weight control, controlling hypertension, and health promotion.

Marnie

Marnie is a 52 year old woman, who has a PhD and is currently studying for a diploma in teaching people with a disability. Her present study is very much related to one of her two daughters, who has an intellectual disability. Throughout the time of the study Marnie was experiencing marital problems, which, she acknowledged, strongly influenced her life perspective. She is mostly accepting of her body, although she acknowledges that she needs to do some work to maintain a level of fitness and health.

Growing up on a farm, Marnie remembers being constantly physically active, including walking to and from school. Apart from a little netball, team sports were not part of her exercise at this stage. Like many of the women interviewed, exercise at the completion of school was non-existent. Apart from yoga, karate, and tramping, Marnie did not

become physically active again until her early 30s, when she had completed her PhD. At this time she was expecting the first of her two children and was living on a small farm. Farm work, young children and table tennis all helped Marnie become physically fit.

Currently Marnie is walking, biking, playing table tennis, and doing yoga. She considers her exercise empowering as she feels more confident, fit, and capable. It is also vital for stress relief in what is a very stressful period in her life. Marnie exercises for health promotion, social interaction, and to be fit and healthy in old age.

Rachel

Rachel is a 45 year old mother of six children and a grandmother of one. She is currently employed as a physical instructor at a local gym centre.

Rachel's childhood was also spent on a farm where she was outside all day, every day, constantly involved with childhood activities such as tree climbing and bike riding. She was involved in sports at school, being the second fastest runner at the local school. After finishing school no exercise was undertaken; however, Rachel had her first three children soon after, without the support of a partner, and considered she was physically very active at that time.

It was after Rachel married and had a further three children that she started attending a gym and then became interested in body building. She recently competed in a body building competition that entailed intense physical training and specific dietary preparation. The latter component was fraught with difficulty as Rachel's husband is Samoan and food is a very important aspect of Samoan culture. The ability to complete this competition was very important to Rachel, who would like to see more women becoming involved in exercise. Self esteem, disease prevention, and to promote health are the main reasons Rachel exercises.

Ann

Ann, the youngest participant at 37 years, is single and is an accountant. She is mostly happy with her physical appearance although she does consider she is overweight; something she is working on.

Ann also had a rural upbringing and remembers much physical activity as a child. School days incorporated swimming, netball, tennis, most team sports, and while at university Ann played basketball, did a little running and began gym work. After completing tertiary studies Ann went to England for three and a half years where she considers she walked more then ever and became very fit physically. She continued to play basketball once a week and also did a little cycling. On return to New Zealand Ann became caught up in work, found herself working up to 80 hours a week and unable to do any exercise at all. After a year without exercise, and an increase in weight, Ann decided to start running again and completed her first half marathon as well as starting to play squash.

Currently Ann is attempting to keep work within a 40 hour week, is playing touch rugby, squash, and has just started playing golf. She tries to get to the gym three times a week. Ann exercises for mental and physical health, stress management, weight control, disease prevention, and to be fit and healthy into old age.

Alice

Alice has two small children, the youngest being four months. She is 38 and is a general practitioner working part-time. Alice was raised in England in a large middle class family. Her father was also a general practitioner, and she considers her family were all "readers rather than doers".

Early childhood was an active time of cycling and playing outside, but by 12 years of age she did very little. Family walks were very short and physical activity was not encouraged. After a brief spell of swimming between 16 and 18, Alice did very little

exercise throughout her tertiary education. It was a time of a love/hate relationship between exercise, weight, and diet, with none lasting very long. This pattern continued until her first visit to New Zealand to do locum work where she met "like minded" people and became very physically active, swimming and doing aerobics and gym work. Alice considers she was the fittest she has been then, before or since. It was also the time when she met her future husband. Returning to England, the exercise decreased and the weight increased. However, Alice finally returned to New Zealand, married and is raising a family.

Over the last year she has either been pregnant or breastfeeding and has found it difficult to exercise on a regular basis. She tries to walk to work; however, time and energy levels often interfere with good intentions. She is struggling with feeling guilty about not exercising, but acknowledges the reality of her present situation. Alice is very aware of the benefits of exercise as a health-promoting and empowering behaviour. She also exercises for weight control, for her mental health, and, like so many of the other participants, wants to be fit and healthy into old age.

Rose

Rose is 40, separated, and has one teenage son. Rose and her family have been in New Zealand for 18 months. She works in a large physical recreation complex, a position that includes education and related courses. Apart from colleagues at work, Rose has very little social life and has focused on work and exercise training for a long distance event.

As a child Rose was physically active at school and at home although her parents were not good role models for activity. Her father was completely inactive and had very little to do with the children, while her mother did a little gardening but very little else. Adolescence saw an increase in physical activity, which she particularly enjoyed, and included tennis, hockey, athletics and horse riding. Her love of physical activity led Rose to physical education teachers' college where exercise dominated her life. In her final year of the course she married and soon after had her son. For a variety of reasons, during the early years of her son's life Rose did very little exercise and coincidentally

put on a large amount of weight. She became ill for a period of time and it wasn't until her son started school that Rose started exercising again. She considers the motivation to start exercising again came from watching the London Marathon. Although not being able to run this marathon, exercise has remained a very important part of her life.

During this study Rose was training up to two hours a day to compete in a gruelling triathlon. Rose cannot imagine life without exercise. She finds it empowering, knows it is health-promoting and disease-preventing, and describes it as great for her self-esteem and mental health.

Chloe

Chloe is 45 years old, separated and has two sons, aged 18 and 20, with only the latter living at home. Chloe has worked in a variety of clerical positions, in one of which she is currently employed.

As she grew up Chloe was physically active, cycling and walking. Her parents were physically active gardening and walking, and like the parents of many of these participants, they had no car and walking was very much part of their lives. Chloe was involved in netball and gymnastics throughout her school years. However, in her teenage years physical activity dwindled apart from tennis, which she continued to play socially. In the early days of her marriage and when her children were small Chloe walked everywhere, and also joined a running club with other young mothers.

At present Chloe is walking four and a half kilometers to work four days a week. Although she has exercised at a gym and enjoyed this, financial constraints have prevented this from continuing. Exercise for Chloe is important for good mental health; for preventing disease, for example, osteoporosis; for weight control; and to remain fit and healthy into old age.

Wanda

Wanda is a 48 year old accountant, who had been happily married for 29 years when we commenced this study. She has two adult sons, both of whom have left home. Wanda's upbringing was in a fundamentalist religious family where traditional gender roles were considered the norm. She is currently studying feminist issues and expanding her own and her husband's horizons. Wanda's husband has a lifelong involvement with motorcycling, which has impacted very much on their married life, incorporating social, financial, and time commitments.

Wanda was physically very active as a child and loved sports including athletics, netball, swimming, and gymnastics at high school. She considers both her parents were good role models as they were physically active and encouraged the children to be so. After her schooling was completed and over the next 15 years Wanda did very little exercise apart from walking and physical activity involved in child rearing and domesticity. When her children started at school Wanda returned to the work force, which she found very stressful. To counteract this stress she would go home after work, then prepare dinner, serve the meal to her family, then return to the gym for a workout before returning home and having her meal.

Wanda has consistently exercised since this time, even when working overseas for a two month period. Exercise is vital for her mental health, problem solving, refocusing, and for stress relief. She considers it empowers her to feel confident in her work and personal life. Wanda also values exercise for promoting both her physical and mental health.

Dianne

Dianne is 53 years old, married with three adult children, all of whom have left home. Although Dianne retired from teaching mathematics at secondary school level a year ago, she does tutor a few students privately. Chronic migraines have blighted Dianne's

life for many years; however, apart from migraines she considers herself to be extremely healthy.

Like many of the participants, Dianne was physically active during her childhood, walking and biking everywhere. Unlike all the other women though, she did not participate in sports at school. Her parents were not physically active, and considered themselves "bookish" people, who believed you only played sport if you weren't very bright. At university Dianne did 10BX, a Canadian exercise programme popular at that time, and continued to bike to and from University. When her three children were young Dianne was physically very active with domestic activities and motherhood. When the children learnt to swim so did Dianne, and swimming has been the mainstay of her exercise since that time.

Currently Dianne swims, walks, and bikes at a leisurely pace. She considers she is fit and healthy and empowered by exercise. Both her mental and physical health benefit, as does her self-esteem and appearance. Most importantly she uses exercise to be fit and healthy now and in later years.

3.5.3 Interviews

Two semi-structured interviews, which Maynard (1994) sees as quintessentially feminist, were conducted using open ended questions. This process enhances the prospect of the participants being active collaborators (Worell, 1996). The first interview was between 45 and 60 minutes long, the second took on average half an hour. Both were audio-taped and transcribed verbatim. Each transcript was read while listening to the audio-tape, firstly to ensure accuracy of transcription, and secondly, to immerse myself in the information gathered.

Semi-structured interviewing has been regarded, rightly or wrongly, as synonymous with qualitative research which has an emphasis on the subjective experiences of

people. Interviewing allows women's voices to be heard within the context of each woman's life, rather than in a context of other people's choosing. It is these stories and knowledge that feminist researchers, including myself, wish to illuminate (Maynard, 1994). Semi-structured interviews, therefore, were chosen to ensure these women's stories were heard and to provide a relaxed, conversational atmosphere where a dialogue could occur and where topics could be explored as they arose. Each woman's particular concerns within the research focus could be discussed without disruption from set questions. Rose's comments gave me reason to believe I managed to achieve this.

> R: I didn't feel that I needed to respond super-intelligently. I felt that I was able to respond as though we were chatting over a cup of tea (Rose, Int 2: p. 15).

Whilst I could ensure a collaborative environment was provided, there were certain influential factors over which I had very little control, such as the age, social class, ethnicity, and the manner and mood of both the participants and myself (Lupton, 1997a). These influences all impact on information gathered, and, in turn, the final interpretation.

3.5.4 First interview

Ten open-ended questions were used as a guide and as a focus during the first interview. The question topics included exercise patterns throughout life, barriers to exercise, how they maintained exercise, and the perceived benefits of this activity. I quickly became aware that women's lives are all encompassing. Discussing one aspect of a woman's life cannot discount other areas. Issues related to body image, weight control, and personal, sometimes difficult relationships continually surfaced. I felt constantly humbled by the openness and willingness of these ten women to share aspects of their life experiences with me.

The interviewing process included reflexive listening as well as a discursive interaction. When appropriate I was able to share my experiences of exercising and also, when asked, was able to provide health-related knowledge. For example, one woman taking medication for hypertension was interested in exploring other risk factors related to cardiovascular disease. This dialogue emulates Carryer (1995), who believes that for equality of relationship within the interviewing process, there is a need to share knowledge and contribute discursively as appropriate.

3.5.5 Second interview

Prior to the second interview I read through the transcripts and made notes of emerging initial themes (Burnard, 1991). I also formulated questions and ideas for clarification to be asked at the second interview. The transcripts were returned for each woman to read. The second interview provided an opportunity for each woman to clarify any points from their reading of the first transcript, and to enable me to ask the further questions. At this time I also gave each woman a copy of the emerging initial themes for their comments. Most women had no difficulty identifying with the majority of these themes.

The second interview, although shorter in duration, was also audio-taped and followed a similar format to the first. Both the women and I asked questions, and clarified and expanded on aspects of the previous interview and the emerging themes. The transcription of this interview was also returned to each woman for further comment. Throughout the data-gathering and analysis phase, all material gathered was returned to the women for validation. Both Opie (1992) and Carryer (1995) see the process of returning transcripts and other material related to the study to each participant, as essential for ensuring the women remain in control of the process. I considered this dialectical relationship ensured power relations were recognised and hopefully balanced, and enhanced the equality I aimed for throughout this study.

Considering power relations, Opie (1992) believes research participants can be empowered by the research process. One dimension of empowerment she considers is

the therapeutic effect of the interviewing process for the participants, in that they have an opportunity to think and reflect on the experience. Wanda provides an example:

> W: I'm just really pleased to have been able to take part in it because it's helped me focus and think about why I do things....It made me sit down and think. Some of the questions you asked, and after we'd had our interview I was thinking about them over the next few days and...yeah, it was very good for me (Wanda, Int 2: p. 11).

Grbich (1999) views the concept of empowerment as somewhat problematic. She asks what does it mean, and to whom, and suggests it has "condescending overtones similar to those of consciousness raising" (p. 54). However, Opie (1992) views this notion differently. Empowerment in this context, as a private dimension of research, can allow each participant's voice and experiences to be heard in a wider social forum. Thus, participants could be seen to be contributing to discussions of social interest which may otherwise remain obscured.

3.5.6 Ethical issues.

Ensuring the well-being of research participants is the central consideration of ethical procedures (Rountree & Laing, 1996). A written proposal for ethical approval for this study was sought through the Massey University Human Ethics Committee and Christchurch Polytechnic research committee. Although approval was granted after minor changes to the participant information sheet, there was considerable discussion at the Christchurch Polytechnic research committee. Both qualitative and feminist methodology were questioned on the small number of participants and issues of rigour, as little was known by many of the committee members. Nursing colleagues on this committee were able to provide relevant information and readings, and were highly supportive of this research proposal. The two main issues which dominate ethical guidelines in research with human participants are informed consent and protection of

participants from harm (Bogdan & Biklen, 1992). Both were addressed before and throughout the interviewing process.

3.5.7 Informed consent

At the initial phone call I provided an overview of the research project and the women's expected time commitment, before answering any questions, of which there were very few. The first meeting, which was not taped, gave both the participant and myself the opportunity to discuss the research process. I explained that as this was a feminist research study, I saw my role as a co-participant with the women rather than as researcher, with the women as subjects. I talked of my responsibility to ensure that the outcome of the study was to generate knowledge for women generally as well as for nursing practice. All the participants showed much interest in both the topic and the process, particularly my wish to explore exercise in relation to the social roles of women. Some had obviously discussed their participation with family and friends, and all were keen to learn the study findings.

Each woman was asked to sign the consent form (Appendix B) when they considered they had all the information they required. Before signing they were also assured that they could refuse to answer any question, and withdraw from the study at any time. Signing the consent form did not, however, prevent any woman from leaving the study at any future time. Before I commenced each interview I gave an assurance that the tape recorder could be switched off at their request, and reiterated that there was no compulsion to answer any question. Any information in the transcript the participant was not happy with would be readily removed. No requests were made for this to occur.

3.5.8 Confidentiality

Before the first interview each woman chose a pseudonym by which she would be known throughout the study. All written material and audio-tapes identified the participant using this pseudonym. The woman who transcribed the audio-tapes was well aware of the need for protecting the participants' identities, and signed a contract

agreeing to protect confidentiality at all times. Only the participants, the transcriber, my supervisor and I have viewed written material. All audio-tapes and consent forms have been kept in a locked file. No identifying feature has been included in this thesis.

3.6 Method of Analysis : An overview

Thematic analysis, the method chosen to analyse the transcripts, is an evolving concept and so there remains a paucity of literature providing pragmatic guidelines. Whilst no interpretation of this form of analysis is the same, the emphasis is on discovering recognizable patterns and themes from life experiences (Aronson, 1998; Phinney, 1998). This analytical process incorporates selecting patterns of words into meaningful units, usually called themes, which are then combined to form a category system. It was this bringing together which Burnard (1991) first identified as problematic. Although he questioned if it was possible to link one person's world view with another, he thought it reasonable to do so, and offered a 14 stage taxonomy with which to proceed. At that time Burnard acknowledged qualitative analysis to be a thorny issue, and in 1995 proposed an alternative perspective to textual analysis. This alternative, which will be considered, can, I believe, be seen as more congruent to both a feminist, and a postmodern perspective.

The use of thematic analysis within a postmodern perspective, however, can be seen to be somewhat problematic. Allen and Hardin (1998) view the language in thematic approaches as a medium, as a way of understanding people's experiences which are expressed through language. The focus of analysis, therefore, is the person's expression of a particular experience, not necessarily the experience itself. This thematic perspective, Allen and Hardin believe, conceals the social origins of language. The information gathered is the participants' interpretation of a particular experience, without regard to historical or social structures. The experiences people recount are not only culturally embedded, but are a construction and interpretation of those events. Maynard (1994, p. 23) agrees and believes there is no such thing as a "raw" experience.

Burnard (1995) would go a step further and argue that the completed analysis adds another layer: that of the researcher's interpretation. Added to the researcher's interpretation of the participant's interpretation is each reader's interpretation. This somewhat obfuscated position is the basis of Burnard's alternative ideas to textual analysis.

3.6.1 Reductionism

Qualitative analysis of any information gathered requires some form of reductionism, and it is this process which creates a problem for Burnard (1995). This brief discussion acknowledges these concerns, but offers no solution. The term reductionism in this context indicates "a process by which phenomena are 'reduced' and distilled in order to attempt to get to their 'essences' " (p. 237). Burnard argues that any form of reductionism disregards the complexity of information gathered, and the plurality of possible meanings in the text. Searching for the "essence" or core meaning is fruitless, as these will not be forthcoming. Burnard (p. 239) suggests "there are no 'hidden' or 'real' meanings embedded in the text". Words said and captured on audio-tape, then transcribed, are a group of words offered at that time, and it is not possible to know if the real meaning has been captured with those words. Is there a "real meaning", and would that meaning be the same three months later? Burnard offers the analogy of trying to discover the meaning of a play by attempting to understand each word of dialogue. The "real meaning" would remain elusive. Pondering endlessly on the transcribed text cannot guarantee that the "real meaning", if it is there at all, will be elicited.

3.6.2 Interpretation

Accepting the elusiveness of the meaning of participants' words is complicated when considering Burnard's (1995) alternative to analysing transcribed texts. Rather than concentrating on what was meant in the spoken word and searching for the "essence", he argues that the researcher should attend to the meaning the researcher ascertains. Burnard (p. 241) believes that "it is impossible to read text without also 'interpreting it'". There is no one way, but many ways, to interpret text. He considers it fallacious to

suggest that a set of transcriptions represent what this group of people really thought. To support this notion he offers three ideas. One is the impossibility of knowing if what a person says is what they are thinking. Two, it is not possible to attribute people's meanings from what is written; and thirdly, people's ideas, beliefs, and consciousness are in a constant state of transition.

Lucas (1997), however, disagrees with Burnard (1995) and believes his proposition of multiple interpretations could lead to introspection and relativism. Lucas argues that even accepting the reality of reductionism, transcriptions can be seen as "socially located conversational events" rather than "decontextualized texts" (p. 114). Research interviews could be seen as a conversational event where conversational practices such as ensuring understanding occurs. In theory such practices could reduce the possibility of multiple meanings. Burnard (1997) remains unconvinced, and points to what he sees as the pivotal point of his argument: interpretation. Many are possible, but no one is the right interpretation.

Another analogy can be drawn, this time with music. Music, like language, is replete with expression. Each composer creates an opus which has both meaning and expression. Those who listen to or play music will, however, interpret it incorporating their historical, social, and cultural contexts. Each interpretation is as valid as another.

Although no definitive answers are possible, Burnard (1995) believes this analytical process may generate ideas regarding the human condition not possible in empirical research. Within a postmodernist perspective, Grbich (1999, p. 52) considers "prediction is no longer valued...reflexivity, ambiguity and a rigorous and continual questioning of the text, without conclusions are favoured". The analysis of information gathered in this study, therefore, has been undertaken with both Burnard's position and a postmodernist perspective in mind.

3.6.3 The audit trail

Accepting that thematic analysis is the researcher's interpretation of participants' words, Burnard (1995) refers to a high and low level of interpretation. The former views the information gathered through a theoretical framework, the latter as an understanding of the participants' words. The analytical process about to be described is at the lower level and is asking, what is happening here and why? What factors influence this group of midlife women as they exercise? There is no foreclosure at this level, to ensure further analysis can be carried out at a higher level.

On completion of the two interviews the transcripts were read several times, which enabled me to become immersed in the information gathered (Burnard, 1991). As I read, I jotted down notes and initial themes as they emerged. Although Burnard (1995) questions the validity of comparing what one person says to another, Phinney (1998), in a recent study, compared themes across five participants, looking for differences and similarities. I found many similarities in the initial themes and had no difficulty in combining these early themes into 29 emerging themes. Seven of these early themes identified by all participants were: exercise growing up, family influences, self esteem, feelings related to not exercising, positive feelings of exercise, constraints to exercise, and lifestyle.

I then reread the transcripts looking for gaps or ideas I had missed, and to ensure I had covered all aspects of the interviews (Burnard, 1991). As I read and listened to the tapes, I became aware of what Carryer (1997b) called a degree of boredom. I felt myself answering the question before the participant, and felt at this stage I had become saturated with the information after hearing it so many times.

3.6.4 Emerging themes

Believing this stage to be completed I condensed these emerging themes into what I considered would be the final six themes. These were: context of exercise, empowerment and exercise, exercise as a health-promoting behaviour, the influence of

gender at midlife, constraints to exercise, and physical activity and exercise. The idea of interpretation came to the fore at this stage. This was my interpretation, and I was aware that another's interpretation could be different (Burnard, 1995). Although Grbich (1999) suggest a colleague or friend read the text to identify emerging themes, or to note omissions, I chose not to do this, as I believe this would only provide me with yet another interpretation.

It was at this stage I found myself constantly mulling over these six emergent themes and feeling somewhat unsure. I continued with the process, however, and colour-coded the transcripts with the six identified themes. As I started to cut out each colour-coded section, Burnard's notion of reductionism haunted me. I retained an intact copy of each transcript before cutting to ensure I had the whole to return to if necessary. The more I cut, the more the context of these transcripts was lost. Once I had completed cutting each section and placing it into the relevant folder, I felt the analysis had gone astray. I did not believe I had any preset ideas of the themes that had emerged, and yet with hindsight, I now saw these were more my ideas, rather than the participants'.

Following a period of reflection and discussion with my supervisor and colleagues, I returned to the folders, reread each section and listened again to the voices of the participants. After a considerable amount of time, I found myself changing some of the colour-coded transcripts from one folder to another. It was only at this stage that the four final themes emerged, which I believe represented the life experiences of the participants. I learnt a great deal, both personally and professionally, through this process, particularly how integrated and interrelated life experiences are for these midlife women.

3.6.5 The final four emergent themes

These four final themes represented what I believed these ten women were saying: exercise is part of me, part of my life; the importance of being fit and healthy; exercise interweaves and changes with life situations; and constraints and conflicts.

Acknowledging again that this is my interpretation, these four themes give a cohesive overview rather than a fragmented picture of what was told in each woman's story.

When these four final themes were given to each participant, I was amazed at the consensus of opinion. Several woman thought these themes emerged from their own transcripts, and were astounded to discover they were a compilation of the ten participants experiences'. There was the odd concept, such as the gym, or the issue of guilty feelings, which was not relevant to every participant, but overall they identified closely to these four emergent themes.

Within a postmodern analysis however, Opie (1992) suggests that this unified representation of physical activity could be problematic. There are two implications related to this position: one, that all participants, including myself, are similarly located, and two, the participants occupy a descriptive rather than an analytical position. Firstly, although we are similarly located in relation to exercise, each woman's life experiences, including my own, are very different. Secondly, there was no expectation that the participants would analyse, as well as describe, their experiences. The consensus reached, I believe, privileged all the participants. It did not claim at any stage that this information is the final word or "truth" regarding exercise and midlife women (Opie).

A low rather than high level of interpretation has been undertaken at this stage in this analytical process. In the next two chapters, a higher level of interpretation will occur as dimensions of the four themes are considered.

3.6.6 Triangulation

Congruent with Lather's (1991) position regarding triangulation as critical for establishing the credibility of information gathered, I will describe briefly the process I undertook. Triangulation refers to the multiple sources of information, methods and theoretical schemes used in gathering information. In the present study, information has

been gathered from the participants, from myself as researcher, and from a wide variety of literature ranging from the populist to the academic, and from a group of interested midlife women who regularly attend a gym. I provided these seven women with a list of the emerging themes and they were asked to mark the themes to which they could relate. Again, it was interesting to hear and see the similarity of experiences. Salient dimensions included self esteem, disease prevention, weight control, positive feelings about exercising, and social interaction. One woman spoke at length, saying how pleased she was to have the opportunity to reflect on how important regular exercise is for her at this stage in life.

3.7 Conclusion

This chapter has discussed both the philosophical underpinnings and the method used in the study. Feminist philosophy was seen as the most relevant for understanding certain aspects of midlife women's lives. The tenets of feminist research include recognizing the disprivileging of the feminine, the reasons for, and the need to challenge this; consciousness raising to offer alternative world views from a women's perspective; and acknowledging the personal is political, thus accepting the value of each woman's experience (Short, Sharman & Speedy, 1998). A postmodern perspective was selected as this genre appears to offer diversity, uncertainty and multiple world views, which together with the philosophical assumptions of feminist thinking, may provide alternative perspectives for understanding the paradox and complexity of women's social worlds.

Burnard's (1995) interpretation of thematic analysis was recognised as being congruent with a postmodern feminist approach, as it offers both flexibility and fluidity. The concept of interpretation was elucidated at more than one level, illustrating the complexity inherent in qualitative analysis. Each interpretation within this approach can be considered to be valid, and the analytical process offers ways of understanding the human condition not considered possible in an empirical project.

The reflexive nature of the interviewing process ensured all participants were able to describe and explore their experiences in an interactive and informative way. Whilst many similar themes arose from the interviews, the group was valued for its heterogeneity and never viewed as a unitary group with each life experience being applicable to all women. In the following chapter the data will be presented, and the interpretive process broadened, to incorporate a postmodern perspective and the lens of gender.

CHAPTER FOUR : Exercise for self

4.1 Introduction

The previous chapter explained and considered the methodology underpinning this study, and the method used. Before proceeding to discuss the four themes which emerged from the interview material, I will briefly reiterate the aim of this research project. I wished to explore the complex factors that influence ten midlife women to maintain physical activity as a health-promoting behaviour over a sustained period of time. In this, and the following chapter, the interview material will be analysed and discussed. Dimensions of the four emergent themes, with pertinent excerpts from the participants, will be provided, with relevant literature interwoven throughout both chapters.

Chapter 4, "Exercise for self", will consider the first two emergent themes, "Exercise is part of me, part of my life" and "The importance of being healthy". Maintaining physical activity as a health-promoting behaviour on a regular basis requires motivation, and being healthy now and in the future was one of the strongest themes to emerge from the interviews. Exercise has also become a part of these women's lives in a variety of interrelated ways, frequently determined by life stages and experiences.

Throughout this study I have constantly been aware of two notions. Firstly, how much each participant enjoys being physically active, and secondly, how intertwined and multi-layered different aspects of these women's lives are. Exercise is no exception. No one dimension of these two themes can be seen in isolation, with many dimensions weaving together. Alice provides a salient example of this as she talks of exercise at a certain stage in her life linked to weight control, self-esteem, body image, and social interaction.

> Al: I arrived in New Zealand late 1990, just before my 30th birthday, so that, I think was very significant as well...probably within about four months I lost quite a lot of weight um...which is important, I suppose to me, definitely...I was working in a job and I was reasonably paid, so I was paying off debts and I actually for once in my life was making some savings, which is unusual for me, and I was swimming virtually every lunch time so I...I had learnt to swim as a kid but I've never really done it ...and so I got quite ...sort of pleased at my ability to do it. And also I got into aerobics classes, mainly with my sister. We used to go at the end of work or something and we both quite enjoyed it (Alice, Int 1: p. 6).

Although each woman's experience of being physically active and adhering to that activity is unique, all these women are subject to a range of similar discourses available at any one time. Disease prevention, fitness and health, weight control, and the "body beautiful" are examples of the discourses in which these women have positioned themselves. Locating oneself in any of these discourses is not only influenced by gender, but other factors such as age, ethnicity, health, socio-economic status, employment, and family circumstances. As I analysed the interview material, I was conscious that no one discourse, or factor, could be seen in isolation. They frequently overlap and this will be seen throughout the next two chapters.

4.2 Exercise is part of me, part of my life

This section addresses the first emergent theme, "exercise is part of me, part of my life". For all participants, being physically active, and exercising, was not seen as something they did on Mondays and Thursdays; it has become very much a part of who they are, a part of their self-concept. The positive feelings generated through being active not only improved their self esteem, but also their body image. They talk about walking tall, about having control in their life, a real sense of empowerment. Although each woman

identified as being midlife, their ages ranged from 38 to 55 and their life stages were considerably different. While two had babies and pre-schoolers, another had teenage children, and one was a grandmother. Employment ranged from part-time at home, to full-time in professional positions, and yet each woman, for a variety of reasons, identified being healthy and fit into old age as very important. Considering the diversity of these participants' life experiences, many of their reasons for exercising were very similar, as will be seen throughout. Whilst I shall discuss the dimensions separately, in reality they are all intertwined.

4.2.1 Self concept, self esteem, and body image

These three dimensions are very much part of psychological health, which Pinto, Marcus, and Clark (1996) believe can be enhanced by physical activity. All participants identified the importance of physical activity for their self esteem and body image. As physical activity becomes an integral part of a person's life the self concept, self esteem, body image nexus becomes apparent, as seen through Rose's comments. In the first excerpt Rose speaks of how physical activity enhanced her self esteem at the time of having her first child:

> R: I think sport gave me greater self esteem and people saw me as something more than just a mum. So there were things to sort of hang onto....I liked this new image of myself and that progressed the rest of my life sort of thing (Rose, Int 1: p. 10).

The second excerpt relates to Rose's current life situation:

> R: Yeah, why do I exercise? It's part of my life now, it's part of my lifestyle. I seriously believe that I'm healthier as a result of it and I can get through a lot of things because....I feel mentally tough as a result of it. If you can put yourself

> through a three hour race, you know that you can cope with things (Rose, Int 1: p. 17).

Although McAuley, (1994) and Morrissey (1997) suggest that the link between improved self esteem and self concept remains equivocal, all the participants, and many other authors, believe the association to be a positive one (Brehm & Iannotta, 1998; Gill, Williams, Williams, Butki, & Kim, 1997; Wankel, 1993). Harriett and Tessa are quite explicit about the psychological benefits they receive.

> H: Well, because you feel better physically and mentally, it must help your self esteem. You're feeling you've achieved something...and you can see the results....the more I exercise, the more I, more alive I feel....You're thinking, I haven't done any exercise so I feel quite slothful. And then when you do, you feel quite pleased with yourself, so oh, it definitely helps your self-esteem (Harriett, Int 2: p. 8).

And Tessa:

> T: Well, for me it's coming from myself. Cause um...yeah, I want to do it regularly and if I don't I feel like I've let myself down.
> J: So does that impact on your self esteem, do you think?
> T: Yes, I think it does. My self esteem's higher if I'm actually exercising regularly, definitely (Tessa, Int 1: p. 13).

It can be seen from Harriett, Tessa, Rose and Alice's words how physical activity has enhanced their feelings of worth and self esteem. They not only enjoy their exercise and believe it is beneficial, they feel good about what they do. Physical activity reinforces their positive self esteem which, as a dimension of well-being, influences and reinforces this health-promoting behaviour.

The relationship between self esteem and body image is inseparable and inextricably linked to society's construction of the ideal body for women. This ideal is promised to those who exercise, with the healthy body being attractive, young, and, most importantly, thin (Markula, 1998). Whilst wanting to look attractive may not be an issue, the present mediated ideal and focus on thinness and youthfulness is problematic for an increasing number of women (Markula). For midlife women it becomes almost impossible. Tessa and Alice speak of their frustration at some of the media's dishonest portrayal of the benefits of taking exercise.

> Al: They go on about those stupid exercise machines, and all these people look absolutely gorgeous and not an inch of cellulite or anything on them, and I don't think I feel pressured as in I want to be like them, I just find it really irritating that it's so false....I don't think it's healthy at all (Alice, Int 2: p. 2).

For Tessa, the unrealistic nature of advertisements is a source of annoyance:

> T: There's one ad in particular...which is that Special K ad where they've got that stupid girl bouncing around in the waves going how fat I am and she's as skinny as a weed and that really annoys me (Tessa, Int 2: p. 3).

Although Alice finds the media influence frustrating there is a certain ambivalence also, when she mentions women's magazines:

> Al: I don't know to what extent, but I mean I tend to ridicule the women's magazines. We have them at work, and I say I'd never buy them, but I do read them (Alice, Int 2: p. 2).

There is a difference, however, between unrealistic expectations and the desire to look and feel good. Brehm and Iannotta (1998) acknowledge this and believe physical activity not only assists women to appreciate their bodies for the way they look, but also for their ability to perform; their strength, flexibility, and endurance. Rose talks about the satisfaction she experienced with her ability to achieve:

> R: Well, I was twelve stone when I started out this thing back in, it would have been '86, and by the end of '87 I was like nine stone three or four pounds, something like that, and very fit and looked it too. I mean, everybody commented on how good I looked and so on and I liked that....And people were impressed that one had a regular commitment to doing this thing...and they saw that you could, you know, if you set something down to achieve that you could achieve it. And all those things made quite an impression on me (Rose, Int 1: p. 9).

The finding that body image is a motivator for this group of women is similar to that of Neis, Vollman, and Cook's (1998) study, where they found body image to be a powerful incentive to participate in exercise. It certainly is for Dianne:

> J: Is your doing exercise related in any way to how you see yourself and your body?
> D: Totally, it enhances your self image, very much...because you feel better....sometimes when I'm really not well and it's quite hard for me just walking up and down steps just because it hurts my head and I hate that whole image. It's a posture thing too. You catch sight of yourself, and I think exercise helps you to keep your posture better, stops you looking older, it even seems to affect the way you peer over your shoulder (Dianne, Int 1: p. 12).

Ann's similar thoughts link fitness and self esteem:

> A: And it was nice to...feel better and to walk better...I did feel very different. It was nice even just running for a bus or something and not being puffed, you know. I remember just enjoying that fitness and that wasn't necessarily because of the thinness, it was separate. It was just nicer to be fitter.
> J: Good. And is it good for your self esteem?
> A: Yeah, totally....You feel glowing with health, I think. (Ann, Int 2: p. 5).

Alice talks of how, after being away for 18 months, when she returns home she finds, to her delight, that people notice the effects of her regular exercise:

> Al: So I went back and um...initially I kept the fitness up really well and it was so nice to go back to N where people knew me and everyone was saying, you look brilliant, you know, you look really good and you're so fit and it lasted quite a long time (Alice, Int 1: p. 7).

The images offered to women by the fitness industry, and supported by health professionals and the populist media, tend to focus on body image. It is certainly easier to visualise somatic changes rather than levels of fitness. However, the social construction of the female body ensures the focus remains on body image. Health benefits are the explicit goal, the implicit one being an ideal body. Developing either one, or both, requires discipline, self surveillance, and control, all concepts inherent in health promotion discourses, which Lupton (1997b) suggests are central in constituting the contemporary body. She believes it is through discourses of health that we think, talk, understand, and live our bodies. This is apparent in the participants' words above.

Lupton (1997b), drawing on the work of Foucault, sees the body as a site of struggle and control, being constructed and influenced by competing discourses. Success is a "civilized" body, one that is under control and disciplined, made manifest by meeting the dominant discourses of femininity, attractiveness, slimness and health. The acceptability and powerful status of these discourses are apparent, as body image is clearly linked to being physically active and healthy for this group of women.

4.2.2 Positive feelings related to exercise

Positive feelings of well-being experienced when participating in exercise included empowerment, being in control, personal enjoyment, and the associated physical and psychological benefits. Six participants articulated the sense of empowerment they experienced. In these two excerpts, Rachel and Rose describe their feelings:

> R: It [exercise] makes me more confident in how I look and what I'm wearing. It's a very personal thing, isn't it?....You walk taller, you know, you're just like a rooster in a hen house. You strut your stuff, don't you. That's what it does for me. I feel good within (Rachel, Int 2: p. 5).

And Rose:

> R: I mean, to me exercise is very empowering...and you know, I wouldn't let go of that now....L, who's been coaching me, she said in her experience she hasn't met anybody quite like me, who has no problem in going out and exercising (Rose, Int 1: p. 19).

Empowerment incorporates feelings of control. A self-reporting instrument, the health locus of control, has featured in a few of the quantitative nursing studies related to physical activity as a health-promoting behaviour (Duffy, 1997; Duffy, Rossow &

Hernandez, 1996; Gillis & Perry, 1991) This instrument is purported to measure the extent to which people believe they have control over their health outcomes. The general consensus from these studies was that midlife women who had a high internal health locus of control were more likely to participate in exercise. As each participant in the present study was committed to being physically active, it could be argued that they too have a high internal locus of control in relation to exercise. Tessa talks of what this means for her:

> T: So that's the main thing [exercise] for my health...and it's one of the things you can do which you've got control over I suppose, there's lots of factors that you can't control and you don't know what's going to happen (Tessa, Int 1: p. 14).

Dianne also identifies feelings of empowerment and control:

> J: So overall it is an empowering process? Exercise and being fit.
> D: Yes, I think so. And I suppose if you were really down to it and you actually worked out an exercise programme and got yourself to a schedule and to a place, then that's taking control of your life as well (Dianne, Int 2: p. 7).

In a study investigating exercise and subjective health, Ransford and Palisi (1996) contended that people who were aware they were more active than their peers felt a sense of achievement. This, they believe, leads to positive definitions of health and well-being. Harriett speaks of her being the oldest at the gym she attends:

> J: So you don't feel intimidated when you go to the gym?
> H: I feel old when I go....I'm the only one, yes, some of them are young enough to be my granddaughters. They don't have anyone there like over 28 or 30....I look around and I think,

> well, there's no-one here my age, why aren't they here? (Harriett, Int 1: p. 18).

Although conclusive evidence remains elusive, Morrissey (1997) acknowledges that anecdotal evidence points to exercise promoting feelings of well-being. All the participants in this study confirm this, with a variety of reasons being offered. Endorphin levels is a possibility offered by Marnie and Rose:

> J: I'm interested...when you say that you've just exercised, say like you've come back from a bike ride or you've just come back from yoga, you're really a different person.
> M: Yes, yes. Particularly I mean the bike ride's obviously the endorphins, I think the high you are on, it's just, you know, you just feel great...and you've got that incredible fresh air and things through your whole system.
> J: And it's...a mental and physical thing for you.
> M: Definitely. Oh, very definitely (Marnie, Int 1: p. 12).

Rose's exercise levels are the highest of all the participants, as she was training for a triathlon during interviewing. In this excerpt she is talking about the feelings she experiences as she trains:

> R: At around about two thirds of the way through a workout...I begin to feel euphoric.
> J: Oh right, the old endorphins kick in.
> R: Yeah, they do kick in very well. And...I'm flying high then. And I'm invincible (Rose, Int 1: p. 16).

There is a suggestion the positive feelings experienced when exercising may influence people to adhere to exercise regimes. All participants were certainly keen to maintain their activity levels. Interestingly, Klonoff, Annechild and Landrine (1994) found that

changes in endorphin levels may have some influence on women's ability to maintain activity in women who have undergone exercise training, but very little for those who are untrained.

Wanda and Tessa, who talk about the positive effect for them, identify both the psychological and physical benefits:

> W: Well, this morning I actually had a headache 'cause I'm dealing with a horrible job at the moment...I had appointments programmed throughout the day and I couldn't get to the gym at lunch time, and by four o'clock, my head was throbbing, so I went to the gym at five o'clock and got home not so long ago. My headache's gone and I'm feeling really good and so yeah (laugh). Whether it's psychological or what it is (Wanda, Int 1: p. 10).

Tessa's description of how she feels when she is exercising illuminates again the inter-related nature of exercise:

> T: Yeah, I feel a lot better when I'm exercising regularly. It gives you better self esteem and it makes you feel like you're doing something about, well, I feel like I'm doing something about my weight problem. And it's enjoyable, I like getting out and running, I like running. I never used to (laugh) but I do (Tessa, Int 1: p. 11).

Nies et al. (1998) also identified personal enjoyment of exercise highlighted by all participants as a facilitator of physical activity. They found this enjoyment was sometimes linked to goal achievement, an idea Rose particularly relates to. In this excerpt Rose explains how her family feels about the training she is undertaking for the forthcoming triathlon event:

> R: Um...pretty supportive most of the time....I think they understand that for me I need these challenges and certainly because of the work situation and my lack of social life, I think they realise that I need something to hang on to and therefore sport has very much become that for me, to keep my sanity I guess (laugh). And they know I'm goal driven (Rose, Int 1: p. 15).

The importance of exercise for Rose at this point in time is apparent, although a little later in the interview she questions her motivation:

> R: So there've been times of elation and I suspect that each time I get tireder [sic] I think why am I doing this?...Is this challenge...really what I need to be doing? You know, who am I doing this for? Am I actually doing it for me or am I doing it to impress people?....And I know at the end of the day it's not to impress other people, it's actually for me to be able to say I've done that. But sometimes I do question that, at the moment (Rose, Int 1: p. 15).

Although I was aware there were underlying personal issues for Rose, it wasn't until my final visit that these were made explicit. Rose had been in New Zealand for only 15 months, and had difficulty developing social contacts. Her work environment was difficult, where she was experiencing covert sexism. Rose's marriage was coming to an end, and she had no extended family in New Zealand. Exercise and training provided a life-line for her. As a footnote, the triathlon event which Rose had trained for over the last six months was cancelled one week before it was due to be held. Discovering the personal turmoil and anguish in her life made me realise, once again, the importance of the contextual reality when exploring aspects of life experiences.

Enjoying being physically active is an important factor for all these participants, a finding similar to that of Nies et al. (1998) and Wankel (1993). The latter views enjoyment as a positive emotion, which he believes is linked to intrinsic motivation based on feelings of choice, personal control, competence, and overall well-being. Interestingly, Wankel's study relates intrinsic motivation to personality disposition. People disposed to well-being tend to believe they have control and have high commitment to life events. They view external happenings as challenges rather than threats. It could be argued that all the participants in this study had a tendency towards intrinsic motivation.

However, from a postmodern perspective this is somewhat problematic. The idea that each of us has a "personality" is firmly embedded in society, and can be seen as an essentialist notion (Burr, 1998). People have a particular, fixed, and unified nature, which determines what they can and cannot do. If, as Wankel (1993) suggests, people either have or do not have intrinsic motivation, that may well be the way people perceive themselves, with little opportunity to change. A postmodern perspective suggests people could be seen as fragmented and fluid, with the possibility of a multiplicity of selves, and thus the possibility to change. Our view of ourselves becomes historically and culturally bound (Burr). Without our personality to understand ourselves, what are we left with? Burr considers "identity" as useful, as it "avoids the essentialist connotations of personality, and is also an implicitly social concept" (p. 30). This allows people to identify what or who they are, such as female/male, fit/unfit, happy/sad, rather than this being the way it is (Burr). Therefore the positive feelings all the participants identified regarding physical activity could be seen as part of their selfhood at that time.

To conclude this section, I want to return briefly to Wankel (1993), as he argues that enjoyment is a fundamental consideration for maintaining exercise. People continue because they enjoy the process and the benefits. This can be seen as a positive aspect of adherence, which will be considered again when the negative aspects are interrogated in the following chapter.

4.2.3 Exercise and aging

The desire to be fit and healthy as one grows older and the ability to enjoy the later years was a motivating factor for all the participants. Dianne, Tessa, and Wanda voiced these ideas in different ways:

> D: I think one of the most important reasons for exercising is to be fit and healthy in old age. You can't help it if your brain goes, but if the body goes....I don't think old age is a disease....I firmly believe "use it or lose it" (Dianne, Int 2: p. 4).

> T: Because I want to have a healthy old age and I don't want to be one of these elderly people who have their muscles atrophy and fall over and can't get up (Tessa, Int 1: p. 14).

> W: Yes. I want to stay active. I just see people who are my age and they look twice as old and they're all hunched up and they go to do things and they haven't got any agility and I think I never want to be like that. And I'm sure that exercise helps you mentally and physically (Wanda, Int 1: p. 26).

The significance of motherhood at a later stage of life is acknowledged by two participants, Tessa and Marnie, as they reflect on health and aging:

> T: I'm particularly aware that I didn't start my family till I was 37, so I want to be healthy, and my old age to last as long as I can to sort of see my children for as long as I can (Tessa, Int 1: p. 14).

> M: One big thing, as an elderly parent...when R was born I was 35. My husband is, well I mean it's sort of now slightly irrelevant anyway (laugh), but he's four and a half years older, so we're elderly parents of a special needs child. Statistics would say I'm going to be the survivor of the pair. I want to be there, healthy and fit for as long as I can for R, but also for my own self. I would prefer to sort of drop dead on a walking track somewhere than to exist for 10 years in a home. That's just how I am. I want to live life to the full ...and I want to be fit and healthy to be able to experience everything I can (Marnie, Int 1: p. 6).

The message encouraged in the current health promotion discourses, that regular physical activity is an important dimension of ensuring one remains fit and healthy into old age, appears to have been embraced by these participants. The question that remains, however, is why these women have explicitly chosen to position themselves within this discourse, while many other midlife women, although desirous of remaining fit and healthy, have chosen not to. Lupton (1997b) intimates that being physically active can be associated with constructing one's subjectivity, illustrating the complexity of being and staying healthy. In the following section, the complexity and importance of being fit and healthy for this group of women is discussed and anlaysed.

4.3 The importance of being fit and healthy

The second of the four emergent themes, the importance of being healthy, permeated the study and all the women's thinking, as is demonstrated by Harriett's comments when I asked if health was really important for her. She said:

> H: Oh, very important. Yeah, when you could have all the money in the world and doesn't bring you health, does it? So

> you know, without health you can't do all these things that you want to do (Harriett, Int 1: p. 20).

This section will discuss dimensions identified within "The importance of being fit and healthy", and will include disease prevention, the dominant dimension of physical activity as a health-promoting behaviour. The focus of this dimension tends to be physical, although from a holistic perspective, the three other dimensions to be considered here – stress release, mental health and weight control – could be viewed under the rubric of disease prevention. However, for clarity of understanding, each of these four dimensions will be discussed separately.

4.3.1 Disease prevention

Virtually all the literature, from nursing, to the fitness industry, to the populist media, provide ample evidence of the apparent benefits of physical activity for preventing disease. This focus can also be seen at the political level, with the National Health Committee's (1998) report, *Active for life: A call for action*. Contained in this report is the message that there are health benefits for all New Zealanders who choose to participate in physical activity, with these benefits based on the prevention of disease. Although age is considered, issues related specifically to context and gender are not. This neglect is of concern, especially in light of inconsistent findings regarding the lack of correlation between physical inactivity and heart disease in women (Blair, Kohl & Barlow, 1993; Blair, 1997). None of the participants were aware of this uncertainty for women. The general perception within society is that all people benefit from physical activity, whatever sex, gender, age, or health status.

Risk factors for cardiovascular disease, for example hyperlipidaemia, high cholesterol, smoking, and physical inactivity, are the four leading concerns related to disease prevention cited in much of the literature. Four participants, Harriett, Ann, Chloe, and Wanda all acknowledge a family history of heart disease and were keen to prevent or ameliorate conditions such as hypertension.

> H: Yes, I take medication for high blood pressure, and for high cholesterol, and all those things. So he [GP] advises me to go out and play as much sport as I can....It's supposed to be very good. It's a familial thing in the family so I can't really do much, just keep on going. So I consider I'm pretty healthy (Harriet, Int 1: p. 3).

> A: Genetic, it must be. I've got a lot of heart, well, there has been in the past a lot of heart disease, but then my grandfather used to eat chops for breakfast, sausages. It was I think a lot to do with the diet rather than perhaps genetic, yeah (Ann, Int 1: p. 20).

> C: Yeah. And I have got some heart disease in the family...and being fit never seemed to do my mother any good because she's got heart disease and, but she was a nervous fit sort of person. And she never did any exercise apart from gardening and rushing around (Chloe, Int 1: p. 12).

Reading the excerpt from Chloe, one can get a sense of lay theorizing, of Chloe making personal sense of health and illness. Backett, Davison, and Mullen (1994) believe people define and make sense of health and associated behaviours by incorporating social and cultural norms. Although Chloe's mother having heart disease does not quite fit with the idea that exercise prevents disease, Chloe is keen to continue with some form of physical activity.

Inconsistency of results for women regarding cardiovascular disease are also evident in other aspects of women's health and physical activity (Jones, Franks, Manson, Hoffman-Goetz, & Otis, 1998). The osteoporosis, physical activity, weight bearing nexus is a good example. Although research findings remain inconclusive, the positive

perspective appears to have been accepted. Five participants raised the subject of osteoporosis throughout the interviews in a variety of contexts. Wanda and Rachel were discussing disease prevention when these comments were recorded:

> W: I'm sure it's been proven that weight bearing exercise helps with osteoporosis. So there are only benefits in it as far as I can see. And when you're at the gym you're not doing unhealthy things, you're not pouring drink down you throat, you're not eating...fatty food....You just don't do things that will cause problems later on (Wanda, Int 1: p. 26).

> R: Oh, disease prevention....I've just done a programme for a woman that's had osteoporosis and it's not prevention as such, but it is, she already has it....It slows down because the density of the bones thicken up a wee bit. And I think that's important, especially for women (Rachel, Int 2: p. 9).

Ann identified osteoporosis when she was talking about the benefits of physical activity as depicted in women's magazines:

> A: Heaps of um, articles about that sort of thing in women's magazines, not just adverts. Lots and lots of things about you know, how um, if you don't exercise the osteoporosis is more likely to happen and it's this whole look after yourself for your life sort of thing that's coming through, yeah (Ann, Int 2: p. 1).

And finally Chloe talks about the reasons she particularly enjoys walking:

> C: Well, I like walking. I'm conscious of the need, if you don't use it you lose it, particularly as women get older. I'm aware

> the osteoporosis and bones need the exercise, so you keep doing it (Chloe, Int 1: p. 7).

Osteoporosis is often discussed in the context of menopause, a life stage seen as synonymous with midlife. In a recent study, Slaven and Lee (1997) found menopausal women who exercised regularly were less likely to report menopausal symptons or deleterious psychological problems. Interestingly, issues related to menopause were only mentioned in passing throughout the interviews, and then as part of life, rather than as a pathology. The following excerpt from Harriett is an example. We were discussing weight distribution at midlife when menopause arose, and with these few words Harriett was on to another topic:

> H: I don't know whether I've actually had a menopause [Harriett had a hysterectomy several years ago]. I've never had any symptoms...like hot flushes or felt depressed or anything (Harriett, Int 1: p. 5).

4.3.2 Mental health

The literature covers many concepts under the umbrella of mental health, psychological and emotional health, stress, depression, and anxiety (Morrissey, 1997; Tkachuk & Martin, 1999). Although the psychological benefits of exercise, specifically for women have not been well researched, there is sufficient evidence to suggest physical activity reduces symptoms of anxiety, stress, mild depression, and enhances feelings of well-being (Guthrie, Dudley, Dennerstein, & Hopper, 1997; Jones et al., 1998; Pinto et al. 1996; Wiest & Lyle, 1997). Apart from stress, the other concepts named were not explicitly discussed in the interviews.

Although mental health is seen as being directly related to good health and well-being, it tends to vary in importance for each woman. For Wanda it was the primary reason she exercised:

> W: Yeah, my main reason for going to the gym is to refocus myself because of the work I do....The main reason is for the mental, and the physical is a side piece (Wanda, Int 2: p. 6).

From a holistic perspective, exercise made life easier for Dianne:

> D: I think it's good for your mental health...yes, just makes everything easier if you're fit. Everything....I like to think that your health is linked to what you do and how you treat your body and what you eat and yep (Dianne, Int 1: p. 8).

Ann appreciated the enhanced mental alertness at the beginning of the working day:

> J: I want to know how you feel when you exercise and when you don't exercise.
> A: When I exercise I feel great um...more mental than physical. I mean, I do feel good physically, but I think I feel better mentally....Um, these early morning classes, you know, sometimes I get to Tuesday night and think, oh, I haven't been to the gym till I think yes I have....I don't know why, but I just feel really good afterwards. More alert starting work those days and yeah,....Feel really good having done something and having a run around (Ann, Int 1: p. 14).

The psychological benefits gained from physical activity by the three participants are apparent; however, it is useful to remember McAuley's (1994) skepticism relating to what he sees as "the almost intuitive psychological benefits of physical activity" (p. 551). As discussed in the literature review, both McAuley, and Brehm and Iannotta

(1998) acknowledge methodological and conceptual concerns related to psychological outcomes. These valid concerns appear to pervade all aspects of physical activity, even without the complexity of gender issues.

4.3.3 Stress release

The discourse of stress appears to be becoming ubiquitous in contemporary society, and is commonly attributed as the cause of such problems as depression, a sense of malaise, and anxiety, all said to be symptoms of modern living. It has become almost expected that people will become stressed and Peterson and Lupton (1996) believe stress has become another lifestyle health risk which, without self monitoring, will have the inevitable consequences of ill-health. Supporting this view, Caltabiano (1995) asserts that the deleterious effects of stress for health are well documented, as is the relationship between stressful life events and illness.

To ameliorate social stress, the benefits of physical activity are increasingly being exhorted (Blaxter, 1997; Shephard, 1997). Half of the participants identified stress in their lives, at a personal and professional level, and chose to use exercise both as a stress preventer and stress reliever. The multiple roles many midlife women embrace at this life stage involve balancing a variety of responsibilities, which can frequently lead to stressful situations (Libbus, 1996). In a recent research study, Thomas (1997) found that the greatest stress many women experienced was what they identified as vicarious stress, the stress that originates from the lives of loved ones, rather than from oneself. Marnie had been experiencing relationship problems, which involved vicarious stress over the last few months, and she found exercise invaluable in keeping stress under control:

> J: So if you get really stressed with going through a process like this...you would know that if I go out and have a good bike ride...
> M: Yes...say it's late at night was when you tend to have your rows, out with the dog and (laughing)...I'd go for a walk. Yes.

> And she's good protection too. Yes, and a bike ride is a wonderful way of getting rid of stress and so forth. Yoga is too, has been invaluable for me, for both relaxing and to, just to maintain my sanity, basically (Marnie, Int 1: p. 18).

Similarly, Rachel finds a workout at the gym very beneficial for alleviating the daily pressures:

> R: I have been into the gym after being upset with one of my children perhaps, in a bad mood anyway, it might've been a driver on the street...and I've gone in there and I've pow, pow, powed these weights and pushed, pulled and everything and then come out and like...the problem was not even there any more. Brilliant (Rachel, Int 1: p. 11).

Stress can also arise from external pressures such as the workplace, as Ann and Wanda discuss. In this excerpt, Ann identifies a major stressor and how she manages this:

> A: That's [stress] probably my biggest health risk. I used to smoke, gave that up years ago. I don't obsess over the fat-free thing I, what I try and do is have a fat, um, reduced fat diet....I think that thing is probably the stress I put on myself from work and everything....Exercise helps that sort of thing (Ann, Int 1: p. 21).

Ann explains further how exercise works for her:

> A: And things that had been worrying me at work....I'd start off thinking about them, run without, you know, find myself sort of 20 minutes later not really thinking about anything and

> I'd finish the run and the problem would be solved, whatever was the problem, I mean it was just yeah, it was just good to have some time out (Ann, Int 1: p. 9).

Wanda also uses exercise as a strategy to ameliorate and prevent stress:

> W: And then the work I was doing, investigative work, I started being called in to do more and more fraud jobs and fraud is...very stressful, and I found that the gym was really good. I would go down at lunchtime and clear my head, and everything that I'd been mulling about in the morning, when I came back after lunch, it was just all in its little compartments and I could just carry on with what I was doing and sort things out (Wanda, Int 1: p. 5).

Stress management appears to have become yet another required lifestyle behaviour to ensure one remains healthy. Whilst five participants have chosen exercise as a stress reduction strategy, others did not. Neither Harriett nor Tessa considered their lives to be stressful, therefore whilst they believe the stress discourse can have poor health outcomes, their exercise was not seen in a stress-reducing capacity. Like so many aspects of exercise, each woman's experience is unique, and fulfills different needs.

4.3.4 Weight control

Weight control in contemporary society has become a major preoccupation for women of all ages. The slim female body has become the ideal, the epitome of beauty and acceptability. Images of this so called ideal are ubiquitous in the populist media, such as women's, fitness, and health magazines, and television, which only serves to intensify the normative nature of this discourse (Carryer, 1997a). Whilst the association between the slim body, weight control, and physical activity is not new, Markula (1998) suggests this nexus can become increasingly problematic for many women. Continual exposure

to the media's unrealistic portrayal of the female form can lead to dissatisfaction with their body, and unrealistic physical activity regimes.

Of all the discourses regarding physical activity that converge upon this group of midlife women, weight control can be seen as one of the central concerns. Nine out of ten of these women spoke about weight issues at various times throughout the interviews, with many talking of being overweight, or of just needing to lose a couple of kilograms. The following excerpts illustrate how these women view themselves and their experiences through the lens of weight (Allan, 1994). At the beginning of the first interview I asked each participant to describe how they saw themselves, and immediately weight issues became apparent for Tessa, Alice and Harriett:

> J: How do you see yourself?
> T: Ah..overweight (laugh)...but I suppose I'm moderately attractive....So I do have a fairly good self image from that point of view. Just from the neck down I don't....and I'm more overweight having a one year old because I haven't had a chance to exercise since I've had him (Tessa, Int 1: p. 4).

A little further in the interview Tessa talks of how problematic her weight has become for her:

> T: It's horrible being overweight, you know...it feels like it's not your body, it's someone else's body and it shouldn't be there....It'd be lovely to get a quick fix but you know it's not going to happen...so it's just a matter of getting into the exercise (Tessa, Int 1: p. 7).

For Alice, weight is also an ongoing concern:

> Al: Well, I'm about five foot six. I would consider myself overweight...probably about 75 kilos now....I'm usually round about 70 kilos....I don't feel terrible about myself now but I know that I could be better than I am. I have a moan to my husband regularly about...wanting to be thinner and...fitter rather than thinner I think....So if I could fit my clothes better that would be good (Alice, Int 1: p. 2).

Alice has found it difficult to keep her weight at her desired level when she is not exercising:

> Al: And slowly I, you know, the weight began to creep back on....I mean, the weight went on as a result of the exercise going down, very definitely (Alice, Int 1: p. 7).

Harriett talks firstly of how she experienced her body in previous years, and secondly of how she manages the perceived problem of weight gain in midlife:

> H: I used to be very slim, very, very slim, but in the last maybe five years I've put on weight and that is one of the reasons I like to exercise, to try and keep my weight down because I don't want to get big (Harriett, Int 1: p. 4).
> J: So how important is that [exercise] to you?
> H: It's very important; very, very important to me because ah, a number of reasons. One is to keep my weight down, that's the most important to me...but it should be really that I'm doing it for my health (Harriet, Int 1: p. 11).

Each women has not only equated her body with her identity, but these excerpts have also illustrated the belief that being physically active can assist with weight control and weight loss. This link is supported by the bio-medical discourse, which views the use of physical activity for weight control as desirable (Brehm & Iannotta, 1998; Wiest & Lyle, 1997). Commonly heard negative connotations inherent in being overweight are expressed by Rachel in the following excerpt:

> R: If you're not exercising or if you're not looking good, if you're overweight...overweight's probably more noticeable than anything, people would say, oh, no she should be doing something, shouldn't she....There's a lot of pressure on overweight people (Rachel, Int 2: p. 7).

Whilst weight control may not be the primary reason some women exercise, the focus on the body remains, as Dianne demonstrates:

> D: I wouldn't exercise just to lose weight, but I'm sure that you don't lose weight unless you do exercise. And even if you don't lose weight, what you've got certainly looks better. Cause you don't, I mean, you tone things up and muscle's heavier than fat so you don't necessarily weigh any less, but certainly what you've got looks...you just look better (Dianne Int 2: p. 3).

Whilst the National Health Committee (1998) suggests being physically active controls weight, there appears to be no guarantee of weight loss. Hill, Drougas, and Peters (1994), in a consensus statement discussing the correlation between weight loss and physical activity, believe there is little question that the latter plays an important part in energy balance. How and why this occurs remains equivocal, and like many other areas in this complex subject, further research is urged.

The discourse of weight loss through exercise provides an example of how knowledge is taken for granted as common sense, without foundation. The correlation of physical activity and weight loss as the "truth" is constructed by the fitness and weight loss industry, predicated by the powerful institution of medicine, and reconstructed without critique.

Whether physical activity is used for fitness, health, weight control, or body image, the current construction of femininity, and the medical discourse of health promotion, appear to influence the construction of subjectivity for this group of women. In both these discourses, the slim body is not only perceived as the norm, but also an outward sign of the person's ability for self regulation (Lupton, 1997b). Being overweight therefore, is seen as an individual problem, a sign of weakness, of being out of control, with little regard to situational factors (Allan, 1994). For many women this could necessitate constant surveillance and monitoring of what is perceived as an out of control body. The ensuing power struggles that may occur make manifest Foucault's concept of the body as the site of power, and the consequent power struggles necessary to regulate the venal body (Lupton).

The body appears to be central to each woman's experience of health and physical activity, and it could be argued that the discourses of health promotion are central to the constitution of these bodies (Lupton, 1997b; Vertinsky, 1998). The latter author believes women's bodies are medicalised from an early age, in relation to reproductive health. Additionally, by the age of puberty the majority of young girls evaluate themselves in terms of their physical appearance. In a consumer society fixated with feminine body as young, beautiful, and slim, surveillance and monitoring of the body appears to have become the norm. The identified "body beautiful" discourse will be expanded upon in chapter 6.

4.4 Conclusion

Being fit and healthy can be identified as one of a certain number of overlapping discourses in which this group of women have positioned themselves. Excerpts from the participants have provided salient examples of the dimensions from each identified theme, with literature woven throughout. The dimensions explored included physical and psychological health, self esteem and body image, disease prevention, stress release, and weight control.

All dimensions can be seen to influence, in a variety of ways, the ability of this group of women to maintain physical activity over a sustained period of time. The inter-relatedness of all aspects of physical activity is an abiding concept that will endure into the following chapter, where constraints and conflicts will be explored within the context of exercise interweaving and changing with life situations.

CHAPTER FIVE : Exercise in context

5.1 Introduction

In the preceding chapter, two of the four emergent themes were analysed. "Exercise for self" demonstrated not only the crucial role physical activity plays for all ten participants but the extent to which participating in exercise has become a part of each woman's life. This chapter will expand on personal involvement and examine exercise in context, "the rich social environment" so frequently missing in studies investigating physical activity (Gauvin, Rejeski, & Norris, 1996, p. 391). The interweaved and multi-layered nature of the lives of these ten participants continues as, once again, no one dimension can be seen in isolation from the other.

Studies completed investigating women's participation in physical activity have focused mainly on physical and psychological well-being, with very few exploring social roles, especially across a woman's lifespan (Pinto, Marcus, & Clark, 1996; Verhoef & Love, 1992). Within a feminist study the relevance of the gendered nature of physical activity and social roles is central and will be made explicit throughout.

The final two themes to emerge from the interview material, "Exercise interweaves and changes with life situations" and "Constraints and conflicts", are both highly relevant when exploring factors which influence midlife women to maintain physical activity over time. Participating in, and maintaining exercise are very much linked to each woman's healthy lifestyle and her social roles. Leith and Shaw (1997) believe that many women experience contradictory and complex feelings regarding their participation in physical activity. These feelings, frequently of guilt and frequently ambivalent, will be seen among the constraints these women have identified. The impact and relevance of family influences, time, and financial barriers on these women's ability to be physically active will also be discussed.

5.2 Exercise interweaves and changes with life situations

As I interviewed each participant, I became very aware of the flexibility and adaptability of these women. Throughout their lives different situations had arisen which have required differing social roles, including those of student, colleague, friend, worker, mother, wife, or partner. Physical activity has revolved around these roles and has ranged from a gentle stroll around the block, to a sanity-saving workout at the gym. Social roles are but one contextual factor which, in relation to gender differences and physical activity, has not been adequately addressed (Frankish, Milligan, & Reid, 1998). Others include age, socio-economic status, and family influences. These influences began to emerge as the participants described their physical activity throughout their early years, into adolescence, and adulthood.

5.3 Participation in physical activity

Exploring the factors that influence midlife women's ability to maintain physical activity over time required looking at each woman's physical activity levels from childhood. Whilst Wilbur, Miller, Montgomery, & Chandler (1998) consider activity patterns commenced in early adolescence may predict activity levels in adult life, Mitchell (1997) and Vertinsky (1998) focus on, and highlight concern regarding the decline in physical activity participation evident in early adolescence. Leith and Shaw (1997) question whether the gendered nature of physical activity youngsters experience will influence participation as an adult.

My own participation in physical activity did not begin until my late 20s, and my daily participation did not occur until my late 40s. My total lack of interest in exercise throughout my school years was, I suspect, due more to my inability to perform well in the sports on offer at that time – swimming and basketball – rather than for any other reason. I was keen to understand what, and if, childhood attitudes and behaviours influenced this group of women to be active or maintain physical activity at midlife.

These were my thoughts as I asked each woman to describe her physical activity as a child, as an adolescent and at the present time.

5.3.1 Physical activity from childhood to adolescence

The idea that attitudes and beliefs regarding exercise learned in childhood will influence physical activity in adulthood could be considered equivocal at best. However, Malina (1996), who has undertaken several studies tracking physical activity across the lifespan, suggests that participation in sporting activities during childhood and adolescence may form a foundation for being physically active in adulthood. It is interesting therefore to look at the physical activity levels of the women in this study as they grew up.

5.3.2 Childhood

All ten participants were physically active throughout childhood and early adolescence in a variety of ways. Three women grew up in a rural setting, and remember both themselves and their parents being very active.

> M: We were always very involved in the running of the farm as children...cutting flowers and so active, always tearing around barefoot active, running around (Marnie, Int 1: p. 10).

The gendered nature of rural life three or four decades ago is apparent as the participants remembered fathers being physically active with farm work, while domestic chores appeared to provide plenty of physical activity for mothers. Rachel provides an example of how women were active at that time:

> R: In those days we only had a copper, so that's what she [mother] used to wash...with a big stick and a copper, and I think that was hard enough, pushing up and down with the

> um, with the big stick and drag the washing out to the clothes line. Yeah, so I guess her work was cut out for her, exercising (Rachel, Int 2: p. 1).

There is a beginning realisation of the value inherent in domestic activity (Gill, Williams, Williams, Butki, & Kim, 1997; National Health Committee, 1998; Nies, Vollman, & Cook, 1998). However, Ebrahim and Rowland (1996) found that although previous sporting activity in childhood and young adulthood could be seen as a determinant for sporting activity in adulthood, this was not significantly associated with high levels of domestic activity.

Jones, Franks, Manson, Hoffman-Goetz, and Otis (1998) provide a pertinent example of two women in their 40s who were considered to be sedentary. One woman had arthritis and could do very little apart from watching television. The other was bringing up three grandchildren, which entailed walking daily to and from school and the playground and climbing several flights of stairs to their apartment. The latter, of course, is far from being physically inactive, and yet such activity is only now being acknowledged (Wilbur et al., 1998). Tessa believes that having young children assists her in keeping fit:

> T: I don't feel that I'm not fit at the moment 'cause there is so much exercise involved with lugging round a ten kilogram child (Tessa, Int 1: p. 11).

Acknowledging that the way physical activity has been measured for women is deficient highlights the need for considering household activity as a legitimate form of being physically active.

Women are in a position to be able to influence their family's health, and they can also be seen as moral and cultural guardians (James & Saville-Smith (1994). They are frequently the ones driving the children to sports and after school activities. Certainly,

the National Health Committee (1998) appears to accept women as the guardian of the family's health. Women are the ones who routinely access health professionals, on behalf of their husbands, children, and the elderly. Both of these ideas can be seen as social roles constructed by societal expectations of women with families, and will be expanded further in this chapter.

The advent of the two-car family, with children being driven to and from school for a variety of reasons, such as time or safety, may be considered one of the reasons for an increasingly sedentary society. The majority of these participants, however, were without a family car in childhood; therefore walking or biking to school and elsewhere was the norm.

> M: And we didn't have a family car...mainly our way of getting around was on foot...to get to school...which was quite some distance away from where we were....We had to bike say five kilometers (Marnie, Int 1: p. 11).

Most of these women were involved in sporting activities at school, especially netball and swimming, physical activities seen as suitable for young women, although gymnastics, tennis, and hockey were also mentioned. Family attitudes and beliefs in relation to exercise appear to have been influential for at least two participants.

> D: Yes, well I never took part in any sports at school at all, ahh, I think my parents were very bookish people and always had an attitude that you really only ever played sports if you weren't very bright...so I was always very active, but hopeless at team sports (Dianne, Int 1: p. 4).

Ann has similar memories:

> Al: I remember being quite active and playing netball...but then sort of 11, 12, I kind of dropped out of that and I think I do have a very...my family tend to be all readers rather than doers... and I think we'd never go out for a family walk (Alice, Int 1: p. 35).

At the time these women were youngsters, sport was male-dominated. Cultural pressures and structural barriers constrained young women's physical activities (Vertinsky, 1998). Swimming, basketball, and tennis were seen as suitable activities; however, the gendered nature of physical activity also intersected with cultural, economic and social factors, as it does today. These experiences could be seen as one of many that influenced participation later in life (Leith & Shaw, 1997).

5.3.3 Adolescence

Physical inactivity, particularly for teenage girls, is becoming a worrying trend. Jones et al. (1998), Pinto et al. (1996) and Schnirring (1997) note with special concern that, despite increased information of the benefits of activity for young adolescent women, the trend of declining activity continues. In North America, a culture not unlike that of New Zealand, the public health services have found that physical activity declines up to as much as 50% for adolescent girls, a trend which continues unabated (Vertinsky, 1998). Leith and Shaw (1997) suggest that negative perception of past experiences such as those at school, and the gendered nature of activity, can prevent participation at this life stage. Dianne and Chloe both talk of such experiences:

> D: I was always very active but hopeless at team sports, umm I remember I was in the F netball team...and I hated it...and at high school I use to always avoid PE [Physical

> education]. I loathed it; I felt clumsy and I felt fat (Dianne, Int 1: p. 4).

Body image also affected Chloe:

> C: We had compulsory periods of PE and I think it would be fair to say that most of us did as little as possible. We didn't like the rompers that we used to have to wear; they weren't very attractive (Chloe, Int 1: p. 7).

Although the teenage years were at least 25 years ago for these two women, body image is well remembered as part of the angst of adolescence. Vertinsky's (1998, p. 87) assertion that "By puberty most girls have learned that others evaluate them first and foremost in terms of their physical appearance and sexuality" may have been as relevant in the 1960s as it is today. For young women, adolescence could be seen as the beginning of a lifetime of self-discipline and control in an effort to meet the socially constructed "ideal" female form. The healthy/exercise/slim nexus emphasised in both the medical and populist discourse ensures attitudes formed in adolescence will continue into adulthood. Brehm and Iannotta (1998) acknowledge the negative impact this has for many women, and urge women of all shapes and sizes to engage in physical activity for fitness and well-being, rather than to achieve an impossibly thin body. Media messages at both an implicit and explicit level can, however, make this difficult at what can be a sensitive and influential stage of life.

Throughout this section the participant excerpts provide an insight into the prevailing discourses and practices which have influenced these women's attitudes towards being physically active. The constitution of the body within these discourses is either wholly transformed by social relations, or incorporates a biological dimension (Lupton, 1997b). I am not convinced either way and propose a symbiotic relationship, thus locating the body in nature, constantly being shaped by discourse. Therefore childhood experiences could be seen to influence the position each woman takes up in adulthood. The next

section will look at physical activities chosen by the participants in adulthood and at midlife, and the reasons for those choices.

5.3.4 Physical activity in adulthood and at midlife

In early adulthood, once school was completed, there was a decline in physical activity, depending on the life direction taken by each woman. Rose's physically active life continued apace with her attending Physical Education College. For the other women tertiary education, work, and overseas travel mostly precluded exercise, as they discovered the delights of an increasing social life.

Between young adulthood and midlife, there was a lapse in consistent physical activity for all participants, even for Rose, who had chosen to work in the physical education area. There are multiple reasons for this, some of which will be covered when I explore the constraints and barriers to physical activity further on in this chapter. By midlife, however, all the women were exercising again, to a greater or lesser extent. The following section looks at the interview material gathered when I asked each woman to describe her physical activity over the last year.

This diverse group of women had a wide range of exercise experiences at this lifestage. These include walking, running, swimming, biking, gym work – incorporating weights, step and aerobic work – tramping, touch rugby, golf, table tennis, squash, yoga, and tango dancing.

5.3.4.1 Walking

Walking, either for leisure with or without children, or to and from work, is a popular activity amongst this group. I asked each woman about walking as an activity.

> C: Up until recently I would walk to work which is about four and a half ks, four days a week (Chloe, Int 1: p. 6).

> D: We always go for two big walks at the weekend, we always walk to the movies....and I never take the stairs, I mean, it if was 18 floors I might (Dianne, Int 1: p. 5).

> M: We've joined the Wayfarer's walking group which once a week does about a three hour walk or so...and whenever I can getting up into the hills....I walk the dog for half an hour or so (Marnie, Int 1: p. 10).

> T: Yes, oh yes, we [Tessa and the children] do that. But that's generally slow, particularly if um N wants to walk, so it's not exactly striding out boldly, no. It's easier if you go for a run and then she'll [N] stay in the pram because she knows she's got to stay in there (Tessa, Int 1: p. 22).

The popularity of walking may be linked to this activity being seen as more social than other physical activities. Interestingly, Wankel's (1993) study found that the social nature of the activity was more important for women than men. Also walking has no financial cost, is relatively easy to do day or night, and as Pinto et al. (1996) suggest, women are more likely to participate in moderate activity such as walking. A recent *Listener* article (Stirling, 1999) suggests walking is to the 90s, what jogging was in the 70s, and aerobics was to the 80s.

Two of the participants have been competitive and involved in training over the last year. Rachel fulfilled a long-term goal by competing in a body building competition, and at the time of the interviews Rose was two months away from competing in a triathlon. The commitment necessary for this event was huge, involving time, and much of Rose's energy. Her training regime had yet to peak:

> R: Well, I do 50ks running a week approx...200 ks biking and about 8ks swimming at the moment. Now that will go up to my

> peak mileage week which comes in another three weeks' time; will be 55, 56ks running, 220 ks biking and about 9 or 10 swimming (Rose, Int 1: p. 48).

As explained in the previous chapter, life was particularly difficult for Rose at this time. Since I had last spoken to Rose her marriage had ended, a not completely unexpected development. Through discussion with other triathlon participants, Rose had found that certain life experiences, such as a marriage breakup, were frequently the catalyst for undertaking an event such as a triathlon. A journal entry at this time found me reflecting on exercise interweaving with life situations, and how it could provide an outlet, or perhaps a lifeline at such uncertain times, thus impacting on psychological health.

5.3.4.2 Gym

Harriett, Rachel, Wanda and Ann are the four regular gym users. They all attend a mixed gym and attendance varies from daily to weekly. The ambivalent feelings many women have related to using a gym were apparent with this group of women. Whereas Dianne felt intimidated in a gym environment, Harriett and Wanda were at ease. Dianne talks of her discomfort:

> D: I don't like going to a gym, I feel quite intimidated....I just find a lot of people intimidating and I feel insecure and I feel they are better than I am or they look better than I am (Dianne, Int 1: p. 6).

Harriett and Wanda speak of their feelings:

> H: There's a gym and that's a reason...it's close but also it's not um...not posey and I like that, 'cause I'm not posey (Harriett, Int 1: p. 17).

> W: Most people wear a T-shirt and shorts or tracksuit pants....and you don't need to feel conscious about your weight. T-shirts cover a lot (Wanda, Int 2: p. 3).

The Hillary Commission (1994) has identified intimidation by people involved in the exercise industry as a possible constraint to participation for many. Gym instructors, with their "body beautiful", were keeping people away from gyms as they feared they would not measure up to these standards (Stirling, 1999). Although the participants could relate to these feelings, neither Harriett nor Wanda felt any pressure. Harriett was aware of being the oldest, but perceived this as a positive attribute rather than a negative one. It appears the concerns of body image issues are being taken seriously in some gyms, as some instructors are leaving the lycra off and wearing T-shirts (Stirling). The competitive environment in which gyms are functioning may have also influenced this decision. From a personal perspective, it wasn't until I joined a gym that I realised the "lycra scene" may be more of a myth than a reality.

Whilst Rachel works as an instructor and therefore spends a considerable amount of time in the gym, Harriett and Ann use the gym as part of their exercise programme with other activities incorporated. For Wanda, the gym offers her time for herself, and is very much part of her life. Time for oneself was an important factor also identified by a group of midlife women attending the same gym as I. I clearly remember the general disapproval which greeted the first rings from a mobile phone. These were viewed as an unnecessary intrusion in an environment where time for oneself was important. Wanda quite openly admits she misses gym activity if she can't attend:

> W: If I don't go to the gym, like if I miss a Saturday or through work pressure there's no way I can possibly get there, I actually feel lethargic and that, whereas if I go I get all invigorated (Wanda, Int 1: p. 9).

Wanda has to travel as part of her job but ensures she can continue with her exercise:

> W: For work, if I have to go to Nelson or Greymouth, I generally book into a hotel that has a gym....If I can't, then I go running around the area (Wanda, Int 1: p. 14).

Without exercising Wanda concedes she would be miserable, particularly in relation to her work, which she considers can be very stressful. Although Wanda doesn't believe she is addicted to exercise, she can be seen heading straight for the gym on her return home after being away for several weeks:

> W: People tell me I'm addicted but I'd never thought of it as that, as being an addiction....At about eight o'clock my plane came in, and at six o'clock the next morning I was at the gym. (Laughter) To say hi, I'm back! (Wanda, Int 1: p. 14).

Wanda has not accepted the negative connotations of "being addicted". She sees herself as committed to being physically active, and this may well be the motivation for Wanda to adhere to physical activity. There appears to be a fine line between commitment and addiction, and it is the crossing of that beneficial line which is causing concern in some quarters. Farrell and Thompson (1989) and Stirling (1999) believe that as people are being urged to be physically active with the promise of health benefits, very little is mentioned about the negative aspects of exercise, either physical or psychological. Rose provides a salutary example of crossing the beneficial line:

> R: I set myself a big challenge last time in doing an Olympic distance triathlon...I became quite ill after that for several months...got a tooth infection and couldn't get rid of it and I had course after course of antibiotics...then I had a minor haemorrhage...it was literally six or nine months of not very

> good health, and I knew then that was because I'd overdone it (Rose, Int 2: p. 12).

Whereas there is some evidence to suggest regular, low intensity exercise can benefit the immune system, there is considerable evidence linking high intensity exercise with adverse effects for immune functioning (Newsholme & Parry-Billings, 1994; Ross & Cowley, 1997). The hazards of being physically active are rarely discussed, even though Becker (1993) contends that exercise causes thousands of people to be injured, or suffer ill effects. Of the ten participants in this study, four have experienced injuries, including shin splints, and a knee injury. Rose's experience described above could be considered the most debilitating, and yet neither Rose nor any participant would consider ceasing their physical activity. These women are well aware of the downside of being active, have considered their options, and have chosen to continue.

Rose and Wanda, like most of these participants, have no difficulty maintaining their physical activity, but for many women the situation is entirely different. As has been indicated throughout this study, maintaining exercise over time can be problematic. According to Wankel (1993) over 50% of people who commence exercise will lapse before achieving their goals. Leaving aside for the moment the constraints and conflicts which impact on women exercising, the analysis will continue by considering how and why this particular group of women adhere to physical activity.

5.3.5 Maintaining exercise

The difference between adopting and maintaining exercise appears to be as poorly understood as is the process of adherence over time (Klonoff, Annechild & Landrine, 1994; Marcus, Rakowski & Rossi, 1992; Pinto et al., 1996). Reasons offered for lack of adherence include, but are not limited to, injury, lack of time, poor health, no one to exercise with, age, and embarrassment, with these perceived constraints affecting both women and men. Cognitive barriers such as attitudes and beliefs also influence everyone, but especially women, who, Pinto et al. suggest, may be particularly affected

by societal expectations. My focus at this time will be the positive rather than the negative aspects of maintaining physical activity for these participants.

Disease prevention and enhanced well-being provides the impetus for the majority of these women to continue with their physical activity. Not only do all the participants associate physical activity with leisure, they mostly enjoy their preferred activity. For Harriett, choosing an activity she enjoys is the secret to her adherence. Whereas Ruth, Wanda and Alice relish the time they have to themselves and value this time to solve problems, other participants, such as Dianne, enjoy time alone for some activities, although preferring company for others. Activities such as walking and tramping are seen by Dianne, Harriett and Alice as opportunities to be socially interactive. Wankel (1993) believes that although health goals are significant in maintenance, non-health related goals, such as social interaction, may be just as important, particularly for women. There is an element of social interaction within this group of women, with it being most important for Harriett:

> H: It's nice to have the interaction with people....I've got people who always want to come out with me...so I'll always take a friend, we'll go. M [husband] doesn't come much on the tramping...but we go walking... that's part of it, the social part of sport (Harriett, Int 1: p. 15).

For at least half of this group, however, social interaction is not sought after. Enjoyment, time to oneself, feeling relaxed, escaping domestic issues, and heightened well-being are more relevant and important, as identified by Ann:

> A: Um, just the, the feel, the feel good....Because I feel good, and I can see the results....Just that driving thing that I believe that it's for life, yeah (Ann, Int 2: p. 6).

The context and uniqueness of each woman's experience is as apparent in maintenance as it is in the acquisition of and involvement in physical activity. One commonality among all participants, however, is that their involvement in their chosen activity is on their terms, an idea Vertinsky (1998) believes can energize even the most resistant.

From a purely biological but also populist perspective, Klonoff et al. (1994) indicate that maintenance of exercise may also be related to feelings of well-being, equated with perceived rise in endorphin levels. Again, the literature is equivocal, with amounts and intensity of exercise uncertain in this equation. Certainly the positive feelings related to exercise are frequently attributed to endorphins. Rose is convinced endorphins have a positive affect for her at different levels:

> R: You get hooked into this thing, you need to do it, and I'm completely convinced it's these endorphins...I had this virus again recently and I had problems with arm joints again and it was particularly bad down in Wanaka [on holiday] because I think when I was running, and swimming, and cycling, I was giving my body some natural pain killers with the endorphins....They do kick in very well. And I'm flying high then....I'm invincible. And I've got this silly grin on my face usually, and yes, I'm probably thinking I'm not doing nine minute miles, you know, I'm doing five minute miles (Rose, Int 1: p. 50).

Whilst all participants were eager to maintain their activity, I was surprised to find the life changes that occurred to influence this commitment. At my final visit, approximately six months after the first interview, three of the participants had stopped exercising. One woman had injured her back, one had undergone surgery, and a third was pregnant. These disruptions can be seen as the everyday reality of many woman's lives, which Vertinsky (1998) believes are invariably disassociated from health professionals prescribing physical activity.

Maintaining activity therefore appears to be as complex as other aspects of physical activity. Although enjoyment is an important aspect, social and situational influences can very easily affect one's ability to adhere to exercise over time. Whilst each participant was keen to adhere to exercise, it appears that the context in which they choose to be active may be problematic. Is it in fact necessary to maintain exercise at a continuous level? Are society's physical activity levels more idealistic than realistic? These ten women intend to continue being physically active over time, possibly not consistently, but at a level with which they are comfortable.

However, through personal and professional experience I have found that some midlife women, particularly, do not view exercise as an important part of life, and choose not to indulge in any activity. Leith and Shaw (1997) found that some women disliked being physically active and preferred to be inactive, although they believe very few women are entirely inactive. Similarly C. Lee (1993) found that midlife women may consider other health-related activities, such as diet and rest, to be more important than exercise. As I mentioned before, measuring levels of activity for women has frequently neglected domestic activity. The way people make sense of their health is very much within the context of what they consider to be a healthy lifestyle.

5.3.6 Healthy lifestyles

Backett, Davison, and Mullen (1994, p. 277) view a healthy lifestyle as "a somewhat amorphous concept" based on three areas of personal behaviour: physical activity, nutrition, and avoidance of drugs, namely cigarettes and alcohol. These three can be recognized as the main elements of the medical disease prevention discourse of health promotion. Although this may be the dominant discourse related to health, Backett et al. found that, from a lay perspective, being healthy involved far more than physiological ideas. Emotional, social, spiritual, and moral terms were also considered. Argyle (1997) supports this notion and believes happiness and positive moods strongly influence health. Lay thinking needs to be valued as one of the components that influence the development of a particular lifestyle. For both Marnie and Ann, exercise has been very much part of their lifestyle:

> M: I would say that it's [exercise] ah...for instance, yoga is such a part of me that it is my everyday life, that is part of my living. It's just ingrained in me (Marnie, Int 1: p. 13).

> A: I used to swim when I was at Varsity. When I got to Queenstown I played squash for a while and I got really busy at work and let everything go and that was just existing to work until one day I'd had enough and decided that I needed to really look after myself; life was for living, and so I started running just to get, so I could have time on my own where they couldn't get me at work (Ann, Int 1: p. 14).

For Alice, a health professional herself, she has what she sees as the added burden of trying to practice what she preaches:

> Al: I don't feel bad about myself now, but I don't feel very good physically, you know. I find it very difficult to give patients lots of advice about diet and exercise and I was thinking...practise what you preach (Alice, Int 2: p. 6).

The healthy lifestyle we are all constantly urged to adopt is offered as the antidote to the many problems of modern living (Drew & Paradice, 1996; Peterson & Lupton, 1996). These authors are, however, concerned about the uncritical acceptance of what constitutes a healthy lifestyle, and the tenets of the dominant discourse of health promotion, which focus on individual lifestyle behaviours. There is a gradual awareness that there is more to being healthy than taking exercise, eating low fat food, and not smoking or drinking to excess. Watson, Cunningham-Burley, Watson, and Milburn (1996) suggest that the emphasis on individual behaviours and lifestyle determining health outcomes is based on two assumptions. The first assumption is that each of us can strongly influence our personal decisions regarding our lifestyle behaviours. The

second is that lifestyle changes we make will significantly affect our health. These suppositions have no regard for the social, economic, and cultural determinants of health so frequently ignored in the dominant medical discourse. Thomas (1997) believes that when examining health issues, particularly for women, it is necessary to look beyond the medical and specifically towards social roles.

5.3.7 Social roles

As I read through the interview material it was readily apparent that social roles influence each woman's life on a daily basis. Social roles are constituted from the expectations of, and frequently for the benefit of, a society which privileges the masculine over the feminine. Throughout the last century, the primary roles for women have been worker, wife, and mother, all of which were identified by these participants (Bialeschki & Michener, 1994; Thomas, 1997). The dominant, and some would argue conservative, discourse of femininity constituting women's central role as in the home, intersects with many discursive fields including education, medicine, the church, and powerful others (Weedon, 1997).

Of all the roles women enact, Thomas (1997) found that motherhood, for those who embraced it, was socially deemed the most important. From a postmodern, feminist perspective, motherhood, like gender, cannot be seen as a fixed category, but rather as contradictory and complex. The performance of motherhood, like all gender roles, is not only part of our subjectivity, but it also intersects with socio-economic status, age, ethnicity, and culture. The manner in which each woman embraces motherhood remains subject to a range of available discourses present at a particular time.

For contemporary women, the roles of worker, wife, and mother are frequently performed simultaneously, and incorporating physical activity into an already busy life, could be difficult, if not impossible. Interestingly, Drew and Paradice (1996, p. 563) believe the healthy lifestyle message prevalent today is aimed at "the young, able-bodied and childless", and is therefore unrealistic for women with children. Verhoef and Love (1992) support this idea, as their study found mothers exercised less than childless

women. Despite such obstacles, Wanda and Rose managed to persevere with their exercise, as they demonstrate in these two excerpts:

> R: I used to do a six mile run once a week and it would be on a Sunday morning, and what I'd do is I'd get all the dinner prepared, put it in the oven, and then I'd don my shorts and stuff and out I'd go, and I knew I had exactly an hour to get this run done in and have to be back so I could finish off the dinner so that we could have it Sunday (Rose, Int 1: p.11).

Although Wanda had returned to the workforce, she had not discarded, but rearranged her multiple roles:

> W: And I felt I needed a break between home and work but what I did, I would come home and get tea ready and dish it up for everyone and while they were having their tea I would go back to the gym and do my workout...then come home, have my meal and then read to the children (Wanda, Int 1: p. 4).

Gender-role expectations in relation to motherhood appear to change very little over the lifespan, and can be restrictive for women in all aspects of their life (Bialeschki & Michener, 1994). The populist anecdotal metaphor "empty nest syndrome", supposedly once the affliction of midlife women, appears to be a relic of the past, or is it? As women reach midlife other demands appear such as elderly parents, returning adult children, and grandchildren. Thomas (1995, p. 293) uses the term "sandwich generation" when referring to contemporary midlife women, as she sees them as caught between generations. There appears to be an expectation that women will keep deferring their needs for those of others as long as there is a demand. Harriett's adult daughter and two preschool aged children spend a considerable amount of time with Harriett and her husband, which affects the time Harriett has to herself, as she explains:

> H: We share the responsibilities of cooking the meals, like he [husband] had the meal cooked tonight....When my daughter comes...it's a bit different because he doesn't cook much then so a lot of the responsibility goes back on me....So when she's here I wouldn't go out and do things as much (Harriett, Int 1: p. 10).

Sacrificing their time for the family is frequently disguised by what Bialeschki and Michener (1994) refer to an ethic of care. This ethic finds resonance with virtues commonly associated with women, such as empathy, caring, nurturing, and connectedness (Rogers & Niven, 1996). While the ethic of care may be an estimable ideal it can be problematic for women in that it is often invisible and rarely appreciated within a male dominated society. Doyal (1995) suggests that the present reality of many women's lives bears little resemblance to the idealised notion of the female nurturer. Yet, there remains an expectation that women, especially midlife women, still belong in the private world of domesticity. This expectation is hinted at by Dianne, who comments:

> D: Going off and doing exercise would be very much a last priority, but that's just my own fault really...I mean if tea was late, B's not going to come and say how dare you, or anything like that (Dianne, Int 1: p. 10).

Whilst the ethic of care could be seen to constrain women in families, it could also be seen as an entitlement, as the ethic of care could be extended to oneself (Bialeschki & Michener, 1994). It could also be recognised as providing a means of resistance in lives restricted by matrimony and motherhood. Although resistance may be momentary and fleeting, it offers an opportunity for women to gain a different sense of self; one that is not constrained by socially constructed gender roles (Freysinger & Flannery, 1992).

The final excerpt related to women's social roles is provided by Wanda, who enjoys attending the gym regardless of what she thinks about society's construction of women at midlife. It is possible to see Wanda's attendance at the gym as a form of resistance to the gendered role expectation for midlife women (Wearing, 1995).

> W: The general conception is middle aged women shouldn't be doing this...they don't go to the gym and don't make time for themselves. Their role has been at home and look after the family and be there for the family. I think the role is changing (Wanda, Int 2: p. 8).

Social roles may be changing, and age becoming increasingly irrelevant. However, gender role expectations for women at midlife continue to impose subtle and not so subtle constraints on being physically active. The power inherent in the conservative family discourse is readily apparent in the ubiquitous women's magazines, which urge women, as mothers and wives, not only to make the most of oppressive structures of family life, but also encourage women to oblige their families before themselves and their lives (Weedon, 1997).

Having discussed physical activity from childhood until midlife as well as the influence of social roles, in the next section I will analyse some of the constraints and barriers these women confronted.

5.4 Constraints and conflicts

While discussing these women's participation in exercise over their lifetime, it became obvious that various constraints and conflicts were influential at each life stage. Although some of these constraints are relevant for men as well as women, for example, time and financial barriers, the focus here will remain with this group of women.

Brehm and Iannotta (1998) suggest that there are many barriers in society; however, as some of the excerpts will show, some of these women are not readily restrained by such barriers. The contextual interweaving of physical activity in all aspects of women's lives endures. Rose provides germane insight into the political, social, and economic constraints she confronted as a young mother:

> R: During the first few years of J's life....there was the pressure of being a mum, and the responsibility of needing to be there.... We were very much involved in setting up house and just bringing in enough money to be able to survive because that period in England...Maggie Thatcher was in power...the interest rates on mortgages were enormously high...we both had full-time and part-time jobs....I didn't have the energy either...the ability almost to say I want time for myself....Yeah...that was a time when sport really dropped off for me, and it only started when he [child] started going to school (Rose, Int 1: p. 7).

This excerpt illustrated not only the barriers Rose confronted to being physically active, but also how entwined these constraints can be with the social determinants of health. Vertinsky's (1998) assertion that health gains are more likely to be achieved by reducing social inequality than providing medical care offers a powerful incentive for nurses to identify gender constraints which prevent women from benefiting from being physically active. Whilst some nurses' practice may be inclusive of social determinants, many still practice within the confines of the bio-medical model in which such determinants are habitually neglected.

Constraints can be identified as interpersonal, intrapersonal, or structural, although as with most notions regarding physical activity, constraints are rarely exclusive or clear-cut, but interwoven with each other and the daily reality of life (Leith & Shaw, 1997).

Despite the interweaving nature, and for ease of understanding, I have chosen to discuss these constraints separately in some instances.

5.4.1 Time, work, and family constraints

Time, the concept increasingly elusive in a rapid-paced society, was the most frequently cited barrier in the literature (Booth, Bauman, Owen, & Gore, 1997; Ebrahim & Rowland, 1996). The participants were no exception to these findings, whether in the workplace or at home, with time being seen as a constraint at all levels. Wanda provides an example of a structural constraint: lack of time at work.

> W: Um yeah, work I see as a barrier when I have no control over how long a meeting's going to take...and it gets past twelve o'clock and I'm thinking I'm going to miss the gym and I'm so frustrated (Wanda, Int 1: p. 15).

Drew and Paradice (1996, p. 564) suggest that women can experience time "as a constant pressure", and for those who go out to work, there can be a sense of time belonging to the employer. Although women take work home to complete in the evenings and weekends, some appear to have difficulty having a break during the working day. Wanda, however had no such qualms:

> W: If they start getting off the subject and meandering it becomes a meeting for the sake of meeting...and it's got past twelve o'clock and I think I'm going to miss the gym, I'm so frustrated, I have got up and walked out of a meeting and said excuse me, I have an appointment, I must go (Wanda, Int 1: p.15).

Tessa and Marnie talk about their experience with time at both an interpersonal and an intrapersonal level, each talking about the different approaches she could use:

> T: It's finding the time I think. It's actually getting out the door. I find if I say to myself, I've got to go for a run today, the best thing to do is actually to get up in the morning and put my running shoes on....I suppose I could go in the evening...you can always, if you're really keen you'll make the time (Tessa, Int 1: p. 12).

Nies et al. (1998) found that women without a regular exercise pattern, or who didn't set aside a time for their exercise, were more likely to overlook exercise. This could be perceived as intrapersonal, of not wanting to give time to be physically active. Although Marnie and Tessa both find they have inadequate time, Marnie works out creative ways to ensure her teenage children are not a barrier:

> M: Time, yes, there are ways around that...I mean, I can nip out on my bike when it suits, like the kids being teenagers sleep till eleven thirty, so I get up early (Marnie, Int 1: p. 15).

Tessa, however, had difficulty with this, as her children are younger and she felt she was still at the stage where personal needs are neglected until when, and if, time becomes available:

> T: It's very hard; there's always so many other priorities. You know, if you have a spare moment from the children you've got a list of ten other things that are just as, well, probably more important really....Sometimes I feel like other things should take priority and that you shouldn't sort of...take that time to do it I suppose (Tessa, Int 1: p. 12).

Whereas Tessa has preschool children who constrain her activity, Harriett's children are all adults. This appears to be no guarantee that family responsibilities are over, as this excerpt demonstrates:

H: I think one of the barriers is when my daughter comes and I've just got to, I'm just, I cope with that. Because sometimes she'll say, I want you to stay home Mum, or look, can you do this, and I'll do it (Harriett, Int 1: p. 15).

The nexus of family needs and time is clearly evident in these responses and is well supported in the literature (Booth et al., 1997; Pinto et al., 1996; Shaw, 1994). As family obligations decrease, the converse should apply regarding time and responsibility. However, changing societal expectations, for example, tertiary education and living standards can find adult children remaining dependent considerably longer than their counterparts of the 60s, and 70s. Children of all ages can also impact on purchasing power and economic situations.

5.4.2 Financial constraints

Financial issues were not a concern for all participants, although there was acknowledgement amongst these women that in differing financial circumstances this could be so. Overall, women earn less than men and this can limit women's choice of activity (Pinto et al., 1996). Having said that, there are many physical activities which cost very little, for example, walking, gardening, and tramping. Although Chloe enjoyed working out at the gym, she was unable to continue:

C: But then my membership ran out and I couldn't afford to renew it...if I'd taken up another membership, if you don't feel like doing it then you're still paying for it and I think it's quite expensive really.

J: So you chose not to renew it?

C: Well, I couldn't afford to. It's not a matter of not choosing to, I couldn't even manage the minimum amount they said I could pay per week (Chloe, Int 1: p. 6).

As Marnie's marital status altered, so did her financial situation. Marnie, however, demonstrates her resilience to her altered circumstances:

> J: You mentioned the possibility that you may not be able to afford to go to Bushwise Women? That's not something you've considered before?
> M: Well, no, my husband has a good salary..that means that I could've potentially done a whole lot of stuff, but the constraints were his...even though I had the wherewithal I was unable to do it....Now I have the freedom but probably not the money. Isn't it ironic? However, there are ways around these things. Exercise doesn't have to cost (Marnie, Int 1: p. 15).

The general consensus amongst this group of women was that physical activity did not have to involve financial expense, and it is the message the Hillary Commission (1994) and the National Health Committee (1998) are eager to promulgate.

5.4.3 Guilt

Whereas the constraints already discussed could be relevant for both women and men, feelings of guilt and conflict are more commonly the domain of women. Three of the participants talked about these feelings which can be associated with a lack of a sense of entitlement or a right to leisure, of which exercise may be a part (Henderson & Bialeschki, 1991). An excerpt from Alice hints at entitlement as well as exposing again the intertwined nature of exercise constraints:

> Al: Time is the biggest one, and also guilt about working, having the children. I mean, I really like working...but part of me thinks I should be here all the time for the children....But I do feel guilty when I'm late and I know J's expecting a breastfeed....I know what I would feel if I then said, well, I'm

> off to the gym now....I just don't think I could do that to...I would feel too guilty doing that (Alice, Int 1: p. 29).

As well as illustrating emotional barriers, Alice is seen to be juggling multiple roles, as are many contemporary women. Interestingly, Drew and Paradice (1996) suggest that the guilt that working mothers experience may involve "owing" children time. It would appear that some women in these circumstances have very little time to call their own. Alice and Marnie demonstrate the ambivalence women can experience when they are unable to take time for themselves:

> Al: But now if I don't exercise I just feel guilty. I don't feel physically anything apart from a real feeling more that I'm becoming more and more slobbish....there's part of me that thinks, oh you know I could so easily do this (Alice, Int 1: p. 31).

And Marnie recognises the conflicts she has dealt with:

> M: I used to be a real guilt sponge for just about everything you could think of and I've worked very hard on that....so when I say no, I don't feel guilty about exercising, I always put most other things first. And I get very frustrated if I don't have time left to do my exercise (Marnie, Int 2: p. 4).

It comes as no surprise to learn, then, that motherhood can cause the strongest feelings of conflict and guilt. This has been identified in studies as one of the most significant constraints to participating in exercise (Evans & Nies, 1997; Verhoef & Love, 1992). Although these participants identified as midlife, the role of parenthood was continuing to influence some participants' levels of physical activity.

There are other constraints and barriers midlife women confront in relation to being physically active, such as a lack of suitable exercise facilities, health issues, and psychosocial constraints such as a dearth of role models, and peer norms (Pinto et al., 1996). However, these were not overt issues for this group of women.

5.5 Conclusion

Each woman participated in some form of physical activity as a child and adolescent and they were all aware of their family's beliefs and attitudes towards being physically active. The trend of declining activity at adolescence, discussed in the literature, was evident in this study; however, by midlife all had returned to physical activity in a variety of ways. Each woman's social roles have influenced her ability to be active at different times, with the role of motherhood appearing to be the strongest.

The ideology of maintaining physical activity was strong within this group of women. In support of these beliefs, a number of motivators were identified such as enjoyment, social interaction, time to oneself, and remaining fit and healthy. Although this group of women were keen to maintain exercise over time, life events have interfered with good intentions. What appears to make maintenance problematic is the social context of these women's lives.

Time, family, and financial barriers were relevant for this group of women, with all constraints interrelated and linked to gender roles. The complex and, at times, contradictory feelings related to being physically active were also shown to intertwine with other barriers. Whilst the description and discussion of the findings throughout chapter 4 and 5 is pertinent to the ten women participating in this study, the literature has indicated that many of these findings are not limited to this small group of women.

In the following and final chapter I return to the theoretical assumptions underpinning this thesis to discuss these findings. As physical activity is purported to be a health-

promoting behaviour, I shall also interrogate the discourses of health promotion identified in this project.

CHAPTER SIX: Discussion and concluding statements

6.1 Introduction

In the two previous chapters, dimensions of the four emergent themes were analysed and discussed, with comparisons being made to the extant literature. Working through this process, I was constantly aware of Burnard's (1995) words, "it is impossible to read text without also interpreting it" (p. 241). This analysis, then, was my interpretation of the interview material gathered. This is not to suggest that a different perspective is not possible, as readers may well draw additional or alternative findings and meanings.

This, the final chapter, will discuss what has emerged from the research findings and consider the implications for nursing practice. The limitations of this study will be identified, as will the possibilities for future nursing research into this challenging and little understood field of human behaviour. In line with a postmodern perspective, no definitive answers are forthcoming. This favours reflexivity and a rigorous and ongoing questioning of text without conclusion (Grbich, 1999).

6.2 The aim revisited

Before considering the findings, it would be useful for a moment to revisit the aim of this study. I chose to explore the complex factors that have influenced a group of ten women to maintain exercise over a sustained period of time. I also identified physical activity as a health-promoting behaviour, and was interested to explore how physical activity was constituted as such within current health promotion discourses. The findings of the study, therefore, will be discussed within the discourses taken up by this group of women.

6.3 Health promotion discourses

The current discourses of physical activity as a health-promoting behaviour identified by these participants were disease prevention, health and well-being, and the "body beautiful". These competing discourses provided this group of midlife women with differing ways in which to understand themselves and their world in relation to being physically active. The location each woman took up within these discourses was very much dependent on the contextual reality of each one's life at a specific time. Before considering the other various discourses taken up, I will revisit the dominant discourse of medicine.

Within a postmodern perspective, health promotion discourses are seen as being socially and culturally constructed, with "their practices, justifications and logic subject to change based on political, economic and other social imperatives" (Lupton, 1997b, p. 4). These discursive practices may be constantly changing; however, they continue to be pervaded and dominated by medicine. Epidemiological and scientific knowledge continue to be viewed as the "truth", while the social context of women's lives are frequently neglected. Statistics present people as homogeneous social groups with little regard to inherent multiple differences, a point highlighted by Lupton (1998). She considers that "Social groups are not discrete or mutually exclusive entities but overlap with each other, involving multiple membership" (p. 4). Whilst all participants identified as midlife women whose intent was to exercise regularly, the contextual reality of each woman's life demonstrates the heterogeneity of this group.

The intertwined nature of knowledge emanating from both the modernist and postmodernist periods is also apparent in discourses of health promotion. Whilst Western society is becoming increasingly secular, the moral enterprise inherent in modernity endures in health. The negative feelings that the majority of women identified when not exercising compared to the positive feelings that arose from being

physically active could be aligned to the moral imperative. Words describing the lack of activity included *slothfulness, guilty, lazy, heavy*, and *sluggish.*

Peterson and Lupton (1996) suggest many health promotion activities urge lifestyle changes, calling on the values of the Protestant ethic, in that self-discipline and hard work will reap rewards. Blane, Brunner, and Wilkinson (1996, p. 7) also identify what they consider to be "a strong resonance with traditional morality", with the focus being anti-drugs and alcohol, indolence and gluttony.

The binary opposition good/bad was noted throughout, with good health and fitness an imperative for all participants, while feelings of being bad were articulated by one participant when she was not exercising. Other binary oppositions relating to physical activity identified in the study included healthy/unhealthy, active/passive, masculine/feminine, and real/artificial (Lupton (1997b). For example, one participant felt going to the gym was artificial and preferred her physical activity to be part of her everyday life, such as walking and biking to and from the shops. In each of these dichotomies, primacy was given to the first word, with health being valued above all others. This moralistic stance pervading health could emerge, in part, from the role medicine has played and continues to play in social control.

The knowledge/power nexus alluded to earlier becomes relevant here as Symonds (1998), drawing on Foucault, believes that where there is power, there is resistance. It could be argued that the interests of the powerful, in this case, medicine, are being met by the current discourses of health promotion. Choosing to ignore health-promoting messages, therefore, could be seen as one way of resisting authority in an environment where power is frequently perceived to be held by health professionals. Wearing (1995) believed that Foucault urged people, "as a form of resistance, not to be confined by discourses....he encouraged individuals to refuse what they are told they should be and to reach towards what they could be" (p. 272). Whilst Foucault himself did not translate resistance from the abstract to everyday life, resistances can be understood in differing ways. Resistances may be spontaneous, solitary, uniform, conscious or unconscious, or

a combination thereof (Wearing). With these ideas in mind, the discourses of physical activity as a health-promoting behaviour identified by the participants, and the possible resistance to these discourses, will be considered. Although I will discuss each discourse separately, in reality they are interrelated and constantly changing.

6.3.1 Disease prevention discourse

The discourse of disease prevention emphasises lifestyle theory and focuses on the identified risk behaviours such as physical inactivity, smoking, and high-fat diet, which are frequently linked to chronic disease, such as cardiovascular disease and diabetes. The concept of risk is now the leading model in constructing responses to disease, and Davison, Frankel, and Smith (1992) suggest this model has a tendency to label as pathogenic behaviours considered normal, for example, lying around and eating fish and chips. The moralistic stance alluded to above is also identified by these authors, who see this discourse as "the triumph of self control over self indulgence" (p. 657). Success in self control was alluded to in a variety of ways by all participants, and included improved self esteem and body image, weight loss, physical fitness, and ability to overcome physical and psychological problems.

The majority of the women saw exercise as a disease preventative measure and exercise was one of several lifestyle behaviours exhibited, alongside not smoking, not drinking excessively, and avoiding a high-fat diet. Within this small group, almost half were aware of a familial history of cardiovascular disease, and saw exercise as a preventative measure. Concern was also expressed about raised blood pressure and cholesterol levels, and most of the women were aware of the currently (presumed) link between osteoporosis and exercise. Although research findings remain inconclusive regarding this link, the general thinking amongst the participants was acceptance of the legitimacy of exercise providing positive benefits.

The attractiveness of this politically and medically sanctioned disease prevention discourse is apparent, as few resources are required and the responsibility for personal health remains firmly with the individual. All the participants were not only eager to

have a healthy lifestyle, but they also saw themselves as personally responsible for this, with this being explicitly linked to being physically active. This is not unexpected, as most were aware of the pressure exerted both overtly and covertly through the mass media and the Hillary Commission. Conduits such as these, as well as medicine, continue to construct and reconstruct the disease prevention discourse by defining health risks, and then urging people to be physically active in what they portray as an increasingly sedentary society.

However, viewing individual health issues as essentially intrinsic is problematic for many. Becker (1993) and Caraher (1994) believe this ideology not only victimizes the person and absolves the health professional from any responsibility, but fails to acknowledge the social context in which people live. Williams and Calnan (1996), who believe there is a growing skepticism regarding the risk factor and lifestyle approach to promoting health, agree. They argue that "The perception of what constitutes a 'risk' is intimately bound up with people's cultural beliefs, moral values, personal feelings and the social and material circumstances of their lives" (p. 1614). This was clearly evident in the unique, constantly changing situations for these women. Their understanding of being healthy was very much inclusive of their social roles and their current life situation.

Resistance was not apparent amongst these participants, which is not suprising considering the dominance and official sanction given to this discourse. Being healthy was extremely important to all these women and they were prepared to be proactive in this endeavor. They could be seen as "good and self regulating subjects", whom Lupton (1997b, p. 131) suggests are " 'health' conscious, middle-class, rational, civilized", the very people who are privileged within this discourse. Subjects such as these have affinity with health promotion messages in New Zealand, which not only focus on the individual preventing disease, but also have a tendency towards regulating lifestyles. Whilst successful for many people, these messages can become problematic for those who do not possess the material means, cultural capital, or the desire to embrace such messages (Lupton). Again, the contextual reality of people's lives is missing. For

example, on the one hand health promotion messages urge self discipline and surveillance, while on the other fast food advertising and weight reduction diets are set to seduce the most reluctant.

What becomes evident is the fundamental existential nature of health to our subjectivity. This may in some way explain Foucault's relational concept of power and the social control medicine has. Foucault (1973) believed that our understanding of health and illness is predicated on wider historical and power relations, and he saw the body as being constituted by "the clinical gaze" (p. 118). Within disease prevention discourse, "the clinical gaze" incorporates surveillance, which can have every aspect of life scrutinised for risk behaviours. From this perspective the moral imperative of health becomes transparent, as does the hegemonic power of medicine. Surveillance, including self-surveillance, does not stop at this discourse.

6.3.2 Health and well-being discourse

Health and well-being were constant themes throughout the study, with being healthy and fit at midlife valued by all participants. One commented that having all the money in the world was of little use without being healthy. This finding is similar to that of Lutter et al. (1998), who found that the greatest motivator for active women (a descriptor fitting these women) was well-being. In this study these authors state that the expected outcomes of physical activity were, in descending order of importance, "improved fitness and muscle tone, enhanced psychological and spiritual balance, improved body image, weight control, fun, and resistance to illness" (p. 81). These concepts were amongst those identified by the participants of this study, although in varying order of importance.

All participants, particularly in relation to problem solving both at work and at home, considered psychological well-being important. Physical activity was seen as most helpful in taking time for oneself, to clear the mind, and to work through issues. A spiritual component was alluded to as the "good to be alive" feeling, associated with

walking in the hills, tramping, or just enjoying the countryside. Although there was an element of needing to do exercise to remain healthy, or in Rose's situation for training, all the participants enjoyed being physically active and saw it as part of their leisure time. Walking was an activity many participants enjoyed, not only for the activity, but also for the social interaction which often accompanied it. This finding supports the Hillary Commission's (1999) latest Sport and Physical activity survey, which found walking the number one physical activity for adults, with 80% of women choosing this activity.

Another consistent and notable theme was the desire to be fit and healthy into old age; to be able to be active and to enjoy retirement and the later years. The words "use it or lose it" featured more than once during the interviews. There was the feeling that being active now would help to ensure good health in later years. Being inactive in old age appeared implicitly to be related to being unhealthy, a state these participants rejected. The current discourses of aging, which tend to devalue older people and focus on the decline of physical and mental abilities and activities, may explain these negative connotations (Wearing, 1995).

The social and cultural construction of aging in Western society, particularly for women, has not portrayed a positive image. Frequently, the elderly are not seen for their wisdom, but for their failing health and the inevitable burden that they may become. Linking old age to ill-health emphasises again the importance Western society places on youthfulness and good health. The process of aging can also be seen as a reminder to all that youthfulness does not last for ever, even for the most vigilant (Knapman, 1996).

Health and well-being at midlife for these participants was as diverse as the women themselves. It has been that time of life which has been associated with the anecdotal and somewhat dreaded "midlife crisis"; a time when traditionally one reviews what life has offered, the opportunities taken and those that may be ahead. For these women, midlife is very different to how they remembered their mothers at a similar life-stage. Whereas midlife women of the 1950s and 1960s were mostly confined within specific

gender roles inevitably related to domesticity and family responsibilities, the participants in this study did not regard midlife in the same light. Family responsibilities remain central for many; however, working outside the home and leading independent lives were also evident. Movement within the confines of a gendered society and second wave feminism can be seen to have contributed to these changes.

Lupton (1997b) believes health is seen as an imperative within our society, with the concept of "healthism", the goal of being healthy above all others, being very much a part of the health and well-being discourse. Like the disease prevention discourse the moralistic theme reappears in this discourse, with a moral obligation to health maintenance replacing religious virtue ("Slimmers seek", 1999). Disease prevention and being healthy have similar dimensions, with poor health being viewed as distasteful, and behaviours such as smoking and inactivity being frowned upon. Health remains a personal responsibility within this discourse, which is not necessarily problematic. It becomes so when those who choose not to align themselves with the current health discourse become labeled in derogatory terms, such as "lazy" or "fat" (Peterson & Lupton (1996).

Whilst resistance to this discourse was not obvious for the majority of participants, one woman questioned the perceived pressure to be constantly doing things for self improvement and well-being. She wondered what was wrong with "just being". She was, however, keen to remain healthy, and could be seen to be negotiating rather than resisting this discourse. I would argue that these women resist, negotiate, and take up health-promoting discourses both consciously and unconsciously as they see fit, within the context of their constantly changing lives (Lupton, 1997b).

Personal responsibility has been a recurring theme throughout these two discourses. Such an expectation is reinforced within an individualistic, competitive ideology where healthy lifestyles are considered important. It also demonstrates the embeddedness of these health discourses in society at this time. In the following discourse, the "body beautiful", this responsibility appears to be taken to extremes, and can be seen as the

most problematic for midlife women, living in a society where youthfulness, slimness, and beauty are applauded.

6.3.3 The "body beautiful"

The body image, self esteem, weight control, and physical activity nexus was evident throughout the interviews. Resistance to this discourse could be difficult, as all participants were interested in looking and feeling good. Although not problematic in itself, it is the dissatisfaction with the body that this discourse may engender which raises concerns. Advertising for gyms in the populist media tend to focus on a "newer, slimmer you". Exercise is portrayed as the healthy way to lose or maintain body weight. A photograph of a slim, attractive young woman, holding a very large garment commonly accompanies such advertising, the implicit message being, you too can lose this amount of weight and look like this. It appears body fat is seen not only as a moral failing, but also as insufficient self monitoring of the unruly body. Moral obligation reappears once again, with a recent study showing that women who exercised were more concerned with being slim than with being healthy ("Slimmers seek", 1999). Anecdotally this idea has been acknowledged by staff as representing the views of many women attending a local gym.

Lutter et al. (1998) found that the greatest motivator for inactive women was weight loss, which comes as no surprise considering the present societal obsession with appearance and the body. This is epitomised by the media itself. Television legitimizes the womanly ideal of slimness, as male presenters can have a jowl or two and a spreading waistline, whereas female presenters are, on the whole, slim, young and attractive (McLeod, 1999). This not only legitimises, but constructs and reconstructs a discourse which ignores the reality of many women's lives. This role of "woman" enacted through the "body beautiful" appears to be constituted through discourse and social structure.

Certainly, in the present study, all participants were conscious of their weight. Most believed physical activity was helpful in controlling weight, although none exercised

solely for weight loss. Harriett explicitly stated weight control was the main reason she exercised; however, disease prevention and social interaction were also important reasons for her. Like the majority of participants, she had a multiplicity of reasons for being physically active. The complexity of being physically active was magnified within this very powerful discourse. Participants manifested contradictory feelings, vacillating between being healthy and looking good, and hopefully achieving both. Many spoke of the frustration inherent in media pressure which they cannot escape; the idealistic body shape, the toned and honed body, slimming regimes which appear to offer success, and definitions of health related to being slender, young, and attractive.

Problematising this discourse illuminates the social, economic, and cultural factors which strongly influence women's thinking, and which tends to be overlooked. Although these women have located themselves either consciously or unconsciously within this discourse, their embodied experience of physical activity is inclusive of the reality of their lives; of families, children, work, and relationships. Their locatedness, like their subjectivity, is not fixed, but subject to change and negotiation. Resistance does occur. Some participants not only identified the market driven ideology behind much of the alluring advertising, but were also aware of the societal pressures midlife women confront on a daily basis. Marnie demonstrated resistance as she spoke of how comfortable she was with her body, while acknowledging physical changes related to age.

Our understanding of the body in relation to health has been profoundly influenced by the medical culture, in which it is frequently seen as a physiological object in isolation from the social context (Parker, 1995). From a postmodern perspective, however, embodiment is very much part of the discursively produced subject. The concept of human embodiment, "how bodies are in the world" (Watson et al., 1996, p. 171), has not yet been accepted within health promotion discourses, although the body has certainly been debated within certain social sciences, such as sociology and anthropology. Foucault's work has also interrogated the idea of the human body as inscribed by discourse: so much so that Lupton (1997b) suggests that "discourses and

practices around the promotion of health have been central to constituting the contemporary human body" (p. 6). Certainly in the three discourses discussed, particularly the present one, notions of control, self-discipline, and self-surveillance in relation to the body are discernible. Health promotion from this perspective can be seen as a form of social control, of promoting certain behaviours deemed necessary for a healthy body – a valued possession in a secular society. This may be a truism within the medical discourse, but what of the lay perspective?

6.3.4 The lay discourse

It could be argued that all the material gathered in this study provided a lay perspective of being physically active. It is my interpretation of that perspective, and I have situated the ideas and notions that have arisen into these three current discourses. What I will do now is consider briefly the lay perspective of health in the context of physical activity, which is becoming more strident through the social sciences literature.

A lay perspective offers an understanding of how people define, understand, and make sense of being healthy within the social and cultural context. Until recently the lay person has been invisible in the health genre and this has mostly necessitated a passive approach when confronted with health experts (Bury, 1998). Davison et al. (1992) believe that most people are well aware of the official health promotion message; however, for many this message is immaterial and mostly out of step with popular culture. Although most people acknowledge the effect personal behaviours have on health, these behaviours are not seen as irrational, as some health professionals would view it, but only as part of a wider personal and social context. Health promotion discourses do not predicate the causes of disease, such as heart disease, as confusing and haphazard, but as being certain and relatively controllable (Lupton & Chapman, 1995). The random nature of ill-health appears to challenge such certainty.

This knowledge can influence the health decisions people take, as does other evidence, which may or may not include scientific knowledge. Yet in most instances professional expertise continues to be privileged over popular culture (Lupton, 1998). What is read

in the literature is the voice of the expert, of those in power. What is not heard is the lay perspective, the reality of everyday life for many people. What appears to be forgotten is that decisions relating to health are integral to social and cultural processes (Backett, Davison, & Mullen, 1994). Health behaviours such as being physically active may not necessarily be undertaken for health reasons, an idea noted regarding some women's gym attendance. Whereas all the participants exercised to be fit and healthy, they also enjoyed the other benefits such as weight control, leisure activity, and well-being.

Understanding health, for most people, has been predicated through medical ideology, which can cause a certain ambivalent relationship. Whilst Williams and Calnan (1996) believe there is a more critical relationship between lay people and modern medicine than is suggested by some, they do acknowledge a paradox surrounding the ambivalence lay people experience with medicine. On the one hand there is an expectation that modern medicine will provide all the answers to medical and sometimes social ills, while on the other medicine is criticized for abuse of power, subjugating patients, and rapacity (Lupton, 1994). This not only highlights the fundamental importance and interrelated nature of health for most people, but also the knowledge/power nexus still apparent in medicine.

Certainly the participants demonstrated an awareness and interest in all aspects of health issues, such as the four main risk factors, although this was rarely from a critical perspective. Whereas none of these participants could have been seen as passive recipients of health care, they were most likely to be both reflexive and constantly changing within various contexts. A postmodern perspective would suggest people may be either rational and autonomous or passive and dependent at the time of a health encounter. Whichever position is taken, it will be influenced by many factors such as gender, age, and ethnicity and marked by fluidity and reflexivity. What the lay discourse appears to offer is a useful perspective for disrupting the dominant medical discourse.

As noted earlier in this chapter, each discourse does not stand alone. The interrelated nature of discourses is evident as the participants can be seen located in either one or all

of these discourses. This locatedness is connected to a central recurring thread of this study: the significance of acknowledging the context and uniqueness of each woman's experience of being physically active. With this in mind, why this group of women did or did not maintain physical activity over time will now be considered.

6.3.5 Maintenance of exercise

Understanding how midlife women maintain physical activity over time was the *raison d'être* of this study. What has emerged has tended to focus on these women's beliefs related to being physically active and why, rather than how, they maintained, or as the case may be, did not maintain their activity. Exploring literature, interviewing the participants, and interrogating the interview material has offered a certain level of insight into the factors which have influenced this cohort of women to adhere to physical activity over time. These factors can be seen from a positive and a negative perspective.

All participants enjoyed being physically active and experiencing the feelings of well-being that ensued. Harriett spoke of her enjoyment and how she relished her chosen activities and the social interaction that accompanied many of her activities. Wanda and Rachel, however, found the time they had to themselves when they exercised was cherished and invaluable. Physical fitness and health were appreciated, not only for the positive aspects such as feeling good, controlling body weight, and improved body image, but also for the belief that being physically active now will assist them to be fit in old age. There was a strong desire by each of the women to be active, independent, and healthy as an older person and this may well be a motivating factor for adherence. Certainly the positive aspects identified such as psychological well-being, relieving stress, and problem solving, and a spiritual dimension related to being active outdoors, emerged as motivating factors.

Thompson (1992) and Wankel (1993) support enjoyment of exercise as an essential component of maintenance. The latter believes the key consideration is very simple:

people will continue to exercise if they enjoy doing so. This in itself, these authors believe, can make physical activity self-perpetuating. Using a feminist approach, Thompson found that playing tennis regularly for mothers living in a patriarchal and capitalist society in Western Australia provided an unproblematic and affirming opportunity for leisure. What it also did was provide a means of resistance in lives restricted by marriage and motherhood.

Perhaps the value Wanda and Rachel placed on time for themselves could be seen as a form of resistance. Wearing (1995) argues that "Resistance involves the use of a variety of tactics, solitary or cooperative, to carve out a space for oneself within the constraints of the powerful". She concludes, "Its opposite is acquiescence" (p. 273). Acquiescence was not considered by either Wanda and Rachel, who could be seen to be offering resistance to domestic and capitalist gendered discourses prevalent in society. Thus the ideology of maintenance was not an issue, rather what appeared to be problematic was the context in which being active was performed.

The social context for all these participants was underpinned by a gendered society. Within this gendered culture, femininity emphasises women's supposed maternal and nurturing attributes, encapsulated in what James and Saville-Smith (1994) see as "the cult of domesticity" (p. 32). This construction of femininity not only emphasizes women's social role within heterosexual relationships and the family but also continues to privilege the masculine over the feminine. Each participant's description of physical activity from childhood to midlife echoed with "the cult of domesticity" in either their parents' and/or their own lives. Acquiescing to the needs of others, child rearing, domestic duties, and relationships clearly illustrated this. These could also be seen as constraining factors in the women's ability to be physically active.

The constraints and barriers identified by the participants ranged from the psychological and social, to the environmental. Lack of time, and family and financial constraints were all identified, with these frequently being interrelated. Feelings of guilt were paradoxical in that they could be experienced if one exercised as well as if one did not.

The uniqueness of each woman's experience of physical activity was evident again, as what constrained one woman was not considered by another. For example, whereas financial concerns were not considered by Dianne, Chloe had to stop attending a gym until her financial resources improved. Thus, although the women were eager to continue with exercise, contextual barriers have made this problematic in a variety of ways.

The three discourses discussed: disease prevention, health and well-being and the "body beautiful", could all be seen to play a part in motivating this group of women to maintain their activity. However well motivated each woman was, the reality and constraints of everyday life were also evident. At my final visit to each woman, not only was I amazed at the changes that had occurred over the six month period, but I also learnt first hand how the vagaries of life impact on each woman's ability to maintain exercise over time. Two marriages had ended. One came as no surprise; the other was most unexpected, coming after 30 plus years of what Wanda considered to be "wedded bliss". Three participants had stopped exercising completely. One had sustained an ongoing back injury, another had recently undergone unforeseen surgery, and the other was expecting her third child. In the space of a few months the lives of half the participants had been disrupted. These changes disclose the reality of the context of these women's lives, which cannot be seen as fixed or unitary, but changing, uncertain and unstable.

As with much of this study, definitive answers have not been forthcoming. In some ways more questions have been raised than have been answered. How is maintenance defined, and by whom? Does taking a week or two off exercise make a significant difference? The belief that ideally people should be physically active every day, and if not, three to five times a week, with activity lasting between 20 to 60 minutes requires commitment. Wilbur, Miller, Montgomery, and Chandler (1998) suggest that the perception that activity has to be sustained over a long period of time may in itself contribute to low maintenance, especially for women, who see their time as limited. The

recent change from sustained activity over a 20 to 30 minute period, to being physically active for three ten-minute periods may encourage more people to be active.

Another consideration is the assumption that people know how to be active, which, according to Jones, Franks, Manson, Hoffman-Goetz, and Otis (1998) is incorrect. They consider women need specific messages in a variety of ways regarding the nature of physical activity. It may well be that nurses working in either a community or institutional setting are ideally placed to situate health promotion information within the contextual reality of each woman's life. Just what the role of the nurse could be regarding health promotion programmes and what implications this study has for nurses, will be discussed in the following section.

6.3.6 Implications for nursing

Nurses have an important role to play in promoting health. As noted in chapter 2, many nurses consider the health promotion arena ideally suited to the nursing role. Whilst the Ottawa Charter for health promotion has been ubiquitous in nursing education, it appears that in practice the social context is rarely contemplated, as the emphasis remains on the individual. Despite the rhetoric of community involvement, advocacy, and social responsibility, health professional expertise, which includes that of nurses, continues to be privileged over lay expertise (Lupton, 1998). However, Purkis (1997) believes that whilst nurses' work with health-promoting behaviours has, until recently, been mostly defined within the bio-medical model of health, over the last decade there has been an increasing awareness of the social determinants of health. Whether this awareness has been transformed into practice is arguable. Kermode and Brown (1995) suggest it has not, as although nurses consider health promotion an ideal domain for nursing practice, in reality the focus remains on individual behaviours and lifestyle rather than social determinants.

The unique contribution nurses can make to health promotion is frequently confined by historical and political contexts. Both Parmee (1995) and Rafael (1999) query how nurses can advocate and empower clients when they themselves remain confined by

hegemonic medical and management structures. This is noted particularly within the confines of hospitals. However, many nurses working in the community also locate their practice within the bio-medical discourse, which tends to intersect with time and/or financial considerations. The new right political ideology influencing health care throughout the last decade has not only deterred the interrogation of social determinants, but also restricted nursing practice to traditional methods such as one-to-one health education and disease prevention (Sourtzi, Nolan, & Andrews, 1996).

It could be argued that nurses who continue to locate their practice in the bio-medical discourse are reinforcing the very power structures they wish to see dismantled. Without challenge, these power relations continue to be the everyday reality, not only for nurses but also for the lay population (Symonds, 1998). Nurses need to ask whose voice is being heard, and why this knowledge is privileged over others. There is a growing critique of the bio-medical discourse within the literature, although this is mostly emanating from within the social sciences (Becker, 1993; Lupton, 1997b; Peterson & Lupton, 1996). Nursing's tentative attempt to critique and disrupt the dominant discourse remains just that, as it is confined to the literature but silenced in the practice domain.

Offering a critical voice to current health promotion discourses can be problematic for many nurses, at both an individual and collective level. Not only has nursing's understanding of health and illness been conceptualised by medicine but this approach has also permeated nursing education. Smith, Masterton, and Lloyd Smith (1999), investigating how well health promotion philosophy was integrated into nursing education, found three discourses, those of disease, caring, and health promotion. Whereas disease and care of the sick remained foremost, particularly for nurses working in hospitals, this emphasis was also evident for the majority of nurses working in the community, many of whom worked as employees of general practitioners.

Carryer (1997b) believes that for nurses to be effective in promoting health, they may need to work outside traditional work environments. Although Carryer was referring

specifically to body-size management, I consider this could well be applicable in regard to physical activity. As the current health environment appears to severely limit nurses' ability to work either autonomously or independently, there is a need to develop ways of promoting health within the current perceived constraints. Healthy living centres, wellness clinics, nurse-led school clinics and health seminars are a few of the possibilities, which could incorporate health-promoting behaviours into the contextual reality for women.

Whilst the new right ideology in health care appears to constrain nursing practice, it could also be seen to provide opportunities, particularly within health promotion. An example relevant to this study is the recent promotion of the Hillary Commission's green prescription scheme, where a general practitioner gives written advice on how to be physically active, as part of health care management. The concern however, is the Hillary Commission's recommendation that people with diseases such as hypertension and cardiovascular disease be targeted, rather than well people (Pringle, 1998). Although a commendable idea, the focus is on the individual rather than the social context. Nurses have an opportunity here not only to prescribe and promote physical activity from a wellness focus, but also to ensure the contextual reality of people's lives are considered. This opportunity has not yet been grasped.

Although there is great potential for nurses to promote health beyond the individual approach, this cannot happen until nursing practice incorporates contextual determinants. There is an urgent need for nurses to become political, to challenge the limited thinking of behavioural and lifestyle approaches to promoting health, and to acknowledge the determinants of health inclusive of the social context. Nurses need to be able to critically appraise the current ideology and discourses of health promotion and ensure their voice is heard. Whilst I realise this is a little simplistic, it is necessary if nurses wish to move beyond a dependent to an independent role in providing health rather than illness care. Nurses as members of the community are also exposed to, and take up, the current discourses of physical activity. To be able to do so in a critical way

would enable them to identify the influences and constraints women confront when living in a gendered society.

Looking beyond the health/illness dichotomy inherent in the bio-medical discourse could enable social determinants to be considered. Holmes (1995, p. 361) suggests "illness and health are outmoded categories which do not adequately represent the experiences of real people, and unnecessarily constrain the relationships between persons – some labelled 'ill' others labelled 'doctor, 'nurse' and so on". Rejection of such categories, including female/male, could provide an opportunity to look creatively and rethink ways of working with people as health needs are identified.

A recent example is provided by the burgeoning leisure industry, which I believe could be seen as relevant to health and well-being. Exploring new ways to deliver what people want in their leisure time, this industry has rejected as increasingly useless categories used for classifying consumers (Hayward, 1998). Apparently people no longer act their age, class, or sex; "a thirty something working female probably has more in common with a single thirty something working male, than a non-working thirty something mother of two children" (p. 44). People's desires and needs at a particular time should be the focus, rather than how they are defined. However, classifying people this way could also be problematic. Who defines what people want?

Within the ideology of a market driven culture it could be argued that people's wants and desires are image- and commodity-driven. In the so-called "commodity culture" health, and a fit and slim body are precious commodities. These can be achieved, it is suggested, by being physically active, by "working out" at the gym, with this endeavour being even more successful if one wears of a pair of Reebok sports shoes. Commercial advertising, it appears, uses the notion of health and fitness to sell commodities (Lupton, 1997b). This again demonstrates the interrelatedness of socio-political and cultural influences and health, of which nurses must be aware. Presently medicine, rather than nursing, defines what it is to be healthy, with the underlying assumption that medical

care equates to improved health (Vertinsky, 1998). Categories and definitions can limit both the health professional and lay thinking.

The category of women's health is an example, as this has been problematic for women for many decades. Although women's health has emerged as an area of specialist practice over the last twenty years, Raftos, Mannix and Jackson, (1997, p. 1142) believe it remains as "a taken for granted notion". As such it "is used interchangeably and synonymously to refer to reproductive health, maternal health, neonatal health, family health, and (hetero)sexual health." It appears women's health continues to be constructed within the traditional bio-medical discourse, with little regard shown for either the social determinants of health, or women's embodied experience of health and health practices. The centrality of the body in understanding and experiencing health, needs to be recognised, to enable women to take control their lives (Vertinsky, 1998).

Having spent much of this section critiquing the bio-medical discourse, I want to acknowledge that this discussion is not about diminishing medical knowledge. There is a need to understand the basic physiological and biochemical mechanisms regarding physical activity. However, I strongly believe there is need for nurses to theorize physical activity beyond this limited approach. Apart from Caraher (1994), Kermode and Brown (1995), Purkis (1997), and Rafael (1999), there has been very little critical analysis of nurses' foray into health promotion. Health promotion must do what it aims to do: illuminate health rather than disease prevention, and also consider how relevant, acceptable, appropriate, and relevant health behaviours appear to people (Backett, Davison, & Mullen, 1994).

There is unlimited scope for further nursing research looking at health-promoting behaviours. The Hillary Commission (1999) found that the majority of women surveyed expressed a desire to be more active; thus a fertile area for research is identified. The paucity of knowledge and understanding regarding the benefits of physical activity in occupational activity, particularly in the domestic arena, is also worthy of investigation. Whereas housework and child rearing can provide women with the flexibility of being

physically active while remaining at home, these activities can also be seen as constraints. The performative role of gender, of enacting "woman" discussed in chapter 3, also offers fertile ground for nurses interested in exploring and understanding the constitution of "woman" through language, as well as health promotion within a gendered society.

The domain of health promotion, incorporating the reality of people's lives, offers a rich field for deconstruction by nurse researchers. Having been subsumed within the bio-medical discourse for many decades, there is an urgency for nurses to search for experiences and knowledge beyond their immediate surrounds to advance their understanding of their nursing work (Emden, 1995). Whilst many of the insights gained from this study have come from the social sciences, these can only benefit nurses as they explore the field of physical activity as a health-promoting behaviour, from a nursing perspective. Evans and Nies, (1997), Neis, Vollman and Cook (1998), Pinto, Marcus and Clark (1996), and Wilbur et al. (1998) urge nurses to continue increasing their knowledge in relation to women and exercise. This will enable them to develop gender-sensitive health promotion programmes to benefit both women and nurses themselves.

6.3.7 Limitations of the study.

In chapter 1 I declared my personal and professional interest in physical activity. I do so again, as my ongoing commitment to being physically active will, I believe, influence the interpretation and findings of this study. Having said that, I also believe that my interest should not preclude my participation in a research area that is both salient and relevant for the health of women and nurses alike.

The emphasis on the positive aspects of physical activity could be seen as one of the limitations of this study. Asking for women who had exercised regularly for at least a year was more likely to produce women who have a positive attitude towards being physically active. An alternative could have been to ask for women who had commenced some form of physical activity, and who had consequently been unable to

continue. Interestingly, Gauvin, Rejeski, and Norris (1996) suggest one of the limitations of the literature to date is the study of the negative, rather than the positive effects of physical activity. This study may, in a small way, redress the paucity of studies with a positive perspective.

The homogeneity of this group has already been discussed and apart from all identifying as midlife, there is little reason to see these women as similar. Although all apart from two of the women were married at the beginning of this study, education levels ranged from secondary schooling to advanced tertiary qualifications. Some would be considered financially secure, others not. All but one had children, ranging from babies to adults. Exercise levels over the 6 months' study ranged from triathlon training, to swimming three times a week, to a gentle stroll around the block. These factors make generalisation to a wider group unfeasible.

This study has not only illuminated the complexity and diversity inherent in this group of women's ability to maintain physical activity over time, but has also highlighted the importance of acknowledging the context in which this activity occurs. This knowledge may add to a growing understanding of how and why midlife women position themselves, and how they do or do not resist the current discourses of physical activity as a health-promoting behaviour.

6.4 Concluding statements

In line with a postmodern approach, a sense of closing this discussion will be resisted (Cheek, 1998). This is not difficult as I see this as a beginning point rather than a conclusion. All that has been illustrated here opens up to nursing practice differing ways of understanding women's experiences of exercise in a gendered society. When I began this study, the topic of women's experience of maintaining exercise over time appeared relatively controllable, with manageable boundaries. This idea was the first of many erroneous ideas from which I have learnt much. The complexity of the topic has

required a foray into many academic and populist disciplines, demonstrating again the interweaved and multilayered reality of many women's lives.

Illuminated in this endeavour has been the importance of acknowledging the contextual reality when promoting health behaviours. Whilst nurses have practiced health promotion over the years, this practice has been constrained within the individualistic bio-medical discourse of health promotion. To enable nurses to fulfill their potential in this arena of health care, they must critically examine the health and political ideology which drives the current discourse of health promotion. In this way they will not only understand the environment in which they practice, but also develop ways of working within it. The socio-political environment will not change to suit nurses; therefore nurses need to develop the critical skills necessary to ensure the work they do incorporates the social determinants of health.

The three discourses of physical activity taken up by the participants were disease prevention, health and well-being, and the "body beautiful", all strongly embedded in the moral imperative of health. Each interweaved with the others to motivate and at times constrain each woman. The fundamental importance of health in society was reflected and voiced by all the participants, who were desirous of remaining fit and healthy into old age. How each women maintained physical activity over time was not clearly disclosed or articulated. Whilst they were all motivated to continue, within the time period of the study, half the woman had stopped their activity for reasons mostly beyond their control. They did, however, intend to return to being physically active as soon as they were able.

This study has not been concerned with the empirical attempt of revealing the "truth" regarding maintenance of physical activity for midlife women, but with engendering new ideas concerning certain aspects of the human condition, from which both women and nurses can benefit. A feminist postmodern perspective has permitted this to occur, and offered tentative and diverging ways of understanding the complexity of maintaining physical activity over time.

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APPENDIX A: Information sheet for participants.

My name is Judy Yarwood and I am undertaking a Master of Arts (Nursing) degree at Massey University, Palmerston North. This research study is a requirement of this degree. I am a registered nurse and am currently employed as a nursing lecturer in the School of Nursing at Christchurch Polytechnic.

My supervisor for this study is Dr. Jenny Carryer RGON.

I invite you to consider being a participant in the study described below. You are free to ask any questions before reaching your decision and are under no obligation to participate.

Study outline: In this study I wish to look at the factors which influence the ability of mid-life women to exercise regularly. Although most people know that physical activity helps to keep us healthy, it can be very difficult to maintain exercise over a long period of time, e.g. over a year. I am keen to explore what factors hinder and help mid-life women to exercise regularly. I am interested in women particularly as I believe there are social and environmental reasons which affect women's ability to exercise regularly e.g. time, children, and other family responsibilities.

Your participation: Should you agree to participate in this study, your involvement will consist of an initial meeting to discuss the study and gain your consent, and two interviews of about 1 hour duration. With your permission each of these interviews will be audio-taped and these tapes will be transcribed onto paper. In the first interview we will discuss how and why you exercise. Before the second interview I will return a copy of the first interview to you to ensure I have recorded correctly our discussion. The second interview will give you the opportunity to clarify any particular point and add anything you may wish. You have the right to decline to participate at any stage of the interviews, and you may refuse to answer any questions asked.

Confidentiality: At the first interview I will ask you to choose a pseudonym by which you will be known throughout the study. At no time will your real name or any other information be used which would enable you to be identified. Once the audio-tapes have been transcribed they will be kept locked until the thesis has been marked. You will then be offered the tapes to keep. If you do not wish to keep these they will be wiped. The transcripts are read only by myself, Dr. Jenny Carryer my supervisor and the transcriber, who will be required to sign a confidentiality agreement. At all other times these transcripts will be kept securely locked in a metal cabinet in my office.

Consent form: Before the study commences I will ask you to sign a written consent form. This states that you have agreed to participate and fully understand what is

required of you by your participation in this study. It will also state that you have the right to withdraw from this study at any stage without fear of coercion or disapproval. You may also refuse to answer any particular question at any time throughout the study.

Should you agree to participate I will endeavour to keep you fully informed throughout the course of the study, and at the conclusion a summary of the research findings will be available to you. I will also keep you informed on how I intend to publish the research findings. You will be able to contact either my supervisor or myself at any time throughout this research study.

Judy Yarwood — School of Nursing. Christchurch Polytechnic.
Phone: 364-9074
Dr. Jenny Carryer — School of Health Science. Massey University.
Phone: (06) 356-9099.

Thank you very much for volunteering to take part in this research project.

APPENDIX B: Consent form

MIDLIFE WOMEN AND PHYSICAL ACTIVITY

CONSENT FORM

I have read the Information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular question.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. *(This information will be used only for this research, and publications arising from this research project).*

I agree/do not agree to the interview being audio-taped.

I also understand that I have the right to ask for the audio-tape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information sheet.

Signed: ……………………………………………………………………..

Name: ……………………………………………………………………..

Date: ……………………………………………………………………..