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**A Feminist Study of Older Women's  
Health  
and Health Promotion**

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for the degree of Master of Arts in Nursing**

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## **ABSTRACT**

Older women experience changes in their health as they age but continue to experience health and wellness, and to promote their health. In this feminist study, nine women who are chronologically aged over 70 years have described their understandings of their own health and health promotion. The participants live in their own homes and manage their lives. They also purchase meals on wheels, and may have other people do household and personal cares which they used to do themselves.

This thesis outlines discourses which are currently representative of understandings of older women's health and which provide the context in which older women experience health. This context is dominated by health professionals, especially in medicine, who represent older women's health in terms of decline and deterioration. This conflicts with the representations by these older women.

Nursing is located in the range of discourses, but is found to be most aligned with medicine and therefore replicates knowledge of older women's health in terms of decline and loss. Nursing has also failed to generate knowledge of positive aspects of older women's health. In order for nursing to provide health care which is appropriate for older women, an emphasis on health and wellness from the perspective of older women needs to be further developed. Nursing has a strong invitation to work with elders in a different way to all other health professionals.

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# **CHAPTER ONE: Introduction and Overview**

## **1.1 Introduction.**

Within this thesis I explore nine older women's understandings of health and health promotion. It is a feminist study in which women over the age of 70 years describe what being healthy means to them and whether they actively promote their health. Health is therefore described from older women's interpretations.

Health is central to this study. Aging women are likely to experience both age related and health related changes. The experiences could be distinct, or overlap, as age related changes may affect an individual's health. Nursing has intimate involvement with health and provides nursing care to older women in community and hospital settings. It is important for older women's perceptions, beliefs and practices of health to be visible, in order for nurses to closely align their practices with older women's experiences. Successfully meeting their health needs is more likely to occur if nursing stems from the older woman's point of reference.

I have considered the current possible discourses through which older women's health is understood and reproduced. Knowledge of discourses will contribute to an understanding of the contexts in which older women experience health and health promotion. There are dominant, overlapping and emerging discourses which represent older women's health. The locations of older women and of nursing within these discourses are analysed.

It is not the intention of this study to generate findings which are applicable to all older women. The knowledge gained contributes to knowledge of older women's health, by adding the perspective of nine older women. However this study does provide a glimpse of older women's lives from which nurses may draw insights for their practice.

## 1.2 Personal interest.

My interest in this study developed over two decades in which elderly people have consistently yet intermittently been present in my nursing and personal worlds. My learning has been developmental and incremental. As I age my understanding of aging deepens. It is no longer something which may affect me in two generations or five decades time. It is no longer a process inclusive of health changes which are to be feared and resisted. Older people have challenged my personal definitions of health, as I have observed them living their lives, expressing and incorporating their understandings of health in their actions. My original positioning, two decades ago, involved understanding health within a medically defined framework as the 'absence of illness'. It was inevitable that my positioning would change as I found this definition incongruent with my observations of reality. My understanding has evolved into an understanding of health and illness co-existing under an umbrella called 'life'. The contextual nature of health has become clearly apparent to me as I have observed older people with (to me) apparent health limitations experiencing wellness and health to a (to me) surprisingly satisfactory degree.

Two experiences in particular spurred my specific interest in the meaning of health. The first experience generated a need for me to attempt to understand discrepancies between my understanding of health and the subjective interpretation of a man experiencing health changes at the end of his life. This elderly man was aware of the limited nature of his life expectancy from a brain tumour. He experienced severe visual and mobility difficulties and had periods of incoordination, irritability and immobility. His ability to carry out his usual daily activities was greatly compromised. He experienced health throughout this time stating he was 'feeling fine', 'feeling great', and 'being very well'. The apparent incongruence was challenging to me.

The second experience involved an elderly woman who accepted assistance to manage most of her daily activities. She had multiple medical diagnoses including severe arthritis, hypertension, transient ischaemic attacks ('mini strokes') and myocardial infarctions (heart attacks). During one experience of an acute myocardial infarction, which closely followed a transient ischaemic attack, she reiterated her desire to have

no heroic resuscitation measures but to be kept pain free and to die as she was ready for death. She survived and the following day she described to me how she felt 'very healthy' as she was 'still able to do some things for herself.' This again challenged my definition of health.

My interest was raised. The desire to understand health from my interpretation of what older people would tell me was generated. I have refined this desire and included women only as participants in order to focus on articulating women's experiences. There may be gender diversities in understandings of health and so the search for commonalities was reduced to the diversities amongst women.

### **1.3 Overview of the study.**

The aim of the study is to explain nine older women's understandings of the meaning of health and health promotion. Themes are developed which illustrate health and health promotion activities. The underlying feminist methodology of the study provides a perspective through which the topic is studied. The feminist approach is congruent with valuing diversities and is applied in this study. Nurses have intimate involvement with health and health promotion, and value diversity through the aim of providing appropriate individualised nursing to each person. I will now briefly identify the feminist approach of this study, clarifying my position within feminist scholarship. The meaning of discourse in this study is also introduced.

A feminist approach provides the philosophical underpinning. Within this study feminism is understood as the representation of some women's viewpoints, to generate knowledge in a way which creates a distinct perspective. Diversity is accepted amongst women's viewpoints and therefore universalism is challenged. The perspective offered by feminist scholarship is considered to contribute to a fuller understanding of the concept of older women's health. A very brief discussion of aspects of feminism which are important to this study is presented now, with reference to epistemology, the recognition of diversity and the social construction of gender.

Further discussion of feminist scholarship is addressed in greater depth in chapter three.

There is support for the use of feminist methodology within nursing research (Carrier, 1995; Henderson, 1995; Romyn, 1996; Sigsworth, 1995; Wuest, 1995). Feminist epistemology values the subjective nature of knowledge (Worell & Etaugh, 1994). This is pertinent to nursing as nurses have searched for ways of generating knowledge which improves their practice.

Two epistemological aspects of feminist research underpin this study. Firstly, women's subjective experiences are accepted to be 'true'. Nine older women's experiences of health and health promotion are understood as legitimate sources of knowledge. Secondly, the knowledge developed is recognised to be contextual. It is understood in the particular cultural, socio-political and historical moment in which it was generated.

Universal claims about 'woman' as a single category have evolved into more specific and localised understandings. This reflects current acknowledgement within feminism that diversities exist amongst 'women' (Morawski, 1997; Worell & Etaugh, 1994). In this research themes are generated, but their relative importance and contextual nature differs between participants.

The central focus of all feminisms has become gender, which is perceived as a social construction, rather than biological sex. Gender as socially constructed incorporates concepts of femininity and masculinity, and therefore identity. As feminists identify that women's experiences are constructed within social realms, social processes which discriminate against women are exposed. In the health arena, feminists are claiming women's health experiences to be socially constructed as much as biologically determined (Doyal, 1994). In this study I understood the women participants would have a greater chance of living longer lives than men due to their biology. I also assumed that the social expectations of femininity would be evident, as their past experiences of being wives and mothers would influence their current health.



The notion of discourse in this study refers to the structure of knowledge and social practices and not to linguistic systems analysis. Possible discourses through which knowledge of older women's health is generated illustrate the available social constructions of older women's health. It is useful to understand current discourses and identify which are dominant as power relationships are exposed in this process. In this way congruence and tensions between dominant discourses, older women's experiences and nursing are illuminated. Discourses therefore illustrate the context in which older women experience health.

To summarise, feminist methodology underlies this study. Efforts have been made to ensure participants are not disadvantaged, and that their needs as well as the needs of the research have been met. Thematic analysis has generated themes of older women's health which illustrate the discourses through which older women are understood. Possible discourses have been analysed from gerontological literature in order to identify the context in which older women experience health and health promotion. The discourses in which older women and nursing are located are identified and their relationships to dominant discourses made transparent.

## **1.4 Background to the study.**

In order to provide a context for this study I begin by exploring some important concepts which provide parameters for this study. There are variations in who are considered to be 'older people', and there are changing demographic trends which show older people are living longer and making up a larger percentage of the total population. I then conceptualise health and signal issues relevant to older women. The final parameter is health promotion and the application of this concept to older women.

### **1.4.1 Chronological definitions of the 'older person'.**

In this study I have arbitrarily chosen the chronological age for participants as 70 years and over. This is an arbitrary decision as there is no agreement within literature on the 'older person' on chronological ages appropriate to define the 'older person'. There is a range of over 40 years from the age of 60 years to 100 years (and over).

Age groups within research samples for the 'older person' include ages 60 years and over (Burbank, 1992; Heidrich, 1994; Stevenson & Topp, 1990), 65 years and over (Elnitsky & Alexy, 1998; Heidrich & Ryff, 1993; Rush & Ouellet, 1998), 70 years and over (Perry & Woods, 1995; Whittle & Goldenberg, 1996), and 85 years and over (Schank & Lough, 1990). Some researchers have approached this wide chronological age range by distinguishing two groups; the 'older person' and the 'oldest old person' (Bondevik & Skogstad, 1998; Heidrich & D'Amico, 1993; Laferriere & Hamel-Bissell, 1994; Reed, 1991; Wondolowski & Davis, 1991). Whilst chronological age has relevance to health it is also important to recognise other variables which influence health. However in this study I recognise that chronological age is not predictive of health as individual variations exist. The more important criteria was that the participants have some health related experiences.

In the New Zealand context the usual age of 'older people' for statistical purposes is 65 years (Statistics New Zealand, 1998). However a distinction is made in the report 'The Health and Wellbeing of Older People and Kaumatua' (Ministry of Health, 1997). In this report Maori kaumatua are identified as 55 years of age, and older people of other ethnicities are identified as 65 years and over. This is to acknowledge that many Maori have shorter life expectancy than non-Maori and that many experience age related disability at younger ages than non-Maori. It was not anticipated in my study that Maori women would be interested in participating, due to my non-Maori ethnicity.

#### **1.4.2 Demographic population changes.**

It is important for nurses to generate knowledge of the health of older people as current trends predict increasing numbers of older people, especially older women. This trend is predicted to continue (Henrard, 1996; Richmond, Baskett, Bonita & Melding, 1995). As well as the increasing number of older people there is also a trend for people over 65 years of age to be a growing percentage of the total population. In the New Zealand context the population aged 65 years and over is predicted to rise from 11.8% of the total population in 1996 to 19.5% in 2031 (Richmond et al., 1995).

In conjunction with this increasingly aging population is the trend for women to live longer lives than men (Richmond et al., 1995). As well as some older women living longer, greater numbers are living beyond 85 years of age (Henrard, 1996). This predominance of women in the older age group has been referred to as the 'feminisation of aging' (Bonita, 1996; Henrard, 1996). As there will be greater numbers of older women than in previous decades living to older ages, nurses can expect to encounter them in many health settings.

Clearly nurses must address issues relevant to the additional numbers of older women who are living longer lives. Nurses will be involved in the health care of many older women through episodic and long term health changes. Knowledge is needed in order for effective planning and interventions to occur. Health is however a diverse concept, which I will now briefly address.

#### **1.4.3 Health.**

Health is a complex concept which has been intensively studied and for which there is no single definition to which all lay-people, health professionals and social scientists agree. Tarlov (1996) describes uni-dimensional models as 'conventional' definitions of health in which health is located at one end of a continuum, and illness the other. Points in between refer to variations in health, illness, disability and death. A major limitation of uni-dimensional definitions is that health and illness, or health and disability cannot co-exist within such definitions (Mitchell, 1995). This model has dominated within health professions (Milburn, 1996), and a greater emphasis has been placed on illness and disease in preference to health.

Multi-dimensional models promote holistic perceptions of individuals (Pender, 1996). An holistic approach attempts to focus on the whole person, and is inclusive of physical, mental and emotional aspects. However, attempts to describe aspects of holism constitute a reductionist perspective in which components create the whole. Thus an holistic approach may itself be reductionist. Despite this conceptual difficulty, holism does provide a more integrated understanding of health than reductionist definitions.

The World Health Organisation has described health to be inclusive of physical, mental, and emotional well-being and not only the absence of disease. Maben and Macleod Clark (1995) have challenged this interpretation as 'broad' and 'an ideal state', which is difficult for the individual to achieve. Tarlov (1996) proposes a conceptualisation of health which includes the identification of the level of functioning and well-being of the individual in every day living. Multi-dimensional models portray health and illness as inter-related attributes which can occur concurrently, promoting an holistic perception of the individual.

There are therefore many understandings of the term health, and no single agreed definition. The uni-dimensional model conceptualises health as the opposite of illness and this polarity has enabled an emphasis to fall on illness rather than wellness. A multi-dimensional conceptualisation encourages a more holistic representation of multiple components of health, and is an underlying assumption of this study.

It has been proposed that definitions of health may change with age and therefore be developmentally relevant (Beckerman & Northrop, 1996; Pender, 1996; Perry & Woods, 1995). Pender (1996) describes health to be increasingly complex throughout the life span. Perry and Woods (1995) compared images of health of younger women (aged 18 to 45 years) to the images of health of older women (aged 70 to 91 years). Despite strong similarities, there were differences. However whether these differences are specific to developmental factors only has not been established.

Bonita (1996) has discussed the need for indicators of the health of older women to reflect their health rather than illness in order that overly negative descriptions of aging do not focus policy on illness only. She also describes the need for measures of the quality of life for older women to reflect their experiences and expectations about acceptable levels of functioning in their lives. A distinct focus on older women is therefore important to ensure relevancy of findings and inclusion of wellness in policy planning.

I will now briefly discuss some complexities of the concept of health promotion and how health promotion has been applied to older people.

#### 1.4.4 Health promotion.

There are many definitions of health promotion and this diversity has created tensions and conflicts within the practice of health promotion (Beattie, 1991). Definitions include the prevention of illness/disease, the early detection of illness/disease, and the positive promotion of well-being (Gott & O'Brien, 1990; Kulbok & Baldwin, 1992; Pender, 1996). Distinctions between the prevention and early detection of illness/disease may however be artificial. In conjunction with the development of illness prevention and early detection programmes is the lack of development of the positive promotion of well-being.

There are two target populations of health promotion by health professionals. The individual and communities of individuals have been targeted with the aim of improving health. Modifiable determinants of health have been targeted, and include direct determinants such as individual behaviours, and indirect determinants such as public policy (Beattie, 1991).

The focus on the individual is aimed at reducing selected 'risky' lifestyle behaviours by the individual, and has placed some responsibility on the individual for health. Individual responsibility has emerged out of prevailing political philosophies and has reinforced the focus on lifestyle change (Baum & Sanders, 1995; Lupton, 1998). The focus on the individual is also apparent within literature on older people, as they have been shown to promote their health and engage in health promotive practices (Backett & Davison, 1992; Kaufman, 1996; Mitchell, 1996).

The success or failure of health promoting behaviours for which the individual is held responsible has led to a 'blame the victim' approach to health (Antonovsky, 1996; Becker, 1993; Davison, Frankel & Smith, 1992). Backett and Davison (1992) discuss differences between an individual 'knowing' a behaviour is healthy and 'acting' on this, and they describe culture as a contributing factor to action. Professional expertise holds greater power than lay expertise and the individual is expected to change behaviours in response to professional advice (Lupton, 1998).

However there must be recognition of determinants beyond individual behaviours which address core causes of ill health (Dean & McQueen, 1996), such as social, environmental, cultural, political and economic environments (Dean & McQueen, 1996; Milburn, 1996; Nutbeam, 1997). Becker (1993) and Tarlov (1996) both emphasise that the ability of individuals to directly control their health, and therefore to be responsible for it, is very limited compared with heredity, culture, environment (especially poverty) and chance.

The second target population is the community which comprises individuals. Collins (1995) has proposed a model which directs health promotion activities at both the individual and the community. In this model the individual is located within the community and is influenced by political/economic determinants, macro-physical environment, degrees of social justice/equity and levels of community cohesiveness. Health promoting behaviours can occur within both individual and community levels. This model does recognise influences on health beyond the individual.

Nutbeam (1997) also recognises the importance of the community as he describes interactions of individual, social, economic and environmental determinants of health. He comments on an Australian health promotion report titled 'Goals and targets for Australia's health in the year 2000 and beyond', in which personal health literacy (which includes knowledge, motivation and coping skills), healthy environments and healthy lifestyle behaviours are inter-linked determinants of health. These three influence the fourth determinant of health which is the quality of life, morbidity and mortality. Co-ordination of health action, inclusive of individual and community action, is recommended to address each of the four determinants of health. The influence of determinants of health wider than the individual are again recognised.

To summarise, health promotion has focused on changing individual lifestyles to reduce 'risky' behaviours and therefore prevent illness and disease. This emphasis on the individual has been applied to elders, who have been found to engage in behaviours which promote their health (Backett & Davison, 1992; Kaufman, 1996; Mitchell, 1996). The focus on the individual, however, must be applied with caution as there is the potential to ration health care in the 'blame the victim' approach if



health promotive measures are not effective or not utilised. The impact of broader determinants of health must also be acknowledged and addressed. A model in which political, economic, environmental and social factors affect health and health promotion, acknowledges influences on health beyond the individual. There is however little recognition of the positive promotion of well-being within health promotion.

## **1.5 Overview of the thesis.**

This thesis is presented in six chapters.

This chapter (the introduction) describes the background and purpose of this feminist study which identifies what being healthy means to nine older women and describes whether they actively pursue a healthy state. I have briefly addressed the application of feminist methodology in this chapter, however a more detailed discussion will occur in chapter three. The concepts 'health' and 'health promotion' are briefly explored and the dominance of uni-dimensional definitions is made explicit. The particular use of the concept of discourse in this study is also made explicit.

Chapter Two illustrates the possible discourses through which knowledge of older women's health is constructed. This is in keeping with feminist principles as the social construction of older women's health is exposed and provides a context for understanding the participants' experiences of health and health promotion. The positioning of nursing within the various discourses is also discussed.

Chapter Three identifies the methodology and the method utilised in this study. Commonalities which underpin feminist scholarship are described. Thematic analysis is the method of data analysis for this study. The research processes are discussed in order for the reader to understand details of the research method.

Chapter Four begins the presentation of analysed data. The participants are briefly introduced. Themes from the analysed data represent being healthy as contextual

independence and autonomy. The theme of independence includes the importance to participants of living in their own homes and being in control of their own lives. The process of accepting others doing things is also included. Also discussed is the theme of autonomy in which being determined, making the effort and taking calculated risks are identified to be important. These themes also illustrate some ways in which the participants promote their health.

Chapter Five presents further analysed data. Two further themes are presented, in which being healthy is described as having a sense of health and of choosing some actions which promote health. The experience of having a sense of health is presented in holistic and multi-dimensional terms. The possibility of a definition of health appropriate to the life stage of the older women also emerges. Health promotion is incorporated in life as a choice of activities which promote individual health.

Chapter Six discusses the data analysis in relation to the discourses which are shown in chapter two. There is also discussion on the relevance of these findings to older women and to nursing practice. Limitations of the study are discussed and possibilities for future study are suggested.

## **1.6 Summary.**

This chapter has briefly described the topic of this study, provided an overview and highlighted how my interest in the topic developed. The range of complex meanings of the concept health is also discussed. Health promotion has been briefly analysed including the relevance of this concept to elders. This chapter has also presented the layout of the six thesis chapters.

In the next chapter I will undertake a literature review and identify the possible discourses through which knowledge of older women's health is generated and understood. The discourses provide the context in which to locate a consideration of older women's experiences of health.



## **CHAPTER TWO: Discourses of Older Women's Health and Health Promotion**

### **2.1 Introduction.**

In the previous chapter I have identified the concepts of health and health promotion which are the topic of this study, signalled the underpinning feminist methodology and the use of thematic content analysis. In this chapter I will briefly discuss the concept of 'discourse' as there are multiple interpretations, and describe how the concept is applied to this particular study. The discourses which represent understandings of the health of older women are examined through a comprehensive literature review. The positioning of nursing within the discourses is also identified.

In this study my reason for identifying discourses is to explain ways in which social knowledge and practices about older women's health are known, understood and taken up. Discourses also constrain the ways in which knowledge and understanding occur, as they influence what is able to be said, meant and known. Discourses are historically located, and evolve and change over time. The discourses which I identify are therefore relevant to the last decade of the twentieth century. It is also important to identify how nursing is situated within these discourses, to identify congruency and tensions between the positioning of nursing and the positioning of older women.

### **2.2 Conceptualisations of discourse.**

There are many definitions and applications of the term discourse (Fairclough, 1992; Parker, 1992; Potter & Wetherell, 1987). It is therefore a practical simplification to refer to two predominant conceptual approaches. Through these two approaches discourse is understood as either referring to the structure of knowledge and social practices or to a language system (linguistics) (McHoul & Grace, 1993). There are multiple applications which fall amongst these two main strands. However it is the first conceptualisation of discourse, in which the meanings of social practices and knowledge are structured by and within discourses, which I draw on in this study.

The concept of discourse was used by Michel Foucault. He was a French philosopher who has contributed to and influenced western thinking in the second half of this century. He is acknowledged by Kelly (1994) to be credited with theorising the concept of power and making power a part of philosophical discussion. McCarthy (1994) claims that the main insight from Foucault's analysis of power was that it showed the privileging of certain discourses through the recognition of their 'truth', which created a "political economy" of truth (p. 253). I will discuss the concept of power after I expand on definitions of discourse. There are now many interpretations of Foucault's texts, and I will draw on the work of McHoul and Grace (1993).

McHoul and Grace (1993) claim that the broad application of the concept discourse, to refer to a body of social knowledge, stems from the work of Foucault. They suggest that Foucault's interest was in the relationship between structural systems of knowledge and forms of social control. They also note that knowledge was conceptualised by Foucault, not as technical know-how, but as conditions for the acceptance of truth. These conditions which influence the construction of knowledge include social, political and historical contexts. Discourses do not therefore occur in isolation, but are influenced as well as influencing. Thus social knowledge is affected by prevailing conditions.

Burr (1995) provides a useful definition of a discourse as "a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events" (p. 48). Parker (1992) similarly identifies discourse as "a system of statements which constructs an object" (p. 4). Weedon (1987) refers to discourse as historically located constructs of meaning which are specific to particular groups and cultures. Discourse is therefore representative of ways of knowing and understanding an event or phenomena. Multiple representations of reality exist through multiple discourses. Discourses may compete as dominant, emerging, overlapping or marginalised discourses which represent events or phenomena in different ways.

Following on from the notion of discourse as a form of social control is the idea of discourse making available a way of knowing and meaning. This is expanded by

Fairclough (1992) who suggests that discourse constructs as well as reflects social entities. Therefore different discourses represent the same social entity in different ways. The ways in which discourses structure knowledge limits what knowledge is available and how that knowledge is known.

Surber (1998) discussed Foucault's interest in rules of discursive formations. Each discourse has rules and meanings apart from structural rules, which are available and define that discourse. In this way hegemonies are produced and reproduced by discourse which limit ways in which social practices or objects are able to be written, spoken or thought of. This raises epistemological questions of what counts as knowledge, as what can be thought is confined to discourses operating at that particular time in history.

Each discourse is a representation of reality and as such claims truth. Burr (1995) links claims of truth to power. Power stems from competing discourses when one discourse prevails and predominates in its claim to represent 'truth'. Dominant discourses derive power from being embedded within institutions of power. Institutions reproduce power by supporting dominant representations of reality which become 'the' legitimate representation. Social control therefore stems from embedded power. In this conceptualisation power is not so much a negative force which acts through domination, but which acts through incorporation and locatedness (Fairclough, 1992). Discourses which are not dominant are overlapping, marginalised and emerging discourses. Each discourse interprets reality in different ways and this interpretation creates truth for each discourse.

An example of an institution of power, within the discursive field of health, is medicine. The dominant bio-medical discourse has embedded power and medicine reproduces this power through constructions of illness which become assumed truths and are replicated. Other discourses are marginalised as medicine claims to represent 'the' truth, and gains power from this representation. An example of a marginalised discourse within this discursive field is complementary medicine. The construction of health and illness differs between bio-medical and complementary medicine.

Complementary medicine has less embedded power than the dominant bio-medical discourse.

The historical context adds another important dimension to discourse. The historical context is relevant as discourses change over time and are not static (McHoul & Grace, 1993). The ways in which people think and speak about objects or practices are specific to the time in history in which the thinking or talking occurs. This contextual aspect enables us to understand the transient nature of knowledge and of how knowledge structures change.

As previously identified this study applies the term discourse to refer to systems of social knowledge. The aim of identifying discourses is to make visible the contexts in which older women experience health. Discourses therefore are analysed in order to illustrate contexts in which knowledge of older women's health is structured and reproduced. Dominant, emerging, overlapping and marginalised discourses are shown. Understanding these discourses creates a climate for the analysis of power, however this is beyond the scope of this work. The positioning of nursing within current discourses of older women's health will also be made visible. This approach is consistent with feminist research as feminism identifies the importance of context. Once the available discourses are made visible the positioning of participants of this study and nursing will be analysed (in chapter six). This discussion will provide a broader context through which older women's health can be understood.

### **2.3 Discourses of older women's health.**

I have examined literature on older women's health and identified seven discrete discourses. They comprise social, bio-medical, psychological, biopsychosocial, functional, economic and wellness discourses. Each discourse represents the health of older women in a different way and through this representation claims 'truth'. I will now examine each discourse, and identify how older women's health is known and understood within each.

### 2.3.1 Social discourse.

The social discourse refers to social representations of older women's health within western societies. The ways in which western societies understand older women are represented in print and audio-visual media. These representations of older women's health define this discourse.

Whilst older people are often represented as a homogeneous group who share the same chronological age of over 65 years, they are likely to be more varied in physical abilities, personal interests and financial resources than other age groups (Sperry, 1996). The stereotyping of elders however through similarity limits expression of individual differences within and between cultures, ethnicities, genders and socioeconomic factors. It also restricts socially accepted practices to those known through this discourse. The stereotypical representations of older women have tended to be negative.

Public knowledge of older women is reproduced in stereotypes which are incongruent with the experiences of older women themselves (MacDonald, 1993). Older women are often portrayed as victims of aging bodies which are failing in comparison to those of younger years (Gutmann, 1996). Since the end of the nineteenth century older women (and men) have been constructed as social problems, represented by the negative stereotypes of decreased well-being, depression, poor health and poverty (Markson, 1997). Markson identifies the cause of the perpetuation of this myth, despite evidence to the contrary, to be the persistent belief in youthfulness as an essential aspect of women. The social construction of older women is therefore influenced by the valuing of youthfulness, which affects women's social identity and self esteem. Older women are defined by their lack of physiological youthfulness as well as by negative social constructions in which youth is 'the norm' and older women are defined as deficient.

A second stereotype of elders consists of the almost fairy tale image of the 'perfect grandparents' who, amongst other traits, are kind, loving, family oriented, generous, grateful and supportive (Hummert, Garstka, Shaner & Strahm, 1994). Hummert et al. claim that all adult age groups construct elders in this way. This is a strong image

through which older women are socially constructed and which has a strong caring component. Reproduction of this stereotype reinforces the importance of these attributes and limits other behaviours available to elders and non-elders.

In contrast to the predominant portrayal in western societies, older women themselves have experiences reflective of their culture as well as their age. Cultural variations exist and are evident in the lives of older New Zealand women. Armstrong (1996) describes diversities amongst older Maori, European, Chinese, and Central European women. Chronological age for these women was not a particularly useful way of identifying 'old', and most defined 'old' as people who were older than themselves and also less active or able. For the Chinese women there was a responsibility to enter 'old age' physically and psychologically fit, and to work to remain fit. These women are senior in their families, and contribute to the upbringing of grandchildren. Maori women may have the role of *kuia*, which brings some status, and is available until voice is lost. Armstrong describes older women with Chinese and Maori ethnicities to have expectations and responsibilities in which they are productive and generative. The Central European and European New Zealanders do not have similar positions of status.

To summarise, the prevailing stereotypes within western societies portray older women to comprise a homogeneous group. This group either experience decline and are to be pitied, or are selfless grateful and supportive elders. Both of these social constructions of older women illustrate understandings of older women's health within the social discourse. This discourse illuminates one context in which older women are defined.

A second discourse is the bio-medical discourse in which medicine is located. I will now illustrate how this discourse defines social knowledge of older women.

### **2.3.2 Bio-medical discourse.**

The bio-medical discourse represents older women in biological terms. The focus on the bodies of older women includes the physical changes of aging and the causes of these changes. Medicine constructs older women's health in physical terms and claims



an interest in the changes which occur. Comparisons are made to the 'norm' of younger bodies.

Aging is a process which starts to occur after early adulthood and which involves less vigour being experienced (Wickens, 1998). Whilst this definition is applicable to populations it does not explain individual variations of aging. Aging has been medicalised and pathologised since the nineteenth century, as science has taken an interest in this process (Markson, 1997). Medicalisation refers to the process whereby medicine has claimed an interest in the process of aging and has redefined aspects of this normal process as deficits which require medical intervention (Sidell, 1995). The sequelae to medicalisation is pathologising the body, as aging becomes understood in terms of physiological changes (Sidell, 1995).

Within the bio-medical approach causes of aging have been studied in a context of loss or deficiency in comparison to younger years, such as loss of maximal breathing capacity (from 165 litres per minute at age 25 years to 75 litres per minute at age 85 years), renal filtration rate, and maximal heart rate (Wickens, 1998). Whether there are genetically pre-programmed changes related to aging or whether aging occurs as a result of wear and tear at molecular level is still unclear as changes at genetic, cellular and organ levels are all able to explained by both theories (Wickens, 1998). Within this discourse the search has focused and continues to focus on biological bases of aging as well as diseases related to aging (Wetle, 1998). The aim of knowledge within the bio-medical discourse is to increase the life span, albeit healthy life spans (Wetle, 1998).

The distinction between aging and disease however is not clear, and some changes which have been attributed to aging may be due to disease (Wickens, 1998). Two changes which have previously been associated with aging and used as research parameters, filtration rate and cardiovascular function, have been found not to change in some older people who demonstrate similar values to younger adults (Piantanelli, Rossolini & Basso, 1992). This blurring between increasing age and disease processes aligns aging with disease. However it is important to note that it is possible to age without disease (Wickens, 1998). Attempts to separate the two associated variables

has highlighted the inappropriateness of using chronological age as a way of grouping older people as homogeneity is assumed. In an attempt to overcome the diversity of age as identified by chronological age there has been an unsuccessful search to identify bio-markers of aging (Piantanelli et al., 1992).

There has been little recognition of older women within this discourse, as until recently aging has been generalised (Markson, 1997). Women have been assumed to be the same as men and therefore any differences in aging have not been considered (Woods, 1994). Sperry and McNeil (1996, p. 61-62) aptly illustrate the bias against women as they explain the inclusion of women as participants as "inevitable and necessary because of the need to study conditions like osteoporosis, which is especially common among older women". Research on cardiovascular disease has been discriminatory against women as studies have been conducted on men and generalised to women without consideration of potential differences (Preski & Burnside, 1992; Woods, 1994). As well as being excluded on the basis of their sex older women also face discrimination through exclusion as research participants because of their age. In the context of approximately 50% of new malignancies occurring in people aged over 70 years, this age group is excluded from most clinical trials (Fentiman et al., 1990). Findings from chronologically younger males are therefore generalised to older women without reference to potential differences. Woods claims that addressing this issue is complex as simply adding women to a study will not address the issue of the 'male as the norm' which is embedded within this scientific discourse.

Understandings of health and illness in the bio-medical discourse arise from physiological conditions (Yardley, 1997). Within this discourse knowledge of older women is related to illness concepts of decline, disease, degeneration and chronic illness. Diseased states such as heart disease, osteoporosis, cancer and dementia are health issues representative of aging women. Comparison is made to physiological attributes of younger years. An excellent example is menopause which is often perceived to be a disease of oestrogen deficiency with serious health consequences, and requiring intervention in the form of hormone replacement therapy. The process is defined in physiological terms and not by women's own experiences. The voice of



women who do not experience more than minor discomforts, managed through their own strategies, is not present within this discourse.

Within the bio-medical discourse therefore health is represented as the absence of illness, and the emphasis on illness silences discussion on health. This reduces other positioning for older women who become defined as deficient or diseased. Within the New Zealand context Campbell (1997) illustrates the dominance of bio-medical research within gerontology. He states there are three main categories of research. Two of these categories are bio-medical, and consist of 'community based epidemiological studies' and 'bones, falls and fractures'. The third category is sociological in which aging and its social effects are investigated.

Yardley (1997) claims that the costs and limitations of the bio-medical model have become apparent as chronic illness and disability have overtaken acute transmittable disease during the latter part of this century and that there is a growing recognition of the importance of social influences on health. Social factors including lifestyle factors and the environment have been recognised to play an important role in longevity (Wickens, 1998) as well as the development of disease. This recognition has allowed some emphasis to be placed on the prevention of disease. However health promotion efforts have targeted "high risk" individuals because medical and behavioural approaches have dominated health promotion (Dean & McQueen, 1996; Milburn, 1996). This approach has been criticised as the emphasis on the individual has ensured the socio-politico-environmental contexts which affect health have been ignored (Becker, 1993).

To summarise, the bio-medical discourse which is embedded in the powerful institution of medicine defines knowledge of older women in physiological terms. The changes associated with increasing age are constructed in terms of decline and deficiency and are compared to younger years. Until recently older women have not been included in research with the exception of being valuable for research on hormonal changes which affect women and diseases specific to women. Although limitations of this discourse have surfaced, the dominance of bio-medicine continues

as institutions such as medicine reinforce the construction of health and illness within this discourse and continue to emphasise illness.

### **2.3.3 Psychological discourse.**

The third discourse, the psychological discourse, overlaps with the bio-medical discourse. However the focus is on the mind of older women rather than their physical bodies. However there is still a negative portrayal of older women who are depicted as mentally deficient, or declining.

Many psychological states in the older woman have been linked to aging and loss (Markson, 1997). The damaging stereotype exists of the older woman experiencing mental decline, being unable to make decisions, being dependent and losing interest in topical events (Ginn & Arber, 1993; Wearing, 1995). Ginn and Arber (1993) suggest that these negative stereotypes of older women may be a necessary social control as older women, freed from reproductive roles, may otherwise become contenders for dominant and powerful positions.

Within the fields of mental health and psychology certain psychological constructs perceived to be applicable to older women have been studied. Mood states have received considerable attention as they are perceived to be important to the health of elders. However the mood states which have received attention are mood disturbances, and little is known about positive mood states (Gibson, 1997). Depression has been measured using uni-dimensional or multi-dimensional mood state inventories, many of which do not have established reliability and validity (Gibson, 1997). Gallo, Anthony and Muthen (1994) identify that elders are likely to report lower rates of depression when standard diagnostic (DSM-III) criteria are used than when symptoms of depression are used. They believe this is due to older adults being less likely to acknowledge dysphoria than younger adults.

Loneliness is another concept which has also been studied in older adults. In the New Zealand context a study by Hector-Taylor and Adams (1996) investigated the relationship between loneliness and gender, age (not predictive), lesser education, income, and living alone (predictive of state but not trait loneliness). Thus loneliness

was sub-grouped according to its source. The opposite of loneliness has also been studied in the form of social supports. Support systems for elders are found to be predominantly the 'family'. The experiences of the care giver and of the recipients of care have been addressed (Johnson, 1999). Discrepancies are suggested in the findings of studies in which both care giver and care receiver experiences are represented (Johnson, 1999). Findings also suggest that this support is perceived by participants to be a characteristic of family life, and not a remarkable experience.

Intellectual abilities have also been measured. Whilst it appears to be correct that some measures of mental agility such as reaction times do not reduce until approximately 70 years of age, other complex mental tasks reduce from mid-life (Wickens, 1998). However these changes are highly variable and older people may complete tasks by using a greater range of experience and information to problem solve than younger people who draw more extensively on memory (Sperry & McNeil, 1996). Knopf (1992) posed that limitations of traditional studies have contributed to this perception, as the scope of memory tasks and materials used in memory research has been narrow. Their preliminary findings indicated qualitative changes rather than quantitative changes in memory performance of elders. Sperry and McNeil support this position as they indicate results from the longitudinal Baltimore study on aging show the brain "may do more adapting and less declining with age than previously thought" (p. 69).

Further evidence to contradict negative stereotypes is given by Heidrich and Ryff (1996) who claim support from empirical studies for the premise that older people may experience better mental health and psychological well-being than younger adults. They also claim that whilst older people experience less anxiety than younger adults, women experience higher levels of stress than men. Elders continue to cope with stress according to their personality and this ability does not reduce with increasing age (Sperry & McNeil, 1996).

Markson (1997) describes challenges by feminist psychologists to research projects in which men's experiences have been generalised to women. Gibson (1997) reports that many self reporting mood state questionnaires have been developed in young adult

populations and then applied to older populations. Some redress has occurred as recently specific aspects of women's experiences have been studied. Feminist theorists have described key aspects of women's lives to include a desire for affiliation, and that women understand themselves through relationships with others (Markson, 1997). This initial research however does not focus on older women and the relevance to older women has not yet been established.

To summarise, despite evidence to the contrary, the psychological discourse represents older women as declining in mental functioning and abilities, and becoming less competent than in younger years. Mood states have been studied, but are predominantly negative moods. The dominance of this social construction does not allow a positive image of mental abilities and positive moods amongst older women. A possible reason for the negative representation of older women's health in the psychological discourse is the influence of the institution of medicine. Medicine favours illness and thus focuses on deterioration and decline. The field of psychology has been influenced by medicine (Yardley, 1997).

#### **2.3.4 Biopsychosocial discourse.**

Since the late 1970s there has been interest in the generation of combined biological, psychological and social knowledge (Yardley, 1997). Behaviours and beliefs have been studied in order to determine their impact on the presence or progression of disease (Yardley, 1997). Psychosocial factors have been correlated with illness and disease, to show that they do affect health and illness. An example is the positive effect of the presence of social support on both emotional and physical health (Heidrich & Ryff, 1996). Another example is the multi-factorial and complex interactions between genetic and environmental factors which are suggested to affect longevity (Baggio et al., 1998). However Yardley criticises work within this discourse because non-bio-medical aspects are included in a predominantly bio-medical framework. An example is the measurement of personality which becomes treated as an objective measure of underlying realities, rather than as a changeable concept which is socially constructed. In this way the bio-medical discourse continues to constrain.

There is an apparent holism within this discourse as the mind-body split, evident in the bio-medical and psychological discourses, appears to be united. The body is further influenced by social and environmental factors. However, holism remains an illusion as reductionism continues to dominate. Concepts which are correlated include combinations of physical, psychological and social factors, however they continue to comprise a reductionist approach.

A further development within this discourse is the concept of 'quality of life' (Hughes, 1993). There is no clarity about how 'quality of life' or 'life satisfaction' should be defined or measured. The concepts which are often included are the physical environment (housing), social networks, socio-economic factors, psychological well-being, physical health, life satisfaction and the older person's subjective assessment of their quality of life (Hughes, 1993). Religious orientation, having meaning in life and local environment are also suggested to affect the quality of life (Sperry & Wolfe, 1996). Wellness indexes have been generated and applied to men and women (Slivinske, Fitch & Morawski, 1996). Whilst physical, psychological, social and spiritual factors which affect the quality of life are studied, there appears to be little linking to the impact of economic or political factors. Minkler and Cole (1999) call for a new political and moral economy in order to create an equitable distribution of resources and also to generate recognition of the productive aspects of elders' lives in western societies. Focusing on the economic and political factors which influence quality of life will provide a context which is broader than the individual. This is a fruitful subject area for moral economists who consider notions of fairness and reciprocity and, in the arena of aging, what elders are 'entitled to' (Minkler & Cole, 1999).

To summarise, the biopsychosocial discourse has generated knowledge of elders which contributes to a greater understanding of their health. Social, biological and psychological factors are observed to have an effect on health. However whilst this discourse appears to be broader than the bio-medical and psychological discourses, a reductionist approach continues to be present. The bio-medical influence continues to influence the ways in which truth is defined and generated within this discourse. Thus

the bio-medical discourse influences and constrains the development of knowledge within the biopsychosocial discourse.

### **2.3.5 Functional discourse.**

The functional discourse defines older women's health as the ability of women to function by completing selected tasks which comprise daily activities. The ability to perform these tasks is measured. The health of older women is therefore defined by the ability to perform the tasks.

A common measure of the health status of older people is the ability to perform activities of daily living (Laditka, 1998). The ability to self care has been studied as an important component of an individual's ability to function (Torrez, 1997; Yardley, 1997). The increasing concern with functional abilities is linked to demographic changes in which older people, (mainly women), are living longer and requiring more assistance with functioning with subsequent economic implications (Manton & Stallard, 1990; Rodgers & Miller, 1997). However there appear to be limitations to measurements of 'activities of daily living'. These limitations stem from the variety of definitions, measurement scales and reporting methods used.

Definitions vary according to the number and type of activities included in the measure, and are frequently identified as personal cares such as dressing and toileting, and self-maintenance cares such as shopping and housework (Rodgers & Miller, 1997). Alternative terms include activities of daily living (ADL) and independent activities of daily living (IADL) (Menec, Chipperfield & Perry, 1999). The effectiveness of measures used to identify limitations to activities of daily living have been questioned. An ongoing difficulty lies in the identification of what constitutes a disability, and whether using an aid is included or excluded from criteria (Spector & Fleishman, 1998). Rodgers and Miller identified substantial measurement error in measuring activities of daily living and also point out that there are a high number of different indexes used. Self reporting has been compared to performance based tests and some discrepancies found (Kempen, Steverink, Ormel & Deeg, 1996). Greiner, Snowdon and Greiner (1996) suggest it may be useful to use measures of self-rated



functioning in order to predict future functional decline in health as well as mortality, by asking an elder to compare his/her functional abilities to others of the same age.

Much research in this discourse is quantitative. McCormack and Ford (1999) claim that standardised instruments are able to effectively measure certain aspects of an elder's ability to function, but that more complex assessments are not able to be measured by standard tests. The individual impact of culture, life experience, social structures and values affect health yet these factors are not measurable through current standard tests. McCormack and Ford call for further debate about the appropriateness of standardised assessment testing.

The testing of functional limitation is further criticised as the context of health is neglected and one aspect of health is isolated and assessed. Factors such as stress and poverty which influence health are ignored (Yardley, 1997). Ginn and Arber (1995) highlight differences between older men and older women as women are more likely to have functional disabilities. Yet, partly because they live longer lives, women will be less likely to have a spouse to assist and enable them to remain in their own homes.

A consequential aspect of functional limitation is access to assistance (Torrez, 1997). Aronson (1991) describes the role of women in the care of elders and highlights that women are recipients of care as well as providers of unpaid care. It is clearly evident that much assistance is provided by 'family' (Aronson, 1991; Prosser, 1998). The social expectations of 'family' are therefore important, and Aronson suggests a social construction in which daughters should be 'dutiful' and mothers should be 'undemanding'. Within the New Zealand context Prosser identified that most older people care for themselves. However for those who did have assistance 52% of personal care assistance was provided by family and friends. Family and friends clearly provide most of the help for everyday activities.

To summarise, knowledge of older women is constructed in functional terms. Measurements are applied to measure the personal care and self maintenance abilities and disabilities of elders. However the appropriateness of the testing tools is also

being questioned, as there are measurement errors, a variety of measurement instruments, and the complexities of self caring are overlooked.

### **2.3.6 Economic discourse.**

Knowledge of older women's health within the economic discourse is presented in financial terms. Health involves the ability to look after oneself and thereby require no financial assistance. Illness involves the need for assistance and therefore a financial dependence on the family or the state.

There are demographic changes in advanced industrial societies which show an increase in the population of older people, and a feminisation of aging (Bonita, 1996; Henrard, 1996; Pool & Bedford, 1997). This trend is predicted to continue (Henrard, 1996; Richmond, Baskett, Bonita & Melding, 1995). Congruent with this trend in New Zealand the population of older women is predicted to rise, with increasing numbers of women living beyond 85 years of age (Prosser, 1998). Much literature relevant to older people refers to the predicted increase in the older population and makes comment about subsequent economic implications (for example Choi & Wodarski, 1996; Khaw, 1997; Laditka, 1998; Mitchell, 1996).

Within the New Zealand context there have been structural changes through health reforms with the aim of improving access to health services as well as improving the effectiveness and efficiency of delivery (Ministry of Women's Affairs, 1998). Words such as funding, access, specified maximum waiting time, service providers, consumers, health delivery, health outcomes, resources, contracting and cost reduction are used within the economic discursive field. Through the utilisation of economic terms older women's health becomes defined through those terms rather than through health terms. In this discourse there is voice for the usage of scarce resources, but no voice for the productive aspects of older women's lives.

As there is a predicted increase in the number of older women whose health is being defined in economic terms, planning for their health care becomes imperative. Planning for effective usage of scarce resources is complex as predictions are made based on current statistics. Whilst it is clearly important to identify trends in order to



plan effectively, it is also important to pay attention to the wider context in which these trends occur so that biases do not develop. To state that there are increasing numbers of older women who are living longer is statistically correct. However to link this projected increase with increasing costs from health care demands portrays a perception of older women as a threat to the economic well-being of society as they are seen to be a burden on the health system (Fenton, 1993). As women live longer lives than men the burden aspect becomes associated with women.

Increasing numbers of older women who live longer affect the composition of the population. However that is only one of several factors. Pool and Bedford (1997) discuss the importance of the composition of the population in social policy planning. They suggest that whilst aging has been studied and acknowledged within this planning, other complexities which make up population compositions, and are therefore important components of social planning, have not been studied or factored into the planning of change. Myers (1998) identifies fertility, mortality and migration predictions as well as changes in family structures, to have relevance to economic and social structures, and to also have political and economic consequences. The wider context therefore needs to be recognised, as focusing on only one aspect such as aging ignores other less known aspects which are important components. Aging is then potentially able to be targeted in an isolated way rather than contextually.

Older women are therefore increasing in numbers and defined in economic terms as burdens to be planned for. They are also labelled dependent as they comprise one portion of the 'dependency ratio'. The dependency ratio is defined as the dependent population (aged up to 15 years and over 65 years) compared to the workforce population (aged 15 to 64 years) (Prosser, 1998). Prosser expresses the concern which has been raised about the changing ratio, in which there will be increasing numbers of dependent people compared to the workforce population. In 1996 the ratio comprised 105 people not in the labour force compared to 100 who were. This ratio in the future is expected to be similar to the 1956 ratio in which there were 166 people not in the labour force for each 100 people who were in the labour force.

Despite this change Pool and Bedford (1997) predict that in the year 2051 the dependency ratio will still be below the 1961 baby boom level. The difference however will be in the composition of the dependent group in which older people will dominate those aged under 15 years (Pool & Bedford, 1997; Prosser, 1998). Whilst concern is expressed about the increasing numbers of older people they are only one part of the dependency equation. Thus fertility rates will affect the dependency ratio (numbers of women in paid work) as well as the composition of the dependency group (numbers of children).

Whilst there is a need for planning in order to provide appropriate resources for an increasing number of older women, few older women will become dependent. Currently approximately 80% of elderly women live in their own homes, 15% live with their children or other relatives and only 3.5% live in residential homes (Prosser, 1998). There has been a re-allocation of resources within disability support services so that there is now a greater emphasis on providing home support services to enable older women to stay in their own homes (Ministry of Women's Affairs, 1998). If this funding continues and required support is provided it will be a viable option for the majority of older women to remain in their own homes. However the level of funding will require review as the Health Funding Authority's current priority is to meet the needs of people with high needs and women with lower needs may be missing out (Ministry of Women's Affairs, 1998).

Chronic illness is of concern as the incidence rises with increasing age. However it is also important to place these statistics in context with other age groups in order that older people are not 'blamed' for costs associated with chronic illnesses. In New Zealand the 1996 household survey found 9% of girls under the age of 15 years, 17% of women aged 15-64 years and 49% of women over 65 years of age experience some form of disability (Ministry of Women's Affairs, 1998). Therefore 51% of older women do not experience disability. There is also an emerging pattern from Europe and North America that the disability prevalence rates amongst older people may be starting to decline (Mathers & Robine, 1998). If this becomes an established pattern older people may experience improved health. However it is important to note that in

these statistics older people are treated as a homogeneous group, and variations from gender, race, ethnicity and socioeconomic resources are not represented.

In summary, economic concerns are located within the economic discourse for an increasingly aging population in which women predominate. The portrayal of older women as dependent and costly is not reflective of all older women and is not contextual, as there are other factors to be considered. However productive aspects of older women's lives are not visible and are therefore not valued.

There is no positioning within the economic discourse for the productive or working older woman. Some older women work in paid employment full time or part time, do voluntary work or are productive in their unique ways. This aspect of older women's lives is unseen, unrecognised and unacknowledged. In 1996, 7.5% of women aged 65 to 74 years, and 5.2% of all older women were in the labour force (Prosser, 1998). Voluntary work is carried out by older people and includes child minding, delivering meals on wheels, coaching sports teams, providing transport for others, education, administration and volunteer work (Prosser, 1998). Approximately 33% of older women aged 65 to 74 years; 17% of women aged 75 to 84 years; and 4% of women over 85 years of age work voluntarily (Prosser, 1998). This is unpaid and mainly unrecognised work (Ministry of Women's Affairs, 1998). However other productive work which women do may not be reflected in statistics as women may not perceive it as work. An example is provided by one of the participants in this study. She teaches a woman who delivers her meals on wheels, and for whom English is her second language, colloquial English. This is a productive aspect of her life. Yet it is not visible within the economic discourse.

To summarise, the economic discourse gives voice to expenditures and hence the negative cost implications of older women. There is a focus on older people, especially women, and their dependency, separated from total population dependency. There is also no voice for productive aspects of older women's lives as much is unpaid and unseen.

### 2.3.7 Wellness discourse.

Over the last decade an interest in wellness has been developing, creating an emerging discourse. Within the wellness discourse there is evidence of older women defining themselves as more assertive, managerial, and autonomous than in previous life stages as they become free of traditional feminine roles (Palmore, 1997). Some older women appear to be located within this discourse as many identify their perceptions of wellness in spite of limitations, and identify their focus on promoting their health (Kaufman, 1996; Strain, 1993).

It is clear that older people have diverse definitions of health (Kaufman, 1996; Sidell, 1995; Strain, 1993). However within this diversity many elders view health in a way which includes combinations of bio-physical, psychological and social categories (Sidell, 1995). Many elders live with and include chronic illness or disability in their definitions of health (Kaufman, 1996; McWilliam, Stewart, Brown, Desai & Coderre, 1996; Sidell, 1995). The inclusion of illness in definitions of health contrasts with uni-dimensional definitions, which if applied to elders would exclude many from being healthy. In New Zealand the number of older people who experience chronic illness or disability is unclear. However in the 1996 Household Disability Survey, 49% of women over the age of 65 years indicated they have some form of disability (Ministry of Women's Affairs, 1998). The inclusion of illness and disability within elder's definitions of health, is representative of multi-dimensional definitions of health.

Some older women are located within this discourse. Armstrong (1996) describes that thirty older New Zealand women, with Maori, European, Chinese and Central European origins, reported having less physical energy, than when they were younger. However this was clearly not a major issue for them as they concentrated on the productive aspects of their lives. The emphasis is therefore on abilities and not on losses. Wearing (1995) encourages older women to challenge stereotypes and create tensions by being active. She encourages an emphasis on ability and activity rather than on inability.

The concept of 'successful aging' is found within this discourse. Factors which contribute to successful aging are identified as socio-economic status, constitution,

personality and social support (Henrard, 1996). Henrard demonstrates the relationship between socio-economic status, health and increasing age, suggesting that access to material resources, both cumulative and immediate, impact positively on health, and lack of material resources can exacerbate the effects of disability and chronic illness. Armstrong (1996) clearly identifies the meaningful lives which some older New Zealand women enjoy and which contribute to their successful aging. She identifies some cultural diversities which illustrate difference between older Maori, European, Chinese and Central European women.

The wellness discourse is representative of understandings of health of some older women. Diversities are also evident and the search for a recipe for successful aging is unlikely to be fruitful because of diversities. However within the wellness discourse older women promote holistic and multi-dimensional definitions of health and focus on their abilities rather than restrictions. This is currently a small emerging discourse.

### **2.3.8 Summary of discourses of the health of older women.**

The discourses which I have identified within the discursive field of older women's health are the social, bio-medical, psychological, biopsychosocial, functional, economic and wellness discourses. It has become apparent from the analysis of the literature reviewed that the dominant discourses are the social and bio-medical discourses. The representation of women within these discourses focuses on negative aspects of aging and refers to decline and loss of abilities. The social discourse reproduces knowledge within stereotypical social constructions which do not reflect the experiences of all older women. The bio-medical discourse generates and reproduces knowledge of older women in physiological terms. The medicalisation of aging has drawn the process of aging into the institution of medicine. As such the focus on decline stems from changes associated with aging in which comparisons are made to younger physiology.

It has also become apparent that the bio-medical discourse has considerable influence on both the psychological and biopsychosocial discourses. These discourses therefore overlap, and all define older women's health in terms of decline and loss. Knowledge within the psychological discourse depicts mental decline and negative mood states,

with little acknowledgment of mental capabilities and positive mood experiences. Knowledge within the biopsychosocial discourse appears to represent a more holistic understanding of health as biological, psychological and social aspects are understood to be interrelated. However the holistic impression is illusionary due to inherent reductionism.

The functional discourse also represents a negative image of older women's health as knowledge is generated within functional terms. This discourse appears to be a dominant discourse within gerontology and the descriptions of older women's inabilities define their health. There are associated caring and economic implications when inability occurs and 'the family' or the state may become involved.

Within the economic discourse, health is redefined in economic terms. A strong voice is heard in which older women are understood as a drain on financial resources and in which there is no voice for the working, productive and participatory aspects of older women's lives. The population which is aging is increasing, and planning is important in order to ensure resources are available. However an emphasis on the 'burden' of dependent older women must be resisted and all aspects of the dependent population taken into account.

The wellness discourse is an emerging one in which positive images of older women's health are present. There is a focus on abilities and strengths rather than losses and inabilities. The voices of some older women are present within this discourse and therefore representations of health are more reflective of older women's understandings. This discourse has been emerging over the past decade.

I will now suggest two possible reasons for the dominance of negative aspects of decline and loss in the representation of older women's health. In order to do this I will apply the concept of power, which has been discussed earlier in this chapter, to the competing representations of older women's health. To briefly recap the concept of power, each discourse is a representation of truth, and as such is linked to power. A dominant discourse predominates in its claim to represent truth and derives power through embeddedness within powerful institutions. Power therefore stems from



locatedness within discourse and is reproduced through the control of social knowledge.

The first possible reason for the negative portrayal of older women's health is that knowledge is generated predominantly by people who represent the bio-medical discourse (Sidell, 1995). The bio-medical discourse has been shown to influence the psychological and biopsychosocial discourses. The focus of bio-medicine is 'the body' and health is defined in physiological terms. Medicine has taken an interest in aging, with an inevitable focus on the deteriorating and declining changes associated with aging. Truth of older women's health within these discourses is therefore related to decline, and knowledge of decline is reproduced. Medicine has embedded power and therefore a voice for representing older women's health.

The second potential reason stems from the current economic model of many western countries with pension systems. In this model adults generate income through their labours, and once they stop labouring older people become entitled to income based on their needs (Minkler & Cole, 1999). It is possible that the dominance of this mode of thinking has so permeated western societies' perceptions that older people can only be thought of as economically dependent. This dependence can be extrapolated to associated decline and loss in physical, psychological and other terms. Truth within this discourse represents older women as dependent. Whilst some elders do experience dependence the majority are independent, yet the independent voice is not visible. Older people are not able to be known as generative and contributory because this image is not present in the economic representation of dependence. Power is embedded within social and political realms which influence economic factors.

Discussion on the discourses which represent older women's health will be extended to include reference to nursing's locatedness, after I have addressed the discursive field of health promotion and the older person.

### **2.3.9 Health Promotion.**

Research has aimed to increase knowledge of health promoting activities amongst elders. However the lack of an agreed definition of health promotion is reflected in the



variety of approaches taken within health promotion of elders. The emphasis has been on the prevention and early detection of disease, rather than on the promotion of positive health. This reflects the dominance of the medical model within health promotion.

Within the target population of the individual, elders have been found to promote their health by engaging in specific health promoting behaviours (Sidell, 1995), and to do so more than younger people (Walker, Volkan, Sechrist & Pender, 1988). Many health promotion programmes emphasise the modification of individual 'risky' lifestyle factors. Backett and Davison (1992) criticise this approach to health promotion in which what is deemed healthy and unhealthy for some people is generalised to be healthy and unhealthy for all people. The emphasis on individual responsibility also deflects attention from the broader determinants of health including genetic inheritance, environment and socio-political factors (Ward-Griffin & Ploeg, 1997). Despite this criticism it is apparent that some elders do accept responsibility for certain aspects of their health (Sidell, 1995).

At community level in the New Zealand context, a report titled 'Care for Older People in New Zealand' (Richmond et al., 1995) made reference to health promotion in the recommended strategies. These strategies aimed to develop health promotion programmes at national level, and to establish a national programme for the dissemination of information on "normal ageing and wellness strategies for living" (Richmond et al., 1995, p. 85). Support was therefore present for the inclusion of both a preventative and a wellness approach. The wellness approach has been followed up in a report titled 'Facing the future: A strategic plan' which defines a vision for positive aging (Department of Prime Minister and Cabinet, 1997). Eight initial actions have been suggested in this plan which focuses on creating a climate for positive aging. This strategy of wellness promotion is therefore a relatively new development within health promotion for the older person.

Within New Zealand, health is currently being promoted for elders through an immunisation programme against disease, which aims to prevent illness. Older people are being encouraged each winter to obtain free immunisation against influenza. This

is in response to an objective from the Ministry of Health (1997) to protect older people from preventable infectious diseases and the target vaccination rate is 75% of the at risk population by the year 2000.

Health promotion through the early detection of disease appears to be exclusive of older women. In New Zealand as well as the United Kingdom the screening programmes which aim to detect disease early, (cervical screening and mammography), target women aged chronologically less than 65 years. This occurs despite inconclusive evidence about the effectiveness for younger women or lack of effectiveness for women aged over 65 years (Henwood, 1993). These screening programmes have the early detection of disease, rather than promotion of health and wellness, as the primary focus. Older women are not included in the target populations for these programmes. In New Zealand, Sainsbury and Richards (1997) claim there is insufficient evidence to warrant population based screening for early identification of osteoporosis. However they point out that individual bone mineral density measurements may be useful. The responsibility and associated costs therefore lies with individual women.

The targeting of the individual for health promotion has been criticised for ignoring the wider genetic, environmental and political contexts which affect health. Community programmes have been criticised for focusing on illness prevention and detection which have a disease focus. A further suggestion has evolved using a critical social paradigm in order to promote effective health promotion (Ward-Griffin & Ploeg, 1997). This approach is proposed as it is more promotive of empowerment and change than the more traditional paradigms.

To summarise, health promotion is a broad concept, and there are a variety of philosophical approaches which make it a contentious field. There is a small focus on the older person within this field. One approach is to target 'risky' individual lifestyle behaviours and within this approach some elders claim to engage in health promotion activities. Within the approach of early detection of disease, current screening programmes are exclusive of older women. There is a commitment to positive aging

which is in early phases within New Zealand, and which may begin to redress the previous focus on illness and disease.

I will now return to the discourses previously identified within older women's health in order to consider the positioning of nursing within these discourses.

## **2.4 The positioning of nursing.**

Nursing has generated its own knowledge in relation to older women's health and I will analyse the relationship of these constructions to each of the discourses. After analysing the social discourse, I will discuss the positioning of nursing within the bio-medical and psychological discourses together. This is because both discourses focus on the individual 'body', with the bio-medical discourse focusing on the physical body and the psychological discourse focusing on mental functioning.

### **2.4.1 Social discourse.**

The social discourse is important to nursing as society is the context in which nursing occurs. There is evidence that not all nurses display positive attitudes towards elders. Bernard (1998) suggests that gender issues may affect the way in which nurses care for older people, with older men being nursed more positively than older women. She suggests that this occurs because female nurses are fearful of their own aging, rather than from holding ageist attitudes. She encourages nurses to address challenges which stem from aging women (that is all women) and aged women (that is women who are already aged) in order to overcome this barrier.

Burggraf and Barry (1998) express a similar concern about nurses' attitudes towards elders in North America. They indicate that many faculty (up to 87%) who teach in gerontology courses are not specifically prepared in this specialty area. The impact of this is the transferral of values and attitudes reflective of ageist stereotypes and which do not promote positive information of older people. More research is needed however to explore registered nurses attitudes towards older women.

### **2.4.2 Bio-medical and psychological discourses.**

There is a nursing presence within these discourses, although there is tension between theoretical espousing and practical application. Nursing has a core interest in the concept of health but no clearly agreed definition. Some nurse theorists promote a multi-dimensional conceptualisation, however nurse researchers continue to apply uni-dimensional definitions (Raftos, Mannix & Jackson, 1997). Some nurse theorists have illustrated links between health and wellness. Pender (1996) defines health and wellness as actualisation of human potential and stability, through homeostasis and adaptation. She claims that health is holistic but that it becomes fragmented in the minds of health professionals. Mitchell (1995) provides an integrated model in which an illness and disease continuum (ranging from life threatening to no disease/illness) intersects with a wellness continuum (ranging from low level to high level wellness) to provide a state of health. In this model therefore wellness co-exists with disease and illness and multiple dimensions of health are acknowledged.

Whilst nursing promotes these multi-dimensional and holistic understandings of health, nurse researchers have remained reluctant to embrace the accompanying complexities. A decade ago Reynolds (1988) reviewed nursing research on health conducted between 1977 and 1987. She found no agreement about how to measure the concept 'health'. Most measures were physical measures, few were mental health measures and none measured sociological dimensions of health. She concluded that while nurses promote the holistic model of health their research reflected measurement in the uni-dimensional model in which health is the absence of disease or illness.

This trend has continued (Perry & Woods, 1995). Heidrich and Ryff (1993), Heidrich and D'Amico (1993) and Elnitsky and Alexy (1998) have continued to apply assumptions of uni-dimensional models of health in their research. They have measured health and illness as the presence or absence of specific physical or mental health symptoms, medical conditions, number of days spent in bed in the previous three months or the ability to perform specified physical and intellectual tasks. Raftos et al. (1997) support the presence of a reductionist view in their analysis of nursing literature on 'women's health' published in CINAHL between 1993 and 1995. They

claim that holism is espoused in the literature but that a reductionist approach is taken in nursing research.

Nursing literature which is located within these two discourses, investigates changes associated with aging, and which involve decline, deficiency and loss. Medical interventions may be posed as ways to counteract the decline. Drugay (1997) provides an excellent example of this as she discusses the disease osteoporosis. Biological deficits, risk factors and early detection are described. Drugay recommends client education to avoid the development of osteoporosis, or to counteract osteoporosis, as well as education about the risks and benefits of treatment by hormone therapy. The medical model is replicated within this article, and the nurse is described as having a health promoting role of educating the public.

Nursing is present within these two discourses, and replicates reductionist understandings of health. Nursing also applies definitions of health in which disease and illness are excluded, and this reflects the dominance of uni-dimensional definitions of health.

#### **2.4.3 Biopsychosocial discourse.**

Nursing speaks from within this discourse, which may reflect nursing's espoused desire to provide holistic care. Some examples of nursing research within this discourse include the effects of social support on psychological health (Kanacki, Jones & Galbraith, 1996), psychological factors on physical functioning (Resnick, 1998) and physical health on psychological well-being (Heidrich, 1993; Heidrich & D'Amico, 1993).

The importance of research on the 'quality of life' and 'successful aging' of the older person has been identified (Magnani, 1990). The quality of life of the older person is affected by their health, and encompasses biological, psychological, interpersonal, social, economic and cultural aspects (Keister & Blixen, 1998). Keister and Blixen promote nurses and physicians adopting this discourse in order to address the complex needs of the older person. There is no reference to older person's views within this literature.

Nurses have studied social support within this framework, mainly from a deficit framework in which loss of social supports are found to adversely affect health. Trice (1990), Burbank (1992) and Bondevik and Skogstad (1998) agree that social support is an important determinant of health for older people. Trice and Burbank recognise the importance of relationships with others and suggest that 'meaning in life' may be related to these relationships with others as well as performing worthwhile activities. Meaning and purpose in the lives of older people has been described as being created by 'hope' (Gaskins & Forte, 1995). Hope has also been described to influence the quality of life (Beckerman & Northrop, 1996).

#### **2.4.4 Functional discourse.**

Nursing is evident within this discourse, although the literature base is small. The underlying aim is the promotion of independence and self care of the individual. Research has focused on the evaluation of measurement tools, and complexities of the concept of self care. The nursing role has been to teach the individual how to perform activities of daily living, such as personal care, and to assist the individual by meeting their deficits. The theory of self care, self care deficits and nursing systems proposed by Orem (1991) is an example of nursing theory within this discourse.

There is no one tool which is promoted to assess functional abilities. Whittle and Goldenberg (1996) agreed with the implementation of the Multidimensional Functional Assessment Questionnaire/Instrumental Activities of Daily Living (IADL) Scale as a valid way of assessing functional health and instrumental activities of daily living. They promote the use of these assessment tools in order that elders are adequately assessed and the maintenance of functional health and independent IADL can be promoted. The aim of promoting independence is stated as enabling elders to remain in their own homes. Lyle and Wells (1997) evaluated another functional assessment tool. They found the Abilities Assessment Instrument to be a valid tool to measure self care. The Index of ADL developed by Katz, Ford, Moskowitz, Jackson and Jaffe in 1963 is reported by Bennett (1999) to be the most widely used measure of functional disability in nursing practice and research, though there is little evidence of reliability or validity except for its common usage.



Bennett (1999) described inaccuracies in the use of self reporting of measures of functional disability. She cited reasons for elders to give inaccurate answers to be due to misunderstanding the question, or failing to recognise the changes which have occurred and to which they have adapted. She also identifies that there are difficulties within the interpretation of levels of disabilities. However, Bennett does not consider that the tools have been developed using health professionals' understandings of functional abilities rather than the lay person's perspective.

Smits and Kee (1992) applied Orem's concept of self care, and found functional health status to be correlated with self concept, but not with self care. They advocate the promotion of self concept and also self care. The unaided ability to perform activities of daily living as well as physical functioning are frequently associated with independence (Davies, Laker & Ellis, 1997). Independence is an assumed philosophical ideal which is promoted in the literature. Bondevik and Skogstad (1998) found that, contrary to independence being an ideal, being independent in performing activities of daily living was associated with emotional and social loneliness for some elders. The impact of independence therefore needs to be explored further, and possible ethnic and cultural variations identified.

Some complexities of the concept of functional ability have been addressed. Resnick (1998) studied motivation as a factor in the performance of functional activities in elders and found motivation to be multidimensional. Spitzer, Bar-Tal and Ziv (1996) found that older people were more likely to maximise their control by being self sufficient in solving their health problems, thereby promoting their self care. This research has an underlying assumption that if the relationship between the two variables is proven, then altering interventions positively will improve the outcomes. However the full complexities within this discourse are still not being addressed.

#### **2.4.5 Economic discourse.**

Nurses repeatedly cite changing demographic trends in nursing literature (for example Blair & White, 1998; Dungan, Brown & Ramsey, 1996; Heidrich & D'Amico, 1993). Quoting statistical trends of elders has occurred in this study. Discussion on demographic trends provides some background data in order to understand the context



of the study. However nurses also appear to have uncritically accepted the replication of knowledge within this discourse, which represents older women as economic burdens who generate increasing costs associated with chronic disease and dependency as their numbers swell (for example Blair & White, 1998; Burggraf & Barry, 1998; Dungan et al., 1996; Heidrich & D'Amico, 1993; Zhan, Cloutterbuck, Keshian & Lombardi, 1998). There is no voice for productive aspects of older women's lives. The representation of older women's health is therefore a negative one.

#### **2.4.6 Wellness discourse.**

Nurses have a small presence within this discourse. There is evidence that older women include illness and disability in their definitions of health, and therefore experience wellness which includes illness or disability. Schank and Lough (1990) studied the health of older women and found that they experienced good health despite multiple health problems and the presence of illness symptoms. Perry and Woods (1995) have asked older women what health means to them. They found that there were many similarities between the meanings of health to older women when compared to younger women. However one difference was that older women included illness and functional limitations within their definitions of health, which indicates that they retain positive images of health as they age. Viverais-Dresler and Richardson (1991) also found older women retain positive images of health inclusive of chronic illness. They also found that nearly 50% of their participants identified health to be a "bio-psycho-social" construct, and identify this to be congruent with wellness. Clearly therefore some older women are located within the wellness discourse.

Moloney (1997), Morrissey (1998), Porter (1994), and Wagnild and Young (1990) have studied other positive aspects of older women's lives which have relevance to their health and well-being. Moloney asked older women to describe an incident in which they felt strong, and identified the concept of home (literal and metaphorical) as an important component of strength. Morrissey identified independence to be a theme amongst the resources and characteristics of older women living alone. She claimed that the ability of the older woman to construct a lifestyle which was acceptable to the woman contributed to continuing to live alone. Porter explored the concept of risk, associated with living alone, for older widows. She identified ways in which these

widows reduced their risks, which included exercising caution, negotiating reliance and bringing their world close to home. Wagnild and Young found resilience to be a theme amongst older women who were identified by others to be 'aging successfully'. Whilst the foci of these studies are not directly health, the topics are relevant to health and wellness. They promote positive images of aging.

Davies et al. (1997) investigated the positive concept of autonomy and suggested that independence is often used interchangeably with autonomy. They claim autonomy to be multi-dimensional and context-dependent, and recommend that these concepts are viewed as separate though overlapping. A nursing perspective is taken in relation to the ethical aspects of balancing the promotion of independence and autonomy against the potential risks inherent in activities. However there is no discussion of the meaning of independence, autonomy and risks from the elder's point of view.

Nurses have been challenged by Herbert and Salmon (1994) who question their ability to correctly assess patients. Herbert and Salmon are social scientists who compared nurses' perceptions of patients' well-being with the patient's self assessment. They describe nurses' perceptions of elderly patients' well-being to be 'highly inaccurate' when compared to the self rating of the elders. They suggest that this discrepancy arises because nurses base their assessment of the patient on the overt behaviours the patient displays, which are not predictive of well-being. However an alternative explanation may be that nurses are aligning their perceptions with that of the dominant bio-medical discourse rather than the wellness discourse. This discrepancy however does raise interesting questions about nurses' understandings of health.

The discourse in which the older women are embedded clearly differs to those dominated by medicine. The older woman's voice is present and describes events and concepts from the lay person's perspective. Nursing does have a small presence in this discourse, and contributes to hearing the older woman's voice.

#### **2.4.7 Nursing and health promotion.**

Within nursing there are different interpretations of the concept 'health promotion' (Delaney, 1994; Duffy, 1993; Maben & Macleod Clark, 1995). Duffy defines health

promoting activities as regular activities and perceptions in which the person engages in order to maintain or enhance well-being. Maben and Macleod Clark describe 'traditional' definitions in which the individual is persuaded to make lifestyle changes in order to prevent disease, and is also encouraged to be responsible for these behaviours. They also describe the 'modern' approach in which positive health, inclusive of physical social and mental aspects, is emphasised and through which autonomy is promoted. They claim that nursing adheres to the 'traditional' definition.

In alignment with the 'traditional' approach of the health promotion movement nursing has focused on the prevention of illness and protection of current health for the individual (Caraher, 1994; Kulbok & Baldwin, 1992; Maben & Macleod Clark, 1995). There is little reference to the promotion of positive health. Nurses have placed an emphasis on the individual to be responsible for health, through nursing's focus on the individual (Caraher, 1994; Delaney, 1994).

Nurses have demonstrated that elders do engage in health promoting activities. Walker et al. (1988) compared health promoting lifestyles of older, mid-life and younger adults. They identified that older adults claimed greater health promoting behaviours than mid-life and younger adults. These behaviours included adequate nutrition, taking responsibility for health and stress management. Bechtel and Franklin (1993) studied health promotive activities of elders and university students, and identified both groups to be actively involved in such activities. They attributed variations in activities to culture as well as to age. Pascucci (1992) studied motivation for health promotion amongst elders and found 'feeling good, fitness and health' to be main reasons for elders to engage in activities identified as health promoting. Elders have also demonstrated receptiveness to health promotion programmes, and have changed their lifestyle behaviours (Pascucci, 1992; Uriri & Thatcher-Winger, 1995).

Nurses advocate changing 'risky' lifestyle behaviours through the education of patients. The relationship between health education and health promotion is discussed within nursing literature and identified as closely related, though not synonymous. Criticism of this individualistic focus involves the recognition that the context in which health promotion occurs is political and ideological. Caraher (1994), Delaney

(1994) and Kermode and Brown (1995) urge nurses to act within the socio-political arena and encourage people to fight against inequalities which affect their health. However this is currently rhetoric.

There is a wide variety of factors which have been used to measure health promotion behaviours. Specified health promoting behaviours have been studied and measurements of physical and mental health of older participants used to decide whether positive change has occurred. Measures of health have included exercise, strength, flexibility, cardiovascular fitness, self reported sleep, nutrition, self esteem, life satisfaction and mental status (Dungan et al., 1996; Stevenson & Topp, 1990; Uriri & Thatcher-Winger, 1995). Improvements in health have been measured in pre- and post- tests and this improvement has been attributed to the application of health promotion programmes which include regular exercise (Stevenson & Topp, 1990), as well as health teaching and group participation (Dungan et al., 1996). Dungan et al. claim that demonstrating an improvement is an outstanding achievement in this age group as maintaining the status quo is in itself an accomplishment. Their claim includes an assumption that decline is inevitable within aging. However, the possibility that these findings are not specific to the older person is not addressed by the authors. It is possible that improvements could be found in any age group who participated in a similar programme.

Viverais-Dresler and Richardson (1991) applied a functional framework to interpret the health promotion activities of elders in Canada. This framework described role relationships, coping tolerance, values, activity and nutrition. Viverais-Dresler and Richardson identified many different health promoting patterns within each of the five categories. Healthy eating and physical exercise are also identified by Duffy (1993) as measures of health promotion and as interventions in health promotion programmes for elders. Similarly Mitchell (1996) asked older women what influenced their health and found that diet and exercise were main influencing factors.

Extension to the range of factors reflective of health promotion is provided by Blair and White (1998) who focus on issues of urinary incontinence, hormone replacement therapy and immunisations. They ask whether older women are counselled sufficiently

by nurses on these aspects of health promotion. They claim a role for nurses in counselling about all three factors. Uriri and Thatcher-Winger (1995) focus on breast or rectal examinations, mammography, nutrition, exercise and seat belt use in their health risk appraisal of elders.

To summarise nursing's position in relation to health promotion, it is clearly evident that within nursing there is a wide range of activities which fall under the umbrella of health promotion. Nurses apply the traditional concept of health promotion through education, and have taken an individual approach in which risky lifestyle behaviours are expected to change after the application of education. The myriad of activities which represent health promotion may mirror those which are illness preventive. However, there is little evidence of health promotion being pursued through political avenues and also little evidence of the positive promotion of well-being.

#### **2.4.8 Summary.**

Nursing has been considered in relation to each of the discourses of older women's health. Nursing has been shown to be visible and is therefore embedded within each discourse. This range of positions in the representation of older women's health reflects diversity within nursing.

Nursing is present within the discourses dominated by medicine, which are the bio-medical, psychological and biopsychosocial discourses. The knowledge which nursing generates within these discourses is influenced by the social constructions available within the discourse and these consist of negative images of decline. Positive aspects of health are silenced by the dominance of negative aspects of deterioration.

Nursing is also located within the functional and economic discourses. In these discourses nursing accepts the representation of older women as functionally and economically dependent. Knowledge is not generated of older women as productive and contributory people and their independence is not visible. There has been a focus instead on older women with health and dependency issues.

Nursing is present but not strongly visible within the wellness discourse. There is evidence from the literature reviewed that some older women locate themselves within this discourse. The focus is on positive aspects of health rather than on decline. Health changes are included in the definitions of health of older women. It is incongruous therefore that nursing is not strongly embedded within this discourse, as nursing claims to provide individual holistic client centred care. Instead nursing appears to be influenced by the representations of health by dominant and overlapping discourses, rather than the discourse in which older women themselves are located.

## **2.5 Conclusion.**

This chapter has identified discourses through which understandings of older women's health are constructed. The health of older women is understood predominantly through social, bio-medical, psychological, biopsychosocial, functional, and economic discourses. However many older women appear to understand their health within a wellness discourse. Nurses are located within the dominant discourses rather than within older women's discourse. The alignment within dominant discourses places nursing alongside medicine instead of alongside older women.

In the next chapter I will move from discourses which represent older women's health to focus on the methodology and the method of this study. The underlying methodology is feminist. This methodology provides a framework within which the study has been generated and conducted. The method is explained, and the data analysis using thematic analysis is also discussed.



## **CHAPTER THREE: Feminist Methodology and Research Method.**

### **3.1 Introduction.**

In the previous chapter I have considered the discourses through which knowledge of older women's health is generated. The discourse in which older women locate themselves is the wellness discourse. Nursing however is aligned with bio-medical, psychological, biopsychosocial and functional, dominant and overlapping discourses. Nursing is also evident within the economic discourse. I have identified discourses in order to provide a context for older women's health. Context is important within feminist scholarship and research.

In this chapter I will discuss feminist methodology which is the underpinning framework for this study, and the concepts of feminist methodology as they relate to this work. Thematic analysis, the method of data analysis for this study is then described as well as the way in which thematic analysis has been useful for this study. The method is explained in order that the reader can progress through and understand the processes which have been applied.

### **3.2 Feminist methodology.**

There are feminisms rather than one feminism and so it is important to identify some common aspects of feminist research, particularly those specific to this work. I will begin by identifying five key tenets of feminist research, followed by the issue of rigour within feminist scholarship. I will then discuss the relationships between feminist research and nursing, and conclude by examining the relevance of feminism to older women.

#### **3.2.1 Commonalities within feminist methodology and research.**

Feminism is evolving as feminists pursue knowledge to improve the lives of women in particular, and men where gender is identified as central to the inquiry. Plurality and



instability are present in the diverse approaches to feminist epistemology and methodology (Crawford & Kimmel, 1999; Olesen, 1994; Russo, 1999). However, Worell and Etaugh (1994) propose six themes to be present within feminist literature, which represent intersecting values and beliefs of feminism. Each theme represents multiple issues. The first theme is that feminists challenge the tenets of traditional scientific inquiry, and second, that the experiences and lives of women are the focus of knowledge development. Thirdly power relations are viewed as the basis of patriarchal political social arrangements. Following is the theme in which gender is recognised as an essential category of analysis. Then is the attention to the use of language and the power to “name”. The final theme is the promotion of social activism toward the goal of societal change.

The articulation of these themes by Worell and Etaugh (1994) describes my thinking well in relation to issues within feminist literature. I will use five of the six themes to describe issues which have surfaced within feminist discussion and which have relevance to this study. The sixth theme, which I will not examine, is the view that power relations are the basis of patriarchal political social arrangements. The reason I will not describe this theme is that I have analysed power in the context of discourse, in which each discourse represents a ‘truth’ and power stems from the dominance of one ‘truth’ over other ‘truths’. I will now discuss each of the five themes.

#### 3.2.1.1 Challenging the tenets of traditional scientific inquiry.

I will discuss two topics within this theme: the objective versus subjective nature of knowledge; and the participants’ experiences within the research process.

The first topic is the objective and subjective nature of knowledge. Feminist research, as other interpretive and critical methods, embraces multiple approaches to enquiry. Each approach makes a unique contribution to the development of knowledge. Much feminist research does however challenge the assumption within empiricism that knowledge is objective and value free (Worell & Etaugh, 1994). Feminist scholars have claimed that objective knowledge contains inherent values, and have proposed that researchers acknowledge the values which bias their research (Campbell & Schram, 1995). Keddy (1992, p. 6) describes the focus on subjectivity instead of

objectivity as “one of the most liberating aspects of feminist scholarship.” Recognition of subjectivity acknowledges the importance of context.

Knowledge is therefore not perceived to be free from social construction (Lather, 1991), nor free from inter-woven historical, social and linguistic contexts which include race, ethnicity, politics, class, age, religion and other affiliations (Code, 1991). Code argues that knowledge is both objective and subjective. It is objective as the processes for knowledge construction require structures, and subjective as the processes include subjective input from “specifically located subjects” (p. 255). She redefines the objective/subjective dichotomy so that it overlaps instead of being on a continuum. Subjectivity is therefore recognised to be a legitimate part of feminist research.

The second topic is the research participants’ experiences within the research process. Worell and Etaugh (1994) state that “respecting the experience and perspective of the other” is central to contemporary feminist thought (p. 444). Research participants are perceived in ways in which they are not disadvantaged. The researcher aims for non hierarchical relationships for all participants including the researcher (Campbell & Bunting, 1991; Campbell & Schram, 1995). Feminist research processes can generate personal and political challenges for researchers and participants (Maxwell-Young, Olshansky & Steele, 1998). Kitzinger and Wilkinson (1997) claim that researchers may experience inherent conflict as they can reflect and validate a participant’s experiences, or can provide a critique of the socially constructed experiences of the participant. This is an issue feminism has grappled with although Kitzinger and Wilkinson claim current research practices are validating of the participants’ experiences.

In this study each participant is able to scrutinise the themes which I identify, and to ponder her experiences in relation to eight other older women. She is also able to verify the accuracy of themes for her and articulate any discrepancies. I have attempted non-hierarchical relationships with participants, though I feel unclear about the effect of being in a different age group to the participants. In this study a validation of the participant’s experiences is all that is able to be offered.

To summarise, the traditional assumptions and expectations of scientific inquiry have been challenged within feminist research. Within feminism, subjective knowledge is accepted as legitimate knowledge and therefore knowledge is contextual rather than objective. Participants are valued and research processes are made explicit.

### 3.2.1.2 Focus on the experiences and lives of women.

Women's perspectives have, so far, been central to feminist research (Hall & Stevens, 1991; Maynard, 1994). Feminist epistemology accepts women's experiences to be legitimate sources of knowledge (Campbell & Bunting, 1991; Campbell & Schram, 1995; Crawford & Kimmel, 1999; Shields & Dervin, 1993). Two issues have emerged within this theme. The first poses the question "which women?". The second relates to the articulation of experiences.

First, 'Which woman?'

Feminism has been concerned with women's issues. Within feminism, some feminists have initially debated women's issues in terms of equality between men and women, and difference between men and women. This has been an ongoing debate which Evans (1995) describes as the 'equality and difference debate'. Evans describes the progress of the debate. The origins stem from women's early striving for equality with men for equal opportunities, rights and conditions. In order to achieve the quest for equality with men, women have unwittingly sought 'sameness' meaning the same as men. This leaves the status and nature of maleness largely unchallenged. However, there are subsequent difficulties within the concept of sameness. One problem is that sameness means the same on men's terms, and as such women are different.

Another problem with the concept of sameness is that of sameness within the category 'woman' amongst women. Holding to the notion of a unitary category 'woman' precludes differences amongst and between women. This suggests an essentialist (unique female nature) notion of women. Evans (1995) claims that feminists have been slow to learn that variations exist amongst women who do not form a homogeneous group. However, despite this slowness, there is some growing recognition that women are not a singular group but are diverse with varied experiences (Code, 1991; Gonyea, 1994; Harding, 1987; Kelly, Burton & Regan, 1994). Women's different experiences

and understandings are additionally influenced by their sexual orientation, class, race, ethnicity, education, age and nationality (Hall & Stevens, 1991). Women therefore have different identities which are formed by intersections of socially constructed concepts. However each woman will have an identity which cannot be reduced to the groups to which she belongs (Evans, 1995). There is therefore difference amongst women.

More recent feminist work (Bohan, 1997; Lindsey, 1997; West & Zimmerman, 1991) has moved the debate out of the bodies of men and women and enabled it to be considered through the lens of masculinities and femininities. This supports the notion that women are as different from each other as they are from men. Gender therefore can be expressed within as well as between groups of women and men. However the notion of difference between women does allow a critical analysis of the role which gender plays in determining the experiences of women.

Evans (1995) describes another aspect of difference amongst or within women which stems from a postmodern perspective. From the postmodern position there is no universal truth. From this viewpoint it follows that there is no truth which subsumes women, but also there is no truth which puts women first or equal. This position creates a potentially fatal position for feminism in which all truths are relative, and the position that women should remain inferior has equal weighting to the position that women should be treated equally or differently. There is no one position which can account for the issues that some women face.

To summarise the issue of 'which woman?', the notion that there is not one group called 'woman' creates difficulties within feminism. There is debate about how to address issues which affect women, whilst some feminists acknowledge difference amongst women.

The debate about 'which women' is an ongoing discussion in the advancement of feminism. In this thesis I will work from the premise that there are diversities as well as similarities amongst older women in New Zealand. Similarities stem from the long histories older women have to draw on in order to understand their health. I base this

thesis on the premise that there are enough commonalities of experiences of being an older women at this time and that these commonalities are representative of older women's experiences of health. I also recognise diversities which stem from differences as women's experiences are modified by class, race, ethnicity and sexuality and which create unique individual experiences and understandings.

The second issue within this theme is related to the visibility of experience. Ensuring that participants' voices are heard is an important aspect of feminist research (Keddy, 1992). However there are apparent limitations inherent in the articulation of experiences (Maynard, 1994). There is recognition that experience occurs within a cultural context for participants and researchers. Participants describe an experience and their description is reflective of their interpretation of that experience (Maynard, 1994). Values are present within descriptions of experiences. The description generates text. The text identifies the discourse and culture of the individual who has described the experience. As such it is not value free. Reflexivity is a concept which involves the researchers identifying their values which may affect the research. Therefore the meanings and understandings of both participants and researchers are affected by cultural contexts.

I have identified that feminist research focuses on women. Extrapolating research findings from participants to all women has been challenged and diversities amongst women are increasingly being recognised. There is debate surrounding the importance of context for both participants and researchers. Currently this issue is managed by researchers articulating their values in order that potential effects on the research can be noted.

### 3.2.1.3 Recognising gender as an essential category of analysis.

Feminist research has identified gender as a legitimate topic for study (Worell, 1996). Worell identifies that whilst all feminist research takes gender to be central to analysis there are multiple conceptions of the meaning of gender. She identifies gender constructions to include: gender as difference between men and women; gender as socially constructed beliefs which create differences between individuals; and gender as a reflection of asymmetrical power arrangements.



One application of the term gender therefore distinguishes social theories from biological theories of sex (Morawski, 1997). Despite the apparent distinction however West and Zimmerman (1991) point out that 'sex' is determined by the application of socially agreed biological criteria to allocate humans into one of two categories, male or female. They identify gender as activities and behaviours which are socially expected based on sex category (male or female), and that it is interactions which constitute gender. It is therefore a "powerful ideological device, which produces, reproduces, and legitimates the choices and limits that are predicated on sex category." (West & Zimmerman, 1991, p. 34).

Within feminism there is discussion that through gender, social processes privilege men and disprivilege women (Annandale & Clark, 1996). Gender is identified as central to individual consciousness (Fleming, 1994). As such gender is also central to institutional structures and powers. Disprivileging of the feminine and privileging of the masculine is reproduced within institutions, and power structures within institutions reinforce this positioning.

However, in contrast to the centrality of gender within feminist theorising Thorne and Varcoe (1998) challenge gender being perceived to be privileged over other socially constructed concepts. These concepts include race, age, sexual orientation and class. The potential for double oppression for women of non-dominant groups exists within the intersection of these socially constructed concepts. Thorne and Varcoe suggest the acknowledgment of all important determinants of women's experiences.

#### 3.2.1.4 Attention to the use of language and the power to 'name'.

Feminism has named and renamed aspects of some women's experiences such as 'date rape' and 'marital rape' (Kitzinger & Wilkinson, 1997). The naming of these issues exposes them as real experiences and as such they become legitimate and available for study. Older women have not been well represented in feminism (MacDonald, 1993; Pohl & Boyd, 1993). There has been little interest within feminism in older women's issues and therefore silence means relevant issues have not been named and are therefore not available for study. Ray (1996, p. 674) describes the study of aging to be a women's issue "by sheer force of demographics". MacDonald (1993) describes her

experience of being out of step in a man's world during her middle years, and then out of step with feminism in her later years as she was no longer young. It is therefore important for feminism to include a focus on older women in order that older women's perspectives are made visible and inequities illuminated.

#### 3.2.1.5 Promoting social activism toward the goal of societal change.

Feminist research is described by Lather (1991) to include praxis orientated research with the aim of opposing the status quo and generating emancipation. A goal of feminist research therefore is to generate opportunities for change during the research process, through increased awareness or through action (Carrier, 1997; Wuest, 1995). The desire to bring about social change is present and is also recognised as a shared principle within feminism (Hall & Stevens, 1991).

Crawford and Kimmel (1999) also recognise social change orientation to be a commonality of feminist research. The call for societal change applicable to elders is made by Ray (1996), who asks for an increased self awareness and self critique within gerontology. Ray poses a postmodern perspective on feminist gerontology which would enable researchers to reinterpret and view issues in different ways, and through which power relationships would be exposed.

Reflexivity is a feminist innovation (Russo, 1999). Crawford and Kimmel (1999) identify reflexivity as "an awareness of the personhood and involvement of the researcher" (p. 30). The reflexive process involves a recognition of the influence of the researcher on the research. Personal values and interests are made explicit. Values become a part of the research data and the researcher is an active participant of the research (Romyn, 1996).

#### 3.2.2 Rigour in feminist research.

Knowledge is scrutinised and subjected to critique. The framework for scrutiny differs according to the paradigm within which it is generated. The search for knowledge within a paradigm which does not embrace objectivity with established criteria of reliability and validity raises epistemological questions of what constitutes knowledge. Within feminist theories, the generation of knowledge from the subjective has created challenges.



Rigour has been redefined within feminism. Hall and Stevens (1991) preferred the term 'adequacy' to reflect that the interpretations made of data fairly represented the phenomena being studied. Rigour also includes the concept of reflexivity, and critique for bias and potentially oppressive aspects of the research (De Marco, Campbell & Wuest, 1993). Worthwhileness and credibility are also suggested criteria (Webb, 1993). These criteria provide guidance for feminist researchers to ensure research is relevant and justifiable. Research findings may be validated by participants.

To summarise, rigour encompasses useful concepts to ensure that research findings are generated in ways which appropriately reflect feminist concern for the generation of knowledge.

### **3.2.3 Feminism and nursing.**

Nursing has embraced qualitative research methodologies which give credence to individual experiences. Some nurses have described feminism, but few have actually aligned themselves with it. MacPherson (1983) described nursing as embracing the 'new' feminist paradigm as the 'old' biopsychosocial theories were not addressing many areas of women's experiences. Whilst feminist research is identified to appropriately contribute to the development of nursing knowledge, some nurses are noted to resist feminism through fears that men's concerns may be neglected (Carrier, 1995).

Within the discipline of nursing there is recognition of the need to generate nursing knowledge from multiple research paradigms including feminist scholarship (Anderson, 1991; Campbell & Bunting, 1991; Sigsworth, 1995). Feminism and feminist critique has the potential to generate knowledge which identifies a socially constructed context (Campbell & Bunting, 1991; Wuest, 1994). The social construction of gender, class and race is inclusive of "diversity, complexity and relevance" (Wuest, 1994, p. 578). Feminist research therefore has the potential to contribute unique knowledge including social constructions.

Feminist research within nursing is considered by some to be emancipatory, as women give voice to their experiences, and having voice enables women to be free of past

oppression (Glass & Davis, 1998). However others consider there are limitations for the development of feminist scholarship within nursing practice. Romyn (1996) for example, claims that nursing practice requires generalisable, descriptive and prescriptive explanations which are unlikely to arise from the descriptive work of feminism. This ongoing epistemological debate is likely to continue.

#### **3.2.4 Older women and feminism.**

Older women have been largely neglected by feminists whose focus has been younger women's concerns (Arber & Ginn, 1991). Much feminist writing stops at menopause, and there is little for women who are beyond this experience. The experiences of older women are not articulated from a feminist frame of reference and therefore the contribution feminist inquiry can make to improving the lives of older women is not yet imagined or understood.

This study aims to present the voice of nine older women, and to describe their experiences of being healthy and promoting their health. In this way their voice will be present.

### **3.3 Thematic content analysis.**

Congruence is required between the research methodology and the method of collecting and analysing data. In this study, in which feminist methodology provides a philosophical framework, semi-structured open-ended interviews and thematic content analysis have been applied. Semi-structured interviews generate data which is descriptive of the participants' experiences and is appropriate for thematic content analysis (Burnard, 1991). I will now discuss the relationship of the method of interviews and thematic content analysis, used in this study, to the feminist methodology.

Harding (1987) identified that there is no one method specific to feminist research. Interviews are identified as particularly suited to feminist research as participants are able to use narrative to discuss their experiences (Kelly et al., 1994). Semi-structured interviews are appropriate when the researcher wishes to ask some fixed questions but

also wishes to ask subsequent questions in order to yield rich data inclusive of opinions, explanations and personal accounts (Burnard & Morrison, 1994). Participants therefore lead (or co-lead) the direction of the interview and the researcher does not control the topics for discussion. This type of interview is conducive to feminist research as participants retain control over the content of the interview and are able to fully describe the context of their talk. The context of experiences is recognised as important within feminism, and the participants' experiences from history, race, age, ethnicity and other socially constructed contexts are therefore included in the data. The data obtained from semi-structured interviews is varied and may have depth and richness.

I have used taped interviews to obtain and record data, and participants have altered the transcripts so that the transcript reflects what they wish to be heard. This has ensured that the contribution of participants has been accepted in a way which does not disadvantage them. It also ensures that the participants have control over the experiences which they are making visible. The participants are able to reflect on their spoken words as they read them in the transcripts and so are able to alter, delete or rename words used, which ensures that they are able to name the experiences which they wish to present. The data collection methods and participant control of data, and the return of findings to participants for verification reflect feminist scholarship.

Thematic content analysis is a method of analysing transcripts of qualitative data, which has been adapted from a 'grounded theory' approach identified by Glaser and Strauss (Burnard, 1991). Thematic analysis has been utilised to analyse the data and to generate themes from the data with the aim of describing and not interpreting the data (Burnard, 1997). Thematic analysis is congruent with feminist research as it enables the valuing of the subjective and contextual nature of knowledge. An holistic focus has been taken during the thematic analysis in order to avoid reducing the data to words without contexts. The themes are representative of commonalities amongst the participants. The themes show patterns which are present in different ways amongst participants. However it must be recognised that diversities are also present and that the nine participants have different experiences within the themes.

It is appropriate to analyse semi-structured interviews using thematic content analysis (Burnard, 1991; Burnard & Morrison, 1994; Carryer, 1997). Burnard (1991) describes a fourteen step process for thematic analysis, with the aim of producing themes which are detailed and reasonably exhaustive. The process Burnard describes is based on data which has been transcribed in full. After each interview notes are made about the topic talked about. After the interviews are transcribed they are read and re-read, categories or headings made which should account for most of the text. In this way the whole of the data is included in the categories. These categories are reviewed and reduced in number by combining relevant categories together. Colour coding is applied to the text to identify each category and the text is cut up according to the category coding. In this way the data is retained in its entirety and the context of the categorising words is included. Once the text is cut up according to the colour coding the data in each category is reviewed for inclusion in that category. The desirable end result of the data analysis is the identification of themes which remain close to the data yet allow the reader to make sense of the data.

Burnard (1995) discusses concerns about reductionism within qualitative textual data analysis, whereby text is reduced in order to obtain essences. His concern is for the complexity of data and multiple meanings inherent within the text. Attempting to understand the meaning of the participants words involves interpretation by the researcher. Subsequently research findings are interpreted by the reader. Misunderstandings are possible. In this thesis the feminist underpinning of the research has provided a framework in which participants have been asked to comment on the themes and have been involved in dialogue to ensure they are representative of their realities. In this way the potential misunderstandings between participants and myself are reduced.

Burnard (1997) justifies thematic analysis as a descriptive way of presenting data given by participants without reinterpreting it. He posits that grouping participants beliefs, views and opinions through rearranging text and accepting what is said at 'face value' is justifiable as it does not attempt to interpret data. The research is therefore descriptive.

### **3.4 Method.**

#### **3.4.1 The setting.**

In order to study health a community setting was selected. This avoided a concurrent illness component taking precedence over health. Older women who live in their own home, yet have meals regularly delivered, were considered an ideal group from which to gain insight and understandings. Those who also have meals delivered are requesting some form of service provision which will make living at home either easier or possible. This excluded older women who are totally independent and who may not have considered their health to the same degree. Benefits of talking with older women in the community setting included the possibility for women to participate without being directly approached and the comparative ease of maintaining anonymity for participants.

#### **3.4.2 Ethical issues.**

Prior to commencing the study approval was sought and gained from the Massey University Human Ethics Committee, the Canterbury Ethics Committee and the Christchurch Polytechnic Academic Research Committee. The requirements and recommendations made by the three committees were incorporated into the study.

Confidentiality was maintained despite many participants stating that they wouldn't be telling me anything they would not want others to know. All chose a pseudonym and for seven women this was a name of significance to them. The pseudonym or an allocated participant number was used on all tapes, transcripts, and record of biographical data. The transcriber was asked to maintain confidentiality and she signed a confidentiality agreement (Appendix One). The participants checked the transcripts and were able to delete or alter any information that they wished to, and an updated copy of the transcript was given to them to check and to keep. Participants were aware that only they, my supervisor and I would have access to the transcripts and that the transcriber was the only other person to listen to the tapes.

This process appeared to be quite satisfactory. The only alteration to confidentiality came as two participants, who unbeknown to me knew each other, talked to each other

about being involved in some research and they realised that it was indeed the same research study. Neither woman requested any changes to any processes.

All tapes and transcripts were stored in a locked metal cabinet.

### **3.4.3 Participant selection.**

A flyer (Appendix Two) was mailed out with a monthly account to 150 recipients of 'Meals on Wheels' identified by the clerical staff as 'women likely to be over the age of 70 years'. Women were asked to telephone me if they were interested in participating in the study. Nine women responded over the following week, and were invited to consider participating. Three more women responded over the next three weeks. Nine women had been arbitrarily identified as an appropriate number of participants in order to obtain sufficient data. I was concerned about the length of time required for data collection, and felt that due to the health of participants they may not all remain well enough to participate for the duration of the research process. The nine initial respondents were therefore recruited. One of the remaining three, on initial telephone contact, decided that she would not participate as she preferred not to be tape recorded. The other two women were prepared to be contacted at a later date if I needed further participants. However all participants remained well (although one was severely bruised from a fall but remained out of hospital, and one was hospitalised by a stroke from which she recovered and returned home) over the time of data collection and analysis.

In accordance with the Human Ethics Committee requirements once contact was made an information sheet (Appendix Three) was given to the women. They were also given a consent form (Appendix Four). I delivered the information sheet and consent form individually. I believed once the potential participants had met me they would be able to make a more informed decision based on personal contact. I left the information sheet and consent form with them after the first meeting and contacted them the following week to ascertain whether they wished to participate. All nine women agreed to participate.



#### 3.4.4 Data Collection.

Data was collected by tape recorded interviews. Semi-structured open-ended interviews were conducted with three main questions being used: “what does being healthy mean to you?”, “do you do anything to promote your health?” and “do you think being a women has affected your health in any way?”. There were no set follow up questions, no set time frames allocated and no set questions except the three identified above. However follow up questions were used to gain more information or clarify the discussion. After the first interview the data was searched for any very initial impressions and in order that comments and discussion could be shared with other participants in an anonymous way.

It is relevant that I had met each participant prior to the first interview and had spent up to an hour with each person. During this time we had talked about the research processes, our expectations, and what to do if the participant didn't wish to continue the study after initially commencing. I also asked them about aspects of their lives, in order to have a beginning understanding of their social and historical contexts as well as their medical conditions. This also had the advantage of providing me with information which proved to be useful in order to understand data, the context, the relevance of information from the interviews and to ask more contextual questions identifying matters which may otherwise have been missed or overlooked.

#### Interview One

Conversation around the question “what does being healthy mean to you?” initiated the discussion. The first interview lasted approximately one hour for each participant and concluded when each identified that there was nothing else they wanted to add at that time. The first interview was transcribed by a transcriber or myself. I checked each of the transcripts which the transcriber had completed by listening to the tape and reading the transcript. Errors were corrected. The transcript was returned to the participant to check and to change, add or delete any words they wanted to. A small number of alterations were made. Grammatical errors which made sense in discussion but become obscure in written form were altered at the participant's request to the word(s) the participant requested. “Umm's” were removed at participant's requests. One portion of discussion was removed at one participant's request as the topic under

discussion was considered to be irrelevant. The updated transcript was given back to the participant.

#### Interview Two

The second interview commenced with any follow up points the participant wanted to make, or follow up questions that I had. Also shared were comments from other participants in order to ascertain relevance to this participant. The second interview lasted between 40 minutes to one hour. The same transcribing and checking processes which occurred for the first interviews were applied to the second interviews. In total sixteen interviews were transcribed in full by a transcriber employed specifically for this purpose. The remaining two interviews I transcribed as I wished to understand the processes involved, and to decide whether there is an advantage for the researcher to do the physical act of transcribing thereby allowing for data to be 'absorbed' (for me there was not). I listened to each tape recorded interview at the same time as I read the transcript and made corrections to the transcripts. I found that I had an advantage over the transcriber who had only the aural route through which to interpret the data. My recollections and understandings of the conversations the participants and I had enjoyed were invaluable in deciphering some of the data which was elusive to the ear. This allowed greater accuracy of transcribing. However there were still a very few instances when the data was not able to be deciphered.

#### 3.4.5 Data analysis.

In conjunction with the interviews, a personal journal was kept with notes on the interview processes and content, as well as reflections and insights. The tapes were stored safely during and after the interviews. The transcripts were returned to the participants for checking. After the changes were made data analysis was commenced using thematic analysis.

Each transcript was read and the taped interview listened to several times. Each transcript was analysed for initial key ideas and impressions and they were written up taking four to six A4 size pages per participant. The aim was to keep the data whole whilst separating out themes. A reductionist approach was avoided by keeping each topic area whole, and when overlaps occurred by allocating them to both impressions.

Once all transcripts had been analysed the initial key ideas were condensed to one page per participant. These initial key ideas were then scrutinised for similarities and differences. The ideas from the nine pages were then written up on one main A3 size page. Each similarity was grouped identifying the range of experiences within the group. The key initial impressions were then identified and consisted of 38 impressions, inclusive of health promotive behaviours and experiences of gender. Health promotive behaviours were then also grouped on a separate page. Experiences for participants of being women and the effects of gender were also coordinated on a separate page.

Each initial impression, health promotive behaviour and gender effect was then allocated a separate colour (38 colours) and the content of each transcript was colour coded with the relevant colour. Where there were overlapping aspects the information was allocated two colours. The 38 initial impressions were then analysed and condensed into relevant headings which formed six initial themes. Each theme comprised between three and nine initial impressions. The transcripts were again systematically analysed and the relevant theme was identified without reference to the colour already allocated for the initial impression. Once the theme colour was allocated a cross check was then done to see if the initial impression was synchronous with the overall theme. Minor changes were made. Three initial impressions were separated into two parts and re-allocated to two different themes. One initial impression was not found to be useful and was linked into another initial impression. Three initial impressions were reallocated to a different theme. The minor nature of the changes provided a cross check of the themes identified and was a useful process.

Once all the transcripts were colour coded into the six themes the transcripts were cut up according to theme. All the relevant information was put into each of the six theme folders. There was a separate health promotive folder and a gender effect folder. Each theme folder was then carefully analysed to identify whether the theme heading was congruent and reflective of the information contained within the folder. Very few (approximately three) were moved from one folder to another and this reflected the accuracy of analysis. Each theme was re-named without reference to the original

naming, and then was compared to the original name. There was very little difference in terms of the words used to name the themes.

The themes and health promotive behaviours were then sent to all participants, who were given the opportunity to provide feedback and make comments. Six participants stated they identified with all six themes, felt that nothing was missing, and no one theme stood out more than the others for them. Three participants felt a particular affinity for some themes more than others. One participant wrote notes on each theme and provided further comments and examples. This process affirmed the themes to be accurate, relevant and important to participants.

The six themes will be presented in the following two chapters. Due to the overlapping nature of the themes, they are presented in chapter four under the heading of independence and autonomy (independence, staying in control, autonomy) and chapter five under the heading of experiencing health (having an integrated sense of health, multi-dimensional conceptualisations of health and health and aging). Factors which promote health are also presented in chapter five.

In this study all participants have been very supportive of the research and interested in the findings. This has occurred in their own individual ways. Eight of the nine participants read their transcripts. Alice did not wish to read them, however she wanted me to use the data in them, and has been very interested in all findings. Annette read her transcripts and was interested in the initial findings, however she did not wish to follow on to subsequent findings. The participants were asked if they would like a report which would provide them with more information about the themes. Annette declined as she felt she had read enough, and Magdeline was not sure. However the other seven participants all wanted a report, which indicated their interest in the study, and also their interest and receptivity to new information. Each participant has however been extremely eager for me to complete this research process in order that their voice may be heard, as well as for my personal benefit. This interest has had a positive effect on the process for me, and has valued it in ways which would otherwise not be possible.

### 3.5 Summary.

This chapter has illuminated commonalities within feminist methodology. The commonalities are: the acceptance of subjective knowledge; valuing of participants; the focus on women's lives; the identification of power within patriarchal societal systems; the recognition of the social construction of gender; understanding the power of naming; and the aim for change within society. Rigour within feminist research has also been discussed. The relationships between feminism and nursing, and feminism and older women have been reviewed. Thematic content analysis has been shown to be complementary to feminist research. The methods applied in this study have also been described. Ethical issues, participant selection, data collection and data analysis are addressed.

This concludes the background to the study, in which I have discussed the feminist methodology which underpins the study, and the thematic content data analysis. In the following two chapters I will present the data and the data analysis in the context of available literature.

## **CHAPTER FOUR: Contextual Independence and Autonomy**

### **4.1 Introduction.**

The next two chapters will present and discuss the analysed data from the interviews. In this chapter I will describe the meaning of being healthy as having contextual independence and autonomy. In the next chapter (five) I will discuss how being healthy means experiencing a sense of health and choosing some actions to promote health. I will now introduce the participants, followed by the themes that are presented in this chapter.

The participants in this study are Alice, Annette, Belle, Caroline, Jessie, Louise, Magdeline, Maggie and Tida. Their chronological ages range from 75 to 95 years. Each woman lives alone, except for Magdeline and Louise who live with their husbands. Apart from Magdeline and Louise, all are widows. Magdeline states she would not be able to live at home if her husband was not there, and she expresses concern about his health. Louise is carer to her forgetful husband, who has early stage dementia. All of the women except for Caroline have children, and some of these children are themselves retired from paid employment. Seven women live in the same city and two live in nearby townships. They each live in their own home, which comprises a compact townhouse, ownership unit or apartment. Eight have a small garden area, and one has no garden. Each has a meal delivered to her home at least twice a week.

This chapter presents two components of health, contextual independence and autonomy. The first, contextual independence, is the promotion of independence by the participants by making their own decisions and living in their own homes, thereby staying in control of their own lives. This includes the process of adjusting to having others do things that the women used to do themselves. The second, autonomy, is having control of their lives through determination in which making an effort and taking calculated risks feature. Whilst there are similarities between the concepts of



independence and autonomy, the findings from this study support the claim by Davies, Laker and Ellis (1997) that they should be viewed as separate concepts.

MacDonald (1993) and Markson (1997) have both commented on the social representations of older women, which are not congruent with the knowledge of some older women. The social discourse represents older women as experiencing decline and loss of abilities and being less able to function. This representation is not supported by the participants of this study. I will now describe their understandings.

## **4.2 Independence and staying in control by making decisions and living in her own home.**

Contrary to gendered expectations within western society, the older women participants of this study promote their independence and demonstrate self reliance. At the time I began this study I had an expectation that gender would be an integral component of how older women understood and interpreted health and health promoting behaviours. I assumed that societal expectations of women would have affected their understandings and experiences of health. For these participants, past societal expectations were not of independent women, but of dependence on their husbands. However many older women are clearly not dependent and therefore contradictions exist. Whilst independence is not representative of femininity, it is a pervasive societal expectation within the current socio-political context. Older women therefore live in a context of contradictory expectations.

### **4.2.1 Independence.**

Promoting independence was identified by all nine participants as being particularly important to their health. This supports the findings of Perry and Woods (1995) who found independence to be one of three important themes of functionally independent older women's health. The participants in this study, who were not all 'functionally independent', stated that managing to do some things independently promoted positive feelings. Magdeline, who used a scooter to go to the local shops, describes the importance of independence to her health.

M: To go and do my shopping. I did that this morning. That made a big difference. A bit of independence.

K: Is independence part of being healthy do you think?

M: Well it is to me. (Magdeline, Int 1: p. 2).

Louise linked health and independence together.

K: Is health related to independence? Or independence related to health?

L: Well I think yes. Possibly, I mean until this business in [city] when I had the [surgery] I didn't have any cause to ask other people to do things for me, whereas if I'd been a sickly person, then, I don't think I'd have been so independent. (Louise, Int 2: p. 14).

At this time in their lives, being independent was an important aspect of promoting health and feeling healthy. Louise linked independence directly to health. After I had completed the first interviews with participants I commented in my field notes on the large proportion of time when independence was discussed, referred to, or was a component of what was being talked about. When I listened to the taped interviews I again noted the importance of this theme.

However the contradiction was also evident as the participants do not lead completely independent lives. Other people do activities such as cooking, housework, shopping, gardening, and assisting some participants to shower, dress and undress. Tida has someone to assist her to get up, shower and dress in the mornings and the reverse in the evenings. She has a main meal delivered to her and has someone to clean her house. Her family do her shopping.

K: Being able to stay here, is that important to you?

T: Very very important. I'd hate to, no, I don't want to, I don't want to give in.

K: Is that to do with your independence here?

T: Yes it sure is. Yes I like to be independent, but as I say, with all the help I get, and I'm most grateful for all that. I wouldn't like to be without that, well I don't think I could manage to do some of the things I do without help.

K: And is independence linked to health?

T: Yes, in my case yes. I'd hate to be away from the home. (Tida, Int 1: p. 7-8).

Tida recognised that she would not be able to manage on her own, without others doing some activities or work, and she concurrently perceives herself to be independent. They are clearly not exclusive to her. Magdeline lives with her husband.

My husband does not cook, that's one thing, he's good at everything else, wonderful. Amazes me, for 50 years I thought poor [husband], he couldn't do anything, but then I found out it was poor [me] who can't do anything. He's quite capable when you let him go. (Magdeline, Int 1: p. 13-14).

Magdeline's husband now does some of the work which Magdeline used to do. She continues to experience independence within this context. It is evident that the participants continue to experience independence whilst having others do work and activities for them. Therefore independence for these women is contextual. That is, independence refers to being able to do 'some' things rather than 'every' thing independently. It does not mean living a completely independent life, but refers to living and managing their own lives, and doing many or some things on their own. The participants' focus is clearly on what is possible rather than on what is not possible or practical. This focus on positive factors is congruent with findings by Armstrong (1996) whereby older women focused on abilities and not on losses.

The most frequently applied understanding of independence within gerontological literature relates to the individual's level of physical functioning and ability to perform activities of daily living unaided (Davies et al., 1997). The participants of this study do include their physical functioning and abilities to do things in their descriptions of being independent. However their definitions are broader as they include the work by others in their understandings of independence. This is similar to findings of Perry and Woods (1995) who described the inclusion of help from others in the definitions of health by older women. However Perry and Woods found that the help was from the participant's husband and that their combined activities created independence. This differs to seven of the participants of this study who are widows and who extend the

concept of independence to include the activities of 'others'. The notion of contextual independence therefore appears to be an extension of this concept.

The voice of the older women participants differs from that of health professionals in gerontological literature. The older women participants focus on what is possible whilst health professionals focus on deficits in independence. Much research related to independence, or more accurately loss of independence, has occurred within residential care settings, and not in the older person's own home (Davies et al., 1997). Different factors may influence the understanding of independence within various settings, and therefore interpretations of this concept may not be transferable between settings. However, the dominance of health professionals' voices over the lay person's voice is clearly present. The functional discourse is evident through health professionals' descriptions of older women's health as the ability to perform physical and daily living tasks. However the older women participants describe their positioning in the wellness discourse through which they focus on their abilities rather than on their inabilities.

There appears to be a process to be worked through in order to have others do things which the participants used to do for themselves. Activities which have changed include caring physically for themselves, doing housework, gardening, keeping the house in order, shopping, and preparing food and meals. This process involves learning to ask others to do these activities.

M: So I am learning.

K: What is it that you're learning?

M: Well I'm learning to ask when I want something done, and not be a Christian Martyr and try to do it myself.

K: And now you can't, you absolutely have to ask?

M: Mm, which I don't like of course, I hate admitting I can't do things, a blow to my pride. (Magdeline, Int 2: p. 26).

M: It's at the point of having to acknowledge that I can't do these things, I have to admit I can't do it, it's a blow to my pride, I don't like even telling you that I can't do it. (Magdeline, Int 2: p. 30-31).

Magdeline therefore finds that it is a difficult process to learn to have others do things for her. Magdeline also described having to accept that things will not be done the way she likes them done.

Well I've had to give in now that I can't do all the things that I want to do, I have to give in so that my husband feels that he's doing the right things, when he makes the bed and does it in a funny way, you've got no idea. You've got to learn to shut up and not pass any remarks or criticise. (Magdeline, Int 1: p. 15).

The process of accepting the work of others has been challenging for Magdeline, who has recognised changes within herself and that she cannot do everything herself. However the process of having others perform work or activities includes the acceptance that they will not do it the same, and this is hard to accept. Magdeline's feelings also contrast with the social discourse in which elders are expected to be grateful and supportive (Hummert, Garstka, Shaner, & Strahm, 1994). Whilst there is an element of gratitude in Magdeline's comment about learning to "shut up and not criticise", the context is one of mixed feelings. Caroline also described frustration at having to accept things being done the way others do them. She felt upset that some 'helpers' have to do things their own way despite her request that they are done in a way which enables her to manage more effectively when she is alone. Caroline also has found it very tiring having several different home helpers over the course of a week, and believed this contributed to her 'loosing it' and muddling up some appointments (Caroline, personal communication, 13 July 1999).

C: And then I had those plants over there, and then they were over there, and then [home help] put them over there. I couldn't do anything with them at all.

K: Yes, 'cos they would be too heavy to lift?

C: Too heavy.

K: And you'd say it's a blow to your pride when you get confronted with it?

C: Yes it is. You've just got to stomach it. But [home help] says "I think they'd be better over by the window", and I don't like, I like to think about what I'm going to do.

K: So is she taking some of your decisions, like really that's your decision, it's your house, where your plants go?

C: That's right, that's right.

K: Right.

C: That's what you don't like. Oh that big vase that's over in the corner there.

K: Oh that beautiful one

C: She says, oh we'll put it up on top of there, and I said no, we won't. No, it would just topple down in 5 minutes, I want it wedged in somewhere, where it's not going to fall over. All those books you see, she put them up there ... they don't need to be up there, but I haven't got the strength to get them down. But I will, I will in due course. (Caroline, Int 2: p. 11-12).

Caroline therefore has found she must promote her own views in order to have others do what she wants in her home. She must either accept the work, ensure it is done her way or attend to it herself at a later time. The question raised is who is in charge of her home? Caroline must actively promote remaining in control. Louise found she very happily accepted help for some activities but experienced hurt pride for others.

I have no objection to people helping in the house. I don't like housework. I love cooking and I love having people here to meals and I can't do that any more and I don't like that. I mean, as I say my family live up the road and if they want a family meal, they bring it with them and it does hurt my pride a bit that they're bringing their food with them because my real trouble is not being able to stand for very long. And I just can't get used to sitting down and doing things like preparing vegetables, ironing and things like that, I do get annoyed with myself because I can't do it. (Louise, Int 2: p. 24).

Louise was content to accept the work and activities of others when the activities are of little meaning to her. However she does feel upset when they are activities which matter to her. Maggie did not experience difficulty with others doing housework and believed this was due to being used to 'giving orders'. However she did agree with Magdeline and Caroline that others do not do things to the same standards as she



liked, and that this was annoying. In particular her bed was never made as well as she would like. Alice, Tida, Annette and Belle said that having others do work for them was a process which they initially did not like, but they adjusted to it over time.

Well it might have been a wee bit of pride, you know to think that after all those, the years that I've been able to do things and help others, that I have had to be on the receiving end of it. (Tida, Int 2: p. 6).

A: Oh well, with my back the way it is, I think thank god I've got someone to do it for me, I've accepted it that way. But she's a very good lady and anything that, any reaching or anything like that, she'll say don't you get up there, she says let me do that. She's a very good lady.

K: Right, and you're happy to do that?

A: Well I am now, yes, once upon a time I wouldn't have been but I am now. (Annette, Int 2: p. 9).

K: One person told me it knocks her pride when she can't do some of the things that she used to be able to do.

A: Well she's not old enough yet, I reckon. I think you do get a knock to your pride when you're younger, and you, but at 95 I realise that I'm darned lucky, every day's a bonus and what I do is perhaps quite exceptional. So that gives me a boost. (Alice, Int 2: p. 17).

Magdeline and Louise were therefore in the process of making adjustments to having others do some of their usual activities. This process was clearly difficult for Magdeline. However, Annette, Tida, and Alice have made adjustments and do not have negative feelings about others doing activities they used to do. Alice has focused on what she is able to do rather than what she is not able to do. This is a repeated pattern and illustrates some of the complexities of independence and contextual independence.

In summary, health has thus far been shown to be associated with independence, and independence has been shown to be contextual independence which is inclusive of the work of others. These findings further develop the concept of independence of Davies

et al. (1997), who claim that most nursing literature describes independence to refer to physical activities and activities of daily living. They also develop further findings by Perry and Woods (1995) who describe independence to be inclusive of activities of couples. The women participants of this study however include the activities of others in their definitions of being healthy, and therefore contextual independence is present. There appears to be a process through which some older women adjust to others doing work and activities which they used to do. This process can be difficult and may challenge the women's feelings of pride in her abilities.

As previously identified in the discussion on discourses (chapter two), older women's health within the functional discourse is known in terms of their abilities to perform daily living activities which comprise personal cares and self-maintenance cares (Rodgers & Miller, 1997). Measurements of these abilities vary and may or may not include the use of aids or assistive devices (Bennett, 1999; Spector & Fleishman, 1998). Within nursing there are various functional ability measurement tools which are used to assess functional abilities and identify how best to promote independence (Bennett, 1999; Whittle and Goldenberg, 1996).

However, whilst health professionals are concerned with quantifying the abilities of elders in order to balance the deficits, older women have different definitions of health in which contextual independence refers to independence inclusive of the activities of others. Older women are embedded within a wellness discourse as they focus on achievements. Knowledge generated within the functional discourse is however important, as elders continue to experience independence when others perform activities they used to do for themselves. This knowledge is required in order for contextual independence to occur. It is important however for the voice of older women to also be recognised in order that independence is defined as contextual independence, and not defined only by health professionals who focus on deficits and therefore dependence. The wellness discourse generates the development of knowledge from older women's understandings. Nurses may need to redefine their understandings of health so that contextual independence is recognised and promoted.

### 4.2.2 Staying in control.

As well as contextual independence being health promoting, all participants made reference to the importance of remaining in control of their lives through making decisions. Remaining in control was also illustrated by Mitchell (1996) to be an important aspect of health for older women who experienced poorer health. Collopy, Boyle and Jennings (1991) suggest that decisions are made up of decision making and decision implementing. They pose that decision making is important to elders who can continue to make decisions when the ability to implement them is reduced. This premise is supported by participants in this study. Maggie has lived on her own since her husband's death four years ago. She has had a stroke which has affected her speech and altered her mobility. She makes her own household decisions and controls her own finances.

M: I've got a very determined nature ... I sort out the bills, I manage the money. When the post office closed around here, I had money difficulties and they transferred my money to the [suburb] branch and a fantastic man said, "don't worry, I'll bring it to you." Because obviously I can't get it, and he's become a friend of mine over the years and he brings me money anytime I want money.

K: Yes. So for you, having to make those decisions though is important?

M: Yes.

K: And that's part of staying healthy, part of being healthy?

M: Part of my brain health. Mm. Because I've got to use it. (Maggie, Int 2: p. 1-2).

Making decisions and relying on self promotes independence and health. It is important to have to make decisions as this process promotes mental functioning and therefore health. The participants of this study portray a position in contrast to that recognised by Ginn and Arber (1993), which is representative of the psychological discourse, in which older women have difficulty making decisions. Maggie illustrates the significance of continuing to make decisions, whilst someone else implements some of her decisions. Alice is 95 years old, and was widowed in her mid 60's. She lives alone, and has two supportive sons. She agreed that having to do things was good for her health.

A: I think the more you delegate and the less you decide for yourself, the less you're going to be able to do as the years go by .... But no I think it's better to try and do as much of it as you can because the more you do the more you can do, the less you do the less you want to do. It's very easy and that, it could be very comfortable to be, to have someone to think for you and do everything for you at times. But I wouldn't like it always. Times I might think oh I suppose a rest home would be quite nice really, but oh no I'd hate it.

K: So the fact that you actually have to make decisions, that's good for your health?

A: Oh I'm quite sure it is, because it keeps the brain active, and if the brain is active like that, then it functions and all your other functions are going to be working. But if your brain isn't working properly and it's not used enough then all sorts of functions are going to be passed and you're not going to be able to do things. (Alice, Int 2: p. 8).

Alice suggested that 'using' her abilities prevents 'loosing' them. She also referred to the effort which is needed to stay in control as it may be easier to let others make decisions for her. Alice had stated that she learned to be more independent after her husband died, and this is congruent with the expectations of women of her chronological age. Increasing independence is consistent with the claim by Palmore (1997) that some older women may become more assertive, managerial and autonomous than in previous life stages. Independence is incongruent with the social discourse, in which older women are understood to be dependent. Alice learned new skills when she needed them, and became more independent.

A: I'm so definite, I never was definite. He [husband] was a very definite person, what he said went, and we all, the children and I, did everything he said. I don't think I would do that today, I think I'd be more like a modern, younger person, I think he wouldn't like that image, he was very old fashioned.

K: And do you think that that's actually having, having had your time alone, you've had to be involved in those decisions?

A: Yes, I'm quite sure of it yes.

K: Right, so it was sort of practice or?

A: Yes well yes I don't think, if you're determined to live alone and not go into a rest home then you've got to be definite up to a point, you can't shilly shally, you've got to make up your mind and do things. (Alice, Int 2: p. 34).

Alice illustrated the importance of being determined in order to facilitate living alone. Living in their own homes was considered to be very important for all nine participants. The importance of being at home is similar to findings of Moloney (1997) who identified that for some older women a feeling of strength contained having a literal (house) or metaphorical (sense of being in a secure niche) home, and that strength was gained through this sense of home. The participants of this study referred to their literal homes, but did not comment directly on a sense of strength gained from being at home. Morrissey (1998) described the importance for older women of remaining independent through staying in their own homes, and that determination was required in order to remain at home. Some participants have made modifications to their homes to promote independence. Magdeline's husband is skilled at making home modifications to promote her mobility.

That's why he's worked it, to park it [scooter] inside so I can go out without you know yelling at him, I've got independence, I don't have to wait 'til he's ready to let me out. I haven't got that shut in feeling. (Magdeline, Int 1: p. 6).

Independence is therefore promoted by physical aspects of the home, and the ability to get outside. Again the independence is contextual as Magdeline uses a walking frame or her scooter to assist her mobility. However mobility aids are included by the participants in their definitions of independence, in contrast to the position of some measurement scales of functional abilities which exclude the use of aids and assistive devices (Spector & Fleishman, 1998). Caroline has had her house built taking into consideration her needs. She has a lockable exterior gate, windows in strategic places, wide doors, hand rails, a raised toilet seat, spacious shower area, and has underfloor heating and double glazing to create a warm house. Her kitchen is designed so that she can manage by sliding foods, saucepans and utensils rather than having to lift them. She believes living at home is more cost effective for her as well as promoting her independence, than moving into a rest home.

I can actually stand in that corner, and ... hold the pot with one hand and stir it with the other and brace my behind in that corner ... and that thing on the sink, so you see what you're doing is, you fill the kettle and then you put the teapot in the sink and you actually tip the water into the teapot, you don't lift the kettle at all. (Caroline, Int 1: p. 25-26).

It seemed to me that it was far better to spend the money at home, than to buy an expensive place down at, you see in actual fact if you were in [rest home] although they say 'nurse in attendance' that nurse doesn't do anything. All she does is ring the doctor, because I rang [rest home] and I said if I went into your place would anybody be able to help me to have a bath. 'Oh no we wouldn't have time for that.' So in actual fact at home I get seven hours care and two hours house work, which I pay for, or whatever else housework, that I want to pay for. I would not even get seven hours care in a nursing home at all. (Caroline, Int 1: p. 15).

Caroline has assessed the most suitable living arrangements for her needs and has promoted her independence by ensuring her house promotes her ability to live on her own. She indicates that having access to financial resources has meant that she has been able to modify her home, and that this is a less expensive option for her than living in a rest home. Caroline's position supports the claim by Henrard (1996) that having access to both cumulative and immediate material resources has a positive impact on health. Her independence is therefore promoted by being able to access 'sufficient' money. Caroline also expressed that living in her own home was a very important way of staying in control of her life. Maggie who described herself as being very determined, has had a stroke.

Everybody, including my two sisters think I should go into a home and I don't want to go into a home until I'm ready and um the last week and this week, both my sisters raised the matter, don't think I should live alone. Because I've had a little stroke and they are fearful that I may have a major one, but I've got [alarm] around my neck and I can press that and if I die I'll join my husband, I've got no fears of living alone. I've got the telephone ... (Maggie, Int 1: p. 5).



Maggie understood the concerns others have for her, but she had no such fears. She was determined to live in her own home and had confidence in her ability to summon assistance if required through the telephone or home alarm. Annette was also very keen to live in her own home.

K: And is that independence, is that important in terms of health for you?

A: Oh it is, as you get older, your independence I think your independence is about the last thing, I never want to have to go to a home.

K: And what is it that puts you off?

A: I don't know, I think when my daughter was working at [rest home] you see these poor old dears sitting around and they get childish ... To be able to get up when you feel like it, if it's a cold frosty morning or anything you don't have to get up, well why get up!

K: So being able to do what you want and when you want to do it?

A: Exactly, oh yes, that's very important to me. Yes it does help you. (Annette, Int 1: p. 40-41).

Annette expressed the concerns she had of losing control as well as becoming dependent. She expresses her preference to stay in her own home rather than move into a rest home. Two participants had first hand experiences of living or staying in a rest home. Alice stayed in a rest home recently while she recovered from major surgery, and Louise previously lived with her husband in an independent unit attached to a rest home. No other participant had personal experiences of living in a rest home.

I played that [bingo] with them, I don't know it was, it seemed to me like a lot of children sort of, you know, being asked to sit down and have a game, keep you quiet for a while, it didn't appeal to me at all somehow. No I'm very thankful I haven't had to go in there, but I do think they are the answer to many many people's struggles aren't they. I think if I were in one of those places permanently I'd just lose interest in everything somehow. I mightn't of course, but that's how I feel. I've always said I hope I never do go in there, and the family, that's what I say, the boys have been so good about it and helping me in any way they could to live my own life. (Alice, Int 1: p. 21-22).

Alice clearly believed that rest homes were appropriate for some elders, but not for her at that time. She was concerned she would not be able to live her life the way she wanted, and also that she may lose interest in life. Independence and staying in control of her life are clearly important to her health and any loss of independence would not promote her health. She also acknowledged that these thoughts could change. Louise and her husband bought an independent unit in a rest home complex on the advice of doctors who believed she would need support in caring for her husband who was developing dementia. Louise experienced a loss of control and independence while they lived there.

I felt, although we paid enough money for that house for it to be totally ours, it never was ours. The fact that we couldn't put up a sun blind if we wanted to without asking permission and we couldn't put in a fly wire door if we wanted to without asking permission and I just felt we were, first of all being ripped off and secondly we were being treated like, as though we weren't quite with it, you know what I mean? .... She [administrator] just put letters in the letter box telling us what we should be doing .... Eventually they did have a committee with inmates on it .... But they didn't really want the inmates to have any input into what was being said and done. (Louise, Int 1: p. 25).

L: I think I was going into depression, I really do, I was really depressed.

K: What makes you say that, what were some of the things that made you think you were getting depressed?

L: Well I got bad tempered, I felt off colour all the time. Didn't feel I wanted to do anything because what was the point of doing it when it wasn't mine, you know what I mean. I mean I know this place [own home] is a mess now but I'm a darn sight happier here than I was there. (Louise, Int 1: p. 29).

Well I was told I was going to need the support, but I didn't need it. The only time I needed it was to ask them to give [husband] his pills when I had my cataract operation, and also the two days that I took off [carer relief], but they let him out ... I mean if I hadn't been in the house, if I hadn't suddenly stayed to do the washing and cleaned the house out, and I was just about to go when he came back ... I mean when you take someone to a place like that you really expect them to be looked after. (Louise, Int 2: p. 27).

The strength of Louise's feeling is evident by her usage of the terms "ripped off" and "inmate". Both terms suggest strong feelings, and this was evident during both interviews as Louise described these aspects in depth. Louise sold the independent unit attached to the rest home and moved into her own ownership unit as she believed her independence was not being promoted and that her health was being negatively affected. She felt that she was becoming depressed living in the independent unit attached to a rest home, as she had little control over her home and some daily events. She also questioned whether the rest home would provide the support she might require in the future. Louise believed that women in particular are being exploited by rest homes.

It annoys me that everybody not just women, but more women than men because men don't live as long, are being exploited. It's pure exploitation. (Louise, Int 2: p. 26).

Rest homes are perceived to have the potential to lead to a loss of independence. Living in an independent unit attached to a rest home, or a rest home, was understood by Louise, Alice, Annette and Caroline to undermine their ability to do as they wished and to lead their own lives. Louise also felt financially disadvantaged. Other participants expressed a wish not to have to move from their own place, although Tida acknowledged she would probably make the most of it if she ever had to move. Alice theorised that it could be nice to have others do things for her, but quickly dismissed this as giving up independence.

Decision making is therefore an important aspect of staying in control for the participants of this study. It is not necessary to implement all of the decisions, however it is important to remain in control by making the decisions. The psychological discourse is not representative of the knowledge of the participants as they do not present themselves as unable to make decisions, or as disinterested in events. Instead the participants are located within the wellness discourse. Living in their own homes is an important factor to promote staying in control and independence.

### **4.2.3 Summary of independence and staying in control.**

To summarise, health incorporates independence, and this independence is contextual. Independence is promoted by being in control of their own lives and making decisions. Living in their own home is also important to health, including mental health, and promotes independence.

The functional and psychological discourses do not represent the views of the participants. In the functional discourse knowledge of older women is generated in terms of their abilities to perform specified activities, such as self cares and daily living activities. The focus is on inabilities rather than on abilities. However the older women focus on their abilities and they incorporate the activities of others into their definitions of contextual independence. The promotion of independence and staying in control is evident, and locates the participants in the wellness discourse.

In the psychological discourse older women are understood to be unable to make decisions, to experience mental decline and to loose interest in events. The participants are not located within this discourse, as they fiercely promote their contextual independence and control over their lives. Living in their own homes promotes this sense of independence and control. They are therefore located within the wellness discourse.

In conclusion, the importance of promoting independence and staying in control locates the participants in the wellness discourse. They are not represented within the functional and psychological discourses.

### **4.3 Autonomy: determination, making an effort and taking calculated risks.**

In conjunction with contextual independence, the promotion of autonomy is posed as an aspect of being healthy. Eight of the participants described the importance of determination in order to maintain or to promote autonomy and health. This determination is illustrated through the participants making themselves make the

effort. Wagnild and Young (1990) described aspects of determination within the concepts of perseverance and resilience, which they identified as characteristics of older women who have successfully adjusted to major loss. Loss was not a focus of this study. However there is a potential similarity as seven of the participants are widows who may have adjusted “successfully” to loss, and who illustrate determination. Magdeline describes her determination. She had difficulty walking and used a walking frame for short distances, or her scooter for longer distances. She had previously experienced a fractured hip as a result of a fall.

Well I do more exercise, pushes me further when I try to walk, and now they tell me I should try and walk out to the letterbox at least twice a day. Well I make myself do it at least three times a day. That's a big effort. I'm walking with the gutter frame they call it. It supports your arms. (Magdeline, Int 1: p. 12).

Both determination and making the effort are demonstrated as Magdeline made herself walk further than the recommended distance. Annette described her determination when recovering from surgery for breast cancer.

Well I thought, I'm on my own, I'll have to do things for myself, so I more or less forced myself to do certain things. (Annette, Int 1: p. 15).

Caroline experiences urinary incontinence and she described the difference between her attitude and the attitude of a friend.

C: [Friend] she says, I'll just put a pad on. Well I don't want to put a pad on, I'd rather, I don't want to put a pad on.

K: So you're prepared to do your pelvic floor exercises to get your control back?

C; Yes, you've just got to. (Caroline, Int 1: p. 5).

Making the effort is also described as important when health professionals are involved. Many elders have contact with health professionals as they experience health related changes. The participants describe the importance of making an effort and

doing their best, and that the health professional needs to recognise their efforts. Magdeline and Jessie described how health professionals affected them.

This was possibly why I was upset about this [health professional]. And she would say "you're not trying". I am so, yes I am. "No you're not". (Magdeline, Int 1: p. 37-38).

No I didn't think it was [fair ] that's what, want to report her to the SPCA. It wasn't reasonable. (Magdeline, Int 2: p. 9).

Magdeline used humour to express her sense of unfairness and unjustness at this situation, in which she felt the dominance and power of the health professional's opinion over hers. Jessie was also doing exercises to promote her mobility and walking.

J: I didn't feel like going back on the Friday, I felt down to it. On Friday she was so kind to me, she must have had a talk to someone else you know, or looked up my notes or something. And she said "oh you're walking well today, keep on going" you know and I couldn't believe it.

K: So she was a lot more positive?

J: Oh she was much nicer than the first couple of times, I mean she sort of oh she said "lift your bottom" and I said "if you had a bottom like mine you couldn't lift it either".

K: So you were trying and she was expecting you to do more that you could do?

J: She sort of thought I wasn't trying you know.

K: Yes, and were you?

J: I was, I was really trying hard, and the next time I went back, first thing she said "oh you're walking very well today". (Jessie, Int 2: p. 20-21).

Jessie has illustrated the importance of having her efforts recognised, and the sense of dread she experienced when she had not succeeded. Jessie also described her attitude of being 'pigheaded' as the driving force to do her best.

Just pigheaded. I mean when you're lying on your stomach and she says lift your right leg and keep it straight and I can't get mine off the bed sometimes. "Come on you can do



better that that." And I said I can't do better that that, if I could do better that that I'd be doing it. (Jessie, Int 2: p. 23).

Jessie illustrated her determination to do the best she possibly can. The importance of putting effort into maintaining health is congruent with the 'use it or lose it' slogan promoted in the popular press. The participants in this study were motivated to promote their mental health as well as their physical health. The promotion of mental health is in contrast to the position identified by Ginn and Arber (1993), which represents the psychological discourse, in which older women are portrayed as having mental decline. Magdeline, Jessie, Maggie, Louise, and Caroline all completed crosswords in order to promote their mental health as well as for enjoyment.

And the cryptic crossword, that gives me quite a high. I get quite a high when I get it out, I think oh good you know. It's the same as other people go for a walk, I do the crossword puzzle and you work away, sometimes you don't get the last word 'til night time. But you, all day, like there was one silly one last week, it was ... 'allow to do hair', well of course - it was permit, perm it. (Caroline, Int 1: p. 11).

Caroline described the sense of wellbeing she experienced from successfully completing a crossword, as well as the challenge of the process of completing it. Magdeline also promoted her memory by learning prayers and writing letters.

I've made myself learn numbers and learn prayers, I learnt them off by heart 'cos I noticed that I was beginning to slip quite a bit. I'd tell a story and get half way through and then think what the hell am I talking about. (Magdeline, Int 1: p. 25).

Keep your brain active by reading or writing. I mean I write letters now to people that I don't even particularly want to write to but it does me good to try and remember how to spell words because you forget. I hunt out the dictionary to find out some silly word I should know how to spell and I don't and I haven't got a clue so I hunt it out in the dictionary. (Magdeline, Int 1: p. 33).

The stimulus for Magdeline to promote her memory and mental performance was an awareness of changes and the determination to promote functioning. It is evident that making an effort and being determined are again useful attitudes. Magdeline, Jessie and Maggie all referred to themselves as being 'pigheaded' when they described their determination. Maggie and Magdeline also claimed that they have always been determined people.

The promotion of autonomy through determination has another aspect, which is predominantly hidden. Magdeline, Tida and Belle have all experienced falls. Whilst they are all determined women, having a fall has added the element of risk to their experiences. Porter (1994) takes an elder's perspective to describe how North American older widows experience risk while living alone. Porter describes 'exercising caution', 'negotiating reliance' and 'bringing their worlds closer to home' to be strategies the widows used to manage their risks. Porter's aim was to describe older widows' experiences of living alone, and so her findings differ to the findings of this study. Whilst there may be some similarity in the notion of 'exercising caution', the participants of this study describe their experiences of being determined and concurrently experiencing risks. Magdeline had previously experienced a fractured hip.

M: Today I managed to peg out the clothes, but he's [husband] not very pleased about that, he said "you'll fall over, you'll break your neck".

K: Had you decided you were going to do that today?

M: Yes. Well I told you I am pigheaded. Very pigheaded, it has made me do lots of things that I didn't really want to do.

K: So that determination is important?

M: Yes, it's made me do things. Push myself I suppose. (Magdeline, Int 1: p. 13-14).

Determination to complete some housework also has a context of risk. Engaging in activities which are potentially achievable through determination also has the potential for adversely affecting health. Tida has also experienced falls and as a result has had numerous (hip, elbow, knee and ankle) fractures. She has also had a stroke.

I think that with the knowledge I've got, of not trying to do too much that it's kept me, six months now since I've been able to come out of hospital. And you know that you only need to take one false step and you have a fall. (Tida, Int 1: p. 21).

Tida acknowledged that one mistake has the potential for severe consequences. Magdeline described the loss of confidence which she experienced after falling and fracturing her hip.

...but I was terrified, I mean this was to do with lack of confidence I suppose, I'm frightened, to open the oven, the hot air, it frightens me. Stupid, it's through falling and breaking my hip I think ... Somehow you can't [get your confidence back]. See even shifting out of my wheelchair onto, to sit in the easy chair, I'm terrified to do that, for fear that I'll fall ... If I have another fall then it'll make it too awkward for [husband] altogether. (Magdeline, Int 2: p. 37).

The consequences for Magdeline of a fall are profound. The confidence which she lost through a previous fall was difficult to replace. Belle, similar to Tida, has had numerous falls and fractures. She articulated the dilemma.

In fact you're leading a very narrow life when conditions make it safe for you. (Belle, Int 2: p. 10).

Belle illustrates the dilemma which some of the participants experience, in which determination promotes activity, but for which there is also a factor of risk. There is therefore an element of risk involved in completing some of the activities which Magdeline, Belle and Tida are determined to do. The risk can be high (for example, fractures and hospitalisations) and there may be serious consequences if the woman doesn't succeed. It is a difficult dilemma to maintain a balance between promoting independence and taking risks, as the line between them is very fine and any failure may have far reaching consequences. Hip fractures are well recognised causes of morbidity and disability (Norton et al., 1995). Reduced mobility is a potential complication of a fractured hip and subsequent hip replacement, and therefore there is a threat to the level of functioning the woman experiences. The woman's ability to

remain in her own home may be compromised. The risk therefore has to be balanced with the benefit. Magdeline, Belle and Tida therefore live each day with risk.

In summary, the promotion of autonomy has been shown to be facilitated through the attributes of determination and making the effort. Mental functioning is seen to be important and is actively promoted by making the effort to stimulate mental processes. Risks have also been identified to be present when determination promotes some potentially hazardous activities. An unsuccessful activity may risk health and may initiate a loss of confidence which is difficult to restore.

The psychological discourse does not generate knowledge which is congruent with the experiences of the participants of this study. Within the psychological discourse older women are known to experience mental decline, be unable to make decisions, become dependent and loose interest in events. In contrast, the participants illustrate ways in which they promote their autonomy and mental abilities through determination, making an effort and taking risks. They are located within the wellness discourse.

#### **4.4 Summary.**

It has been demonstrated that health is complex. It involves contextual independence which is inclusive of the work of others. Independence is promoted for participants through living in their own homes and staying in control of their lives. Health also includes autonomy for which determination and making the effort are useful attributes. Health is also potentially compromised when 'being determined' and 'making the effort' involves taking risks which are not successful. The promotion of independence therefore is a risk to health as well as being health promotive. The older woman who promotes her health by being independent and autonomous therefore experiences both risks and benefits.

The participants of this study, congruent with claims by MacDonald (1993) and Markson (1997), do not present their health within stereotypical representations of the social discourse. In this discourse negative portrayals of dependence and loss of

autonomy persist. They all recognise changes which have occurred to their health, such as physical and memory changes, but balance these changes with a determination to promote their independence and remain autonomous.

Contrary to knowledge of older women's health in the psychological discourse the participants of this study promote their mental functioning to counteract changes and to promote mental processes. The psychological discourse knows older women as experiencing a loss of mental functioning. However the participants illustrate determination, independence, decisions making abilities and an interest in being autonomous. Their position contrasts with the psychological discourse, and is located in the wellness discourse.

The participants are also located in the wellness discourse, rather than the functional discourse. The functional discourse knows older women as deficient in some self cares and daily living activities. However, whilst the participants do have other people perform activities which they used to do for themselves, they incorporate this assistance into their definitions of independence. They focus strongly on what they are able to do, rather than what they cannot do.

#### **4.5 Conclusion.**

In this chapter I have demonstrated that the participants are located within the wellness discourse and not in the social, psychological or functional discourses. I have discussed the concepts of independence and autonomy which are evident within the participants' descriptions of health.

In the next chapter I will move on to present two further themes which have emerged from the analysed data of the participants' descriptions of health. The first is the experience of a sense of health, which includes intertwined holistic aspects, and multi-dimensional definitions of health which are inclusive of health related conditions. The second is the promotion of health as participants choose activities they believe enhance their health.

## **CHAPTER FIVE: Experiencing Health and Promoting Health**

### **5.1 Introduction.**

In the previous chapter the meaning of health as contextual independence and autonomy was illustrated. The participants in this study incorporate activities by other people into their definitions of independence and autonomy. They focus on what they are able to achieve rather than on deficits, and so having others do things for them does not eliminate health, contextual independence or control. Also identified are the positive benefits as well as risks for some of the participants, in striving to maximise their abilities and lead generative lives.

In this chapter I will present further analysis of the data gathered during the interviews with the nine participants. I will present this section of analysis under two main themes. First is experiencing health, in which integrated and multi-dimensional definitions are illustrated. The potential for a definition of health specific to older women is also discussed. The second theme is the promotion of health through choosing specific courses of action. Some of these actions are specific actions and life choices the woman decides to take and some are influenced by medical practitioners, such as taking prescribed medications. These are described as promoting health.

### **5.2 Experiencing health.**

I will discuss some shared understandings of health amongst the nine participants, although their unique combinations of understandings are also present. The participants described their perceptions of health from many different foci, all of which included a sense of having health or being healthy. Inherent in these descriptions was a shared understanding of health as an important and valuable attribute. There was also a shared understanding of health as multi-dimensional, thereby including health related conditions. Whilst there was a wide variety of health related conditions that each participant experienced, all nine participants included



these conditions in their definitions of health. The potential for a definition of health which is relevant to the life stage of older women is then discussed.

### **5.2.1 Having an integrated sense of being healthy.**

All nine participants described integrated aspects which inter-twine and overlap to create a sense of being healthy. In order to define health, participants have described integrated physical, mental, spiritual and attitudinal dimensions. In this study holistic health was posed by one of the participants, Alice, who described an integrated approach to health.

A: It's the whole system, working, ticking over I think. (Alice, Int 1: p. 11).

K: And being active, do you think, is that related to health?

A: I'm sure it is, yes I'm quite sure it is. It makes a big difference I think to have the exercise, it seems to use up every organ that we have, that is supposed to work. (Alice, Int 1: p. 2).

A: And if the brain is active like that, then it functions and all your other functions are going to be working and in working order. But I think if your brain isn't working properly and it's not used enough, then all sorts of functions are going to be by-passed and you're not going to be able to do things. (Alice, Int 2: p. 10).

Whilst Alice specified physical and psychological aspects of being healthy, these occur within the context of the total person or the 'whole system'. A unified approach to the person is therefore used. This unified approach is in contrast to the reductionist approach of the biomedical and psychological discourses, in which knowledge of older women's health is generated in physiological or psychological terms. The participants of this study clearly identify physical and psychological aspects to health, but they do not define health in these terms. Instead they define health in integrated ways. Their understanding therefore is not located in the bio-medical and psychological discourses.

Belle identified several dimensions which contribute to her health. She described the inter-woven definition of health to which she subscribed.

Being healthy means everything. I give thanks for my good health because it's mental as well as physical isn't it, it's your attitude. I think it helps you to be optimistic but mostly I thank God for my good health. (Belle, Int 1: p. 1).

Happiness is linked to health. But that's part of your mental attitude, optimism, too, isn't it, and faith comes into that. It's all inter-woven. (Belle, Int 1: p. 32).

In this description Belle described health to be important as it meant 'everything'. She suggested health comprised inter-woven physical, mental, spiritual, attitudinal and religious aspects. Happiness was also identified by Maggie to contribute to her health.

Enjoying life is important to health, mentally, you enjoy life, you're happy. I enjoy life and I enjoy reading, enjoy visitors and I used to enjoy embroidery. (Maggie, Int 1: p. 8).

The concepts of happiness and enjoyment that are evident from these statements were therefore experiences which contributed to integrated definitions of health for Belle and Maggie. Gibson (1997) claims that little is known of the positive mood states of older women, as there has been an emphasis on negative moods states such as depression and grief. The participants of this study indicated that happiness and enjoyment are positive mood states which they experienced as a part of their health. This is similar to findings by Perry and Woods (1995) who identified enjoyment and happiness to be health images experienced by 'functionally independent' older women.

Health is also expressed in a positive sense as an ability to cope. Health as coping is experienced by Caroline, Louise and Belle. The concept of coping contributes to an understanding of the complex nature of health. The concept 'ability to cope' was also identified by Perry and Woods (1995) as a health image of 'functionally independent' older women.

C: What health means is that you just cope with things.

K: Yes, so it's coping with changes?

C: Yes, it's trying to cope with changes rather than trying to fight against them. You've just sort of got to get around them. (Caroline, Int 1: p. 1).

But I can cope with things and I think being able to cope is probably what matters most of all, so long as I can cope I think I'm healthy. (Louise, Int 1: p. 1).

There was an inference of adjustment and adapting to life and life challenges. Caroline described how she had adapted to reduced energy levels and that managing the energy she has is important in order to conserve it.

It takes an enormous amount of energy to get out, and you've got to sort of pace yourself, if you're going to go out to the hospital one day, you shouldn't go out the next day. You've only got a certain amount of energy so you've got to sort of space it out. Otherwise you end up, when you go to bed, you see you've got to go to bed very early, not to go to sleep, but you get your little sewing projects around you or your paper and various little things around you and you do them, but if you get yourself too tired you find that you have to sit on the side of the bed before you've got the energy to take your clothes off. (Caroline, Int 1: p. 1-2).

Caroline expressed a systematic approach to the use of energy as she understood energy to be finite. In order to maximise achievements, energy had to be used wisely. Wickens (1998) described a loss of vigour, associated with aging, to be descriptive of older women's health within the bio-medical discourse. The participants of this study do identify with the loss of vigour or energy, but also include descriptions of coping and managing this change in energy. Another way of using energy wisely was described by Belle, who described self-pacing as being organised.

A routine, fits more into one's day. Mental as well as physical. If you're organised, if you're organised too and that's another explanation of pacing isn't it, being organised. I find it an advantage to write a list to myself of what I've got to do and the priorities of them. (Belle, Int 2: p. 9).

Belle illustrated the advantage of being organised and she also described prioritising as a way of coping. Another way of coping was described by Magdeline who promotes her sense of humour, and finds this helpful to her health.

M: Well I've got heaps of sense of humour, doubly active, I have really, I mean I try and see something funny, I don't really even think it's funny, but I try and make myself think that it is funny ... I'd go mad without it. (Magdeline, Int 1: p. 4-5).

Magdeline therefore used humour to manage some of her frustration.

Another dimension of integrated health for participants is the importance of faith. Faith was an important component of health for seven of the nine participants, but was not important to either Alice and Louise. Alice however stated that she envied those with faith as she perceived it to be a personal help and to benefit health. She had searched for faith when she was widowed, but it did not feature in her life to the extent she would have liked.

I used to go to church on Sunday and I taught in Sunday School and I took communion, and all the rest of it, but no, that's gone. As I say I envy those who have it because I think it does help those people who've got it ... but I do think they get a lot of help from that [faith], and that all goes towards health I think. (Alice, Int 2: p. 1-2).

Alice suggested that religious beliefs benefit health by providing support to people who do have such beliefs. Magdeline, Maggie, Belle, Tida and Caroline believed faith to be an important dimension of their health.

K: Do you think your religious beliefs have affected your health in any way?

M: Oh yes. I think I'd be dead without them. (Magdeline, Int 1: p. 26).

Clearly faith was an integral and core part of health for Magdeline. Caroline, similarly, gained support from her faith. She experienced support from her faith which assisted her when she faced health challenges.

C: Well I've tried [to go to church] two or three times, but by the time you've taken a stool to put your foot on, and fiddled about.

K: Becomes such an effort does it?

C: And anyway I can't drive now, so that's it, the eyesight prevents it.

K: Yes, has stopped it.

C: Oh you've got to have something. Yes, you'd never get through all these [operations], going to theatre, if you thought you were on your own. (Caroline, Int 2: p. 22-23).

Despite Caroline's inability to attend church, she gained strength from a sense of not being alone.

The integral nature of faith and health for seven of the nine participants of this study contrasts to health images identified by functionally independent older women in the study by Perry and Woods (1995). Perry and Woods asked the question "what does being healthy mean to you?" and analysed the data through content analysis. Religious faith was not identified as a health image by their participants. This illustrates diversities amongst older women who do not form a homogeneous group, and supports Sperry's (1996) assertion of heterogeneity amongst older women.

The ways in which the participants know and understand their health will now be considered in relation to the bio-medical and psychological discourses. The participants understand their health as integrated dimensions. Knowledge of older women's health, within bio-medical and psychological discourses, is generated through a reductionist approach. A reductionist approach is present as knowledge is constructed in physiological or psychological terms. These discourses are therefore not representative of the understandings of health of the participants.

A further discourse, the biopsychosocial discourse, also needs to be considered. An initial impression is that the biopsychosocial discourse is more representative of the participants' perspective as this discourse defines health within combined biological, psychological and social dimensions. However within this discourse there continues to be a reductionist approach to health, identified by Yardley (1997), as the medical model continues to dominate. This reductionist approach, which is also evident within quality of life scales, does not represent older women's health as an integrated concept. The biopsychosocial discourse therefore does not represent the participants' understandings of health.

To summarise, health for the participants of this study includes integration of physical, spiritual, mental, attitudinal and religious dimensions. Also included are experiences of enjoyment and coping. The participants' definitions of health are not located within the bio-medical or psychological discourses, nor the biopsychosocial discourse. Instead the participants understand their health in an integrated way, and this approach is present within the wellness discourse.

### **5.2.2 Multi-dimensional conceptualisations of health.**

I will now discuss the participants' descriptions of health as a multi-dimensional concept. The participants include illness and disease, as well as many other aspects, in their definitions of health. This inclusion reflects an integrated approach to the person. Multi-dimensional definitions contrast to uni-dimensional definitions in which health is defined as the absence of disease (Tarlov, 1996). Milburn (1996) discusses the dominance of uni-dimensional definitions of health for many health professionals. Health has therefore been defined by many health professionals as the absence of illness and the focus has been on illness rather than health. The participants of this study however do not define their health in these terms.

It is difficult to accurately identify the numbers of older women who experience health conditions. Disability statistics are available, but as health conditions do not necessarily create disability, it is difficult to identify how many older women experience health conditions. In New Zealand 53% of women over the age of 65 years identify themselves as having one or more disability (Statistics New Zealand, 1998). Disability types have been defined as hearing, seeing, mobility, agility, speaking, intellectual, psychiatric/psychological and 'other', which illustrate self defined difficulties in performing certain day-to-day activities (Statistics New Zealand, 1998). Disability and illness are excluded from health within uni-dimensional definitions, but are included in multi-dimensional definitions.

All participants of this study have health related conditions. These include mobility restrictions, recurrent falls, fractured bones, pain, non-insulin dependent diabetes mellitus, urinary incontinence, atrial fibrillation, Parkinson's Disease, cerebro-vascular accident (stroke), gastric ulcer, glaucoma, cataract, osteoporosis, cancer,



gout, depression, pulmonary embolus and cellulitis. Specific actions are taken to manage these conditions on a daily basis or as they arise. However these conditions do not define health for the participants of this study. All participants in this study have described their health in multi-dimensional definition terms.

You know I'm really healthy and well, if only I didn't have accidents, [daughter] says you're rushing too much, but it's just plain accidents, it's my purgatory I think. (Belle, Int 2: p. 8).

Belle believes that she experienced health as well as experiencing accidents. A multi-dimensional definition of health was also articulated by Maggie who described herself as healthy as well as experiencing osteoporosis and several strokes.

M: I feel very healthy um, I've got osteoporosis and um, I'm told that it started at 30, but it didn't affect me until four years ago, um I went to get out of bed but I couldn't. And that was the first indication. (Maggie, Int 1: p. 1).

K: The strokes you have had, how have they affected your health?

M: Not affected my health at all, but they affected my speech, um, I can think mentally but I can't get it out all the time, um, sometimes I talk fluently and some words I know in my brain what I want to say but it doesn't come out. (Maggie, Int 1: p. 2).

Health co-exists with health conditions. Thus Maggie stated that her strokes, which have altered her ability to communicate fluently, have not affected her health. Consistent with findings of Viverais-Dresler and Richardson (1991) and Perry and Woods (1995) the participants in this study described themselves as being healthy at the same time as they experienced health related changes and medical conditions. Maggie has also focused on what she is able to do and what is possible, and not on what she has 'lost'. This does not mean that she is not aware of the changes as she clearly articulated how the strokes have affected her mental processes and speech fluency. The emphasis on possibilities and not on losses is similar to the ways in which the participants described contextual independence in the previous chapter.

Jessie described her understanding of health in which she feels healthy as well as feeling ill.

J: I think I'm healthy. But I feel so tired all the time.

K: So is tiredness related to ...?

J: I don't know what it's related to, because the doctor told me he wasn't sure that I've got Parkinsons Disease and I said "I must have something, I wouldn't feel so damned ill if I didn't." (Jessie, Int 1: p. 1).

Jessie suggests that health can incorporate illness. Schank and Lough (1990) claimed similar experiences of older women, who also experienced good health despite multiple health problems and the presence of illness symptoms. Annette described complexities of being healthy which included health conditions, worn out parts and leading a normal life.

A: Well I think I'm fairly healthy because, I haven't had a cold for years and years with flu or anything like that, but apart from that, there's a lot of me that's sort of worn out but with medication I'm able to lead a next to normal life.

K: And what are the bits of you that are worn out, what does that refer to?

A: Well my wonky old legs. And unfortunately I've got diverticulitis which is rather an awful thing to have, but never mind that's under control.

K: Is it. Yes?

A: And my heart, well on medication I'm surviving alright, and I've got glaucoma, both eyes. I went into the hospital for the start, it was supposed to be cataracts, but they discovered I had glaucoma and the cataracts seemed to have stopped growing. (Annette, Int 1: p. 1).

Annette initially appeared to refer to a uni-dimensional definition of health as the absence of illness (colds and flu), but she then extended her definition to include body parts being 'worn out', and described several medical conditions which affected her in different ways. Annette's description is congruous with claims by Kaufman (1996) and Strain (1993) who state that elders perceive wellness whilst simultaneously experiencing limitations. In subsequent discussions Annette also described having had

breast cancer and a 'bad back'. Her definitions are therefore reflective of multi-dimensional definitions of health, in which being 'fairly healthy' includes experiencing multiple medical conditions.

The participants have described their understandings of being healthy which are inclusive of health conditions. They do not focus on the health condition alone in order to describe their health. Instead they have included their health conditions in their understandings of being healthy. This position contrasts to knowledge constructed within the social discourse, in which older women are portrayed as victims of aging bodies (Gutmann, 1996). The participants understand the changes they are experiencing, but do not portray themselves as victims of failing bodies. This is supportive of claims by MacDonald (1993) that the stereotypes of older women are not necessarily congruent with the experiences of older women themselves.

To summarise, health has been shown to be multi-dimensional. These participants experience health concurrently with medical conditions and illness. The participants' understandings of their health are not represented by the social discourse, as they do not describe their health in terms of loss and decline. Instead they acknowledge the changes which have occurred, and include these changes in their definitions of health.

### **5.2.3 Health and aging.**

I will now describe the participants' experiences of health in relation to aging. Wickens (1998) identified that health changes which stem from disease may be attributed to aging. Berman and Iris (1998) indicated that elders frequently expected decline and disability to occur as they continued to age. It may be that it is difficult to distinguish the basis of changes for both health professionals and for elders. Alice described her experiences of a health change which she attributed to aging.

I seemed to go down [feeling tired] the last four, three or four years, I seemed to go down very badly. But of course I didn't do anything about it thinking it was you know, something you had to put up with in old age. (Alice, Int 1: p. 35).

Alice attributed her lower energy levels to changes from aging, yet subsequently a treatable medical disease was diagnosed as the cause. Representations of older women as experiencing decline and loss occurs within the social discourse and Alice initially accepted this premise of aging as the reason for her loss of energy. The assumptions found within this discourse are therefore potentially life threatening, or quality of life threatening, for older women if they or their health professionals accept their health changes as an expected outcome of aging.

Aging is a universal experience, yet no participants in this study expected to change as they became older. This does not mean they did not expect to live until old age, but that they had never considered the possibility they would not be able to do their usual activities or that they would experience changes in their health in any way. Alice, the chronologically oldest participant, expressed her surprise at finding she had health related changes as she aged.

A: I suppose in many ways getting older makes you more, think about health more, perhaps you think, oh I'd better not do that because [of consequences] (Alice, Int 1: p. 2).

K: Did you ever expect to get older? Did you ever sort of think about it?

A: No I didn't. No I was quite surprised ... No I don't think if you're in reasonable health, you ever think that you're going to get what somebody else is suffering from, I'm sure you don't. (Alice, Int 2: p. 19).

The unexpected nature of health changes and of aging is evident. Alice has linked aging and health changes together, suggesting that she understands a co-existence of the two. Another change for Alice is that she now has an increased awareness of health, and thinks of consequences of actions. A related observation was that she feels just the same as when she was younger, and has to remember that she has changed. This was agreed to by several participants. She goes on to say:

A: I don't think anybody feels their age, from what I, the few times I've talked to people about it. We all know we're old but we don't feel old and we can't understand why we

can't do those same things which I think everybody, doesn't matter what age you are. I think probably you, you expect to do things. (Alice, Int 2: p. 12).

K: Do you feel anywhere near that sort of age [chronological age of 95 years]?

A: No, no, nowhere near it, I don't really. Sometimes I stop to think, and I think, good heavens, what on earth am I thinking I can do that for. (Alice, Int 2: p. 14).

Alice implies there is a discrepancy between her 'experience' and 'knowledge' of her age. It would appear that she does not have an automatic perception of herself at her current age. She then 'remembers' that changes have occurred. The social construction of older women within the social discourse is influenced by a valuing of youthfulness (Markson, 1997). Older women's expectations are likely to stem from within the social discourse as society reflects the assumptions and values of this discourse in everyday life. There is likely to be a level of previous learning for Alice which reflects society's expectations. The effect of the valuing of youthfulness for Alice however is not clear, as she experiences a younger perception of herself and then 'remembers' her age and possibly her abilities.

Alice's position is also not aligned with the bio-medical or psychological discourses. She does not focus on physical or psychological losses and declines, but has an automatic perception and expectation of abilities. This does not mean she is not aware of health changes, which may be losses, but that they are balanced by the possibilities and abilities she does have.

An increased awareness of health, as the women have aged, is also illustrated by Tida.

When we were young we just take it for granted, that you know life would just go on the same. But of course as we get older we realise that we're coming to the end of our existence here and know that we've got to look after ourselves a bit more instead of just taking things for granted. (Tida, Int 2: p. 7).

Aging has therefore promoted an increased awareness and appreciation of health for Tida. Louise also agreed that she thinks differently about health compared to when she was younger.

L: Well in my middle years, I don't think I thought about it much at all. I mean I had operations and things, but they went and I got well, no, I don't think I thought about health then. And if I had had anything wrong I would have had it treated. But now I'm much more reluctant to go to the doctor for things. I'd much rather put it off if I can.

K: Would you ?

L: Mm, I just don't care any more, I think that's what it is. I feel I've had my life. Why worry about it. I mean I wouldn't stay in horrible pain or anything if I could get rid of it, but. (Louise, Int 2: p. 49).

Louise suggested that she would now be selective about interventions. The unexpected changes in health were again demonstrated by Magdeline and Caroline, who described the suddenness with which they found they could not do some of their previous activities.

It's a great blow to you. I mean I've been able to sew very nicely for many years, since I was about eight, I could sew quite nicely, then suddenly you can't see and you can't use your hands. It's a tremendous blow. (Caroline, Int 2: p. 24).

It makes me a bit disgusted as I didn't think I would get old and I didn't think that I would have to cut down on what I did. So that, you know, women I've seen about are still quite fit at my age but there you are, we are all different. Quite a blow. Cos I just didn't think I'd get to that stage and I thought I would go on being active and I used to do lots of sewing. (Magdeline, Int 1: p. 20).

Well I've had to change my way of thinking, cos I mean I just sort of took it for granted that I'd just go on to 80, 90 not out, and be able to do everything, and I've got to realise, as you get older there's a lot of people cannot do the things they used to do, it's a blow to your pride, it's a learning experience, this life. (Magdeline, Int 2: p. 27).



The women in this study have illustrated that they do think differently about health as they have aged. They have expressed that they think more about health than when they were younger, when health was taken for granted. They think of consequences of their actions and have to remember that they are older as it is not an automatic perception. There appears to be a discrepancy between 'knowing that' and 'feeling that' changes have occurred with increasing age. There is therefore support for the premise that some older women do think differently about health as they age.

The participants in this study have raised health issues which are different to those of Perry and Woods (1995). In this study participants were asked to retrospectively reflect back on their lives to think about whether they thought differently about health as older women, compared to when they were younger. Perry and Woods compared the images of health of older women, aged over 70 years, to health images of younger women, aged 18-45 years. However both studies support the concept that there are some differences in the understandings of health of older women, when compared to younger women or when compared to their recollections of health in their younger years.

In the previous chapter, independence for the participants of this study was described as contextual. The participants all live in their own homes with the assistance of other people. 'Functionally independent' older women in the study by Perry and Woods (1995) identified independence as functioning without any, or minimal, assistance. They therefore did not refer to contextual independence. However, when older women require and experience assistance, they appear to adapt and include the activities of others in their definitions of independence. The ability to include contextual independence when assistance is required may illustrate a progression in understanding independence and health. Independence is a part of experiencing health for older women, but is a concept which appears to be contextually relevant.

#### **5.2.4 Summary.**

The older women participants illustrate integrated and multi-dimensional definitions of health. Their knowledge of their health is not represented within bio-medical and psychological discourses, nor in the biopsychosocial discourse. The reductionist

approach inherent within these three discourses contrasts with the integrated understanding of health which each participant expresses. The participants are located within the wellness discourse, in which health is understood to be integrated and to include health related conditions. The participants also suggest their understandings of health have changed as they have aged, as they appreciate and think more about health than in younger years.

### **5.3 Promoting health.**

The participants of this study claim an interest in promoting their health. This interest is similar to literature in which it has been recognised that older people do engage in health promoting activities and are motivated to promote their health (Bechtel & Franklin, 1993; Pascucci, 1992; Sidell, 1995; Walker, Volkan, Sechrist & Pender, 1988). It is apparent that health is valued by the participants, and therefore worth promoting. It is also evident that the participants feel some responsibility for promoting their health.

Well as you get older, your health is so important, it really is. I mean all the money in the world can't buy back your health. (Annette, Int 1: p. 29).

Well I do think that looking after yourself is a big thing ... I've always, right through my life, tried to be wise in what I eat and drink and all that sort of thing. (Tida, Int 1: p. 1).

You owe it to yourself to be, you're responsible to a certain extent for your health, aren't you. (Belle, Int 2: p. 16).

Health therefore had value and was able to be influenced by the individual through making wise choices. There was a consensus of agreement amongst participants that four specified activities were important in promoting their health. Nutrition, physical activity, mental activity and taking medications were specified as health promotive activities. Healthy eating and physical exercise have similarly been shown by Duffy (1993), Mitchell (1996) and Pascucci (1992) to be understood by elders to influence

health. Each participant had other specific activities which were of individual importance. I will now discuss each of the four core factors.

### 5.3.1 Nutrition.

Nutrition is generally recognised as a health promotion activity (Pascucci, 1992). However statistics provided by Sidell (1995) show only 20% of older women in the United Kingdom, aged 65-74 years, state that they eat a healthy diet in order to promote their health. In contrast to this low percentage Zhan, Cloutterbuck, Keshian and Lombardi (1998) show that the majority of the African American, Chinese American and European American participants believe nutrition is an important way of promoting health. All nine participants of this study believed that eating 'properly' influenced and promoted their health. They all bought 'meals on wheels' at least twice a week and this assisted them to both maintain adequate nutrition and to live in their own homes.

Eating 'properly' comprised different specific foods for each participant, although eating vegetables and fruits, and plain foods were commonly identified. Other specific foods mentioned included yoghurt, porridge, home made soups and protein from cheese and meat. No participant referred to low fat and high fibre nutrition, nor maintaining adequate calcium intake. Alice was the only participant to refer to iron levels and she related having low iron levels to being vegetarian.

But I do think that health relies an awful lot on diet and ... good plain cooking, no fancy meals at all and I think I was so in the habit of it that I just continued it all my life and once my husband died and I was on my own, I was 62 when my husband died, and I had seen so many people who didn't bother with good meals ... but I'm sure that meals make a difference, but of course the older you get the less you want to bother with that side of it so it is hard to keep up your interest in food because you haven't got the appetite but I'm quite sure that meals make a big difference. (Alice, Int 1: p. 3).

Alice referred to a time of potential change in nutrition when her husband died, and from reduced interest in food as her appetite has lessened. However she stated that she

maintained eating 'good meals' and that this promoted health. Tida was aware of changes in her food requirements as she has aged.

T: We just don't need the things now that we did ten or twenty years ago.

K: What sorts of things are you thinking of?

T: Well I suppose it's probably our meals, that's one of the big things we don't need to eat so much ... but I still realise that I need to have the same sorts of things only less of it. (Tida, Int 1: p. 8).

Maggie's eating patterns also changed as she has aged, but her reasons were different to Tida's.

I eat fruit every day and I watch my protein, but apart from that, I eat differently from when my husband was alive, Meals on Wheels. (Maggie, Int 1: p. 9).

In contrast to Alice who did not change her nutrition after being widowed, Maggie experienced a change in nutritional patterns.

Jessie, Louise and Annette have diabetes and are 'careful' with the foods they eat in order to manage their diabetes. Louise does not like sweet foods and so it is not problematic for her to avoid eating sweet foods. Annette and Jessie acknowledged it is important to keep their blood sugar levels within an acceptable range. They monitor their food intake, but include some sweet foods when they feel like it. Louise, Annette and Jessie knew their usual blood sugar levels, as well as the recommended range. They were therefore promoting their own health in a way which is acceptable to them.

But I just watch what I eat, and eat what I shouldn't at certain times, but just smaller quantities of it. And even on these bus trips, they'd be passing lollies around and I think why should I miss out on everything and I have one now and again which doesn't hurt you apparently ... I still get meals on wheels four times a week ... I think if you're eating your veges and food like that then you're not doing any harm to yourself, whereas I might be tempted to have something I shouldn't eat. (Annette, Int 1: p. 11-12).

Annette considered that eating an occasional sweet food would not be harmful, in an overall context of 'watching' the foods she eats. Magdeline described nutrition to be health promotive as she ate specific foods in order to prevent constipation, which is a side effect of some of her medication.

I make myself eat porridge which I never did before, with prunes and fresh oranges, so really if I didn't take these things goodness knows how much oil [laxative] I'd be taking. It's to keep me regular, that's part of health of course (Magdeline, Int 1: p. 16).

Belle and Annette took a health remedy to promote their health, which was a mixture of one teaspoon of cider vinegar and one teaspoon of honey mixed in hot water each morning (first thing). They both heard of this mixture from friends and have taken it for many years in order to promote their health. In a similar way Caroline took manuka honey and lemon juice in hot water to promote her health. She also took cranberry juice as a measure to prevent urinary tract infections, and made the effort both to obtain it and to drink it despite the sour taste. Obtaining it is not easy as she relies on others to buy it for her.

Nutrition has therefore been suggested by participants to contribute to health although the relationship is described in general terms. Nutrition has the potential to be affected by life events such as widowhood, which may alter previous eating patterns. Some effort is required for 'good' nutrition to be continued. The development of some medical conditions may also influence nutrition and extra effort is needed to be aware of food intake. Meals on wheels are bought by all participants.

### **5.3.2 Physical activity.**

Secondly, maintaining mobility through being physically active was another commonly identified health promoting behaviour. This is consistent with Viverais-Dresler and Richardson (1991) who identified that 68% of participants engaged in regular exercise in order to promote health. However, the participants of their study, who lived in their own homes, appeared to engage in quite vigorous exercise, such as walking 3-6 miles each day and aerobic exercises. This level of activity differs to the participants of this study as, at the time of the interviews, Alice, Belle, Jessie,

Magdeline, Maggie and Tida all used walking frames to assist them with their mobility. Caroline used crutches. Magdeline and Jessie also used scooters to go outside their homes. It is possible that the emphasis on promoting mobility for the participants may have been influenced by health events as Magdeline, Tida, Belle and Jessie have experienced falls or fractures. Also Magdeline, Tida, Belle and Alice were recovering from surgery or fractures when they participated in the interviews.

I use my walking frame and if I'm not feeling equal to going out I walk up and down the drive there quite a few times, a bit of exercise. (Alice, Int 1: p. 2).

Well I'm disappointed that I haven't made a quicker recovery and it's only exercise that's going to strengthen the muscles that are retarding my recovery. Xrays show that everything went well, it healed well. (Belle, Int 1: p. 4).

Walking, but now grounded to a frame from which I hope to recover to walking well again. (Belle, Int 2: p. 26).

Well I'm still doing the leg exercises she [physio] gave me, I'm still doing those every day ... I do half an hour a day at least ... doing these exercises they have made me walk really ... I can make myself do that to walk but it's only hobbling from one thing to the other. (Magdeline, Int 1: p. 11-12).

Belle and Magdeline were recovering from falls in which they had fractured their hip. Belle walked and continued to be active, taking her frame with her on the bus to go into town. Magdeline had exercised to her limits and been determined to promote her mobility by doing the specified exercises as well as walking with her walking frame. They both expressed disappointment with their walking and expressed their wish to return to the level of mobility they previously experienced. The context within which these participants promoted exercise was that of recovering from health events. There was an evident link with being determined as Alice, Belle and Magdeline all made sure they exercised. Rush and Ouellet (1998) linked mobility and independence together and found some participants equated the two. The contextual independence experienced by the participants however suggests a less direct link, although



independence is also promoted through being able to 'do things'. The context in which Louise exercised differed as she walked to let off steam and promote her ability to cope.

And I go and pull a few weeds out occasionally, I do the washing, I don't do the ironing, standing gives me really horrible swollen feet, so I don't do that, going for a walk with the dog. I walk every day when I've just got [her dog] here. (Louise, Int 1: p. 3).

Louise exercised in order to cope with life, and with her husband's forgetfulness, and found it a valuable way of letting off steam. The goal of activity and exercise for the participants is therefore to promote physical functioning and recovery from health events as well as to increase an ability to cope. Improvements in physical well being can realistically be expected from performing exercises, and has been demonstrated by Dungan, Brown and Ramsey (1996). It is therefore appropriate for elders to expect some improvements in their physical abilities if they engage in regular exercise.

Exercise is an activity which is commonly used in health promotion programmes for elders and has been applied as a measure of risky lifestyle behaviours in health risk appraisals (Uriri & Thatcher-Winger, 1995). In this context it is assumed that lack of exercise is risky to health. However the promotion of activity has been identified in the previous chapter to be health risking at times for the participants of this study. They identified that there may be serious consequences of taking a risk in order to promote independence. In this situation it may be performing exercises that is risky rather than not performing exercises. Thus older women may experience conflict between health promotion through no exercise and health promotion through exercise.

### **5.3.3 Mental activity.**

All participants referred to the importance of keeping their brain active in order to promote mental functioning. Caroline and Magdeline describe the importance of keeping mentally active.

Keep active, keep your brain active by reading or writing. I mean I write letters now to people that I don't even particularly want to write to, but it does me good to try and

remember how to spell words, because you forget. I hunt out the dictionary to find out some silly word I should easily know how to spell and I don't and I haven't got a clue, so I hunt it out of the dictionary. (Magdeline, Int 1: p. 10).

Keep your mind going otherwise you just go into a sort of soggy mess. I think [people decline] because they're prepared to be waited on and I don't think that works. If you haven't got the grocery list to think about, and you look at the little papers that come in. (Caroline, Int 1: p. 10).

Magdeline and Caroline keep themselves mentally active and promote their health by challenging their memories and 'thinking' about issues. Caroline reads the local newspapers, and makes decisions about every day events such as 'grocery lists'. Magdeline recognises that her memory for spelling some words has reduced and describes the efforts she makes to relearn. This approach contrasts to the negative portrayal of older women within the psychological discourse, as mentally declining, unable to make decisions and losing interest in topical events (Ginn & Arber, 1993; Wearing, 1995).

Tida also believed it was important to keep her mind active and that keeping in touch with events promoted socialisation with others.

... if I gave into it I could easily give all the bits and pieces away and if anybody comes in I'm able to still converse with them whereas if I didn't keep up with all the details it would be quite a lonely life I should think. (Tida, Int 1: p. 6).

Tida described potential loneliness and illustrated the importance of knowing about issues in order to have conversation with others. She also intimated that effort is required as she could easily let her mental functioning reduce with subsequent consequences for her.

There is an apparent overlap between promoting health by remaining mentally active and decision making, which was discussed in the previous chapter (four). Decision

making was found to be an important aspect of remaining autonomous, which the participants described as being an aspect of their health.

#### **5.3.4 Taking medications.**

Kaufman (1996) described taking medicines to contribute to health for some elders and claimed a 'medicine' category to their definitions of health. Medications are taken by all participants in this study and polypharmacy is a reality. Many participants expressed that they did not like having to take medications, but that they realised they would not live, or would experience health problems, without them. Magdeline takes medication which controls her pain.

I don't like taking them. I realise if they do what they're supposed to do, they're obviously doing some good. (Magdeline, Int 1: p. 15).

The conflict of taking medications is illustrated. Louise described taking medications for quality and quantity of life and expressed a 'choice' about taking them.

I know I wouldn't exist very long without things like digoxin [heart medication], and I know I wouldn't exist if I didn't take my diabetic pill, I'd get more sick, so I do sort of think about taking pills ... I need to, if I want to keep going, I just need to take the pills the doctor orders. (Louise, Int 2: p. 50-51).

The quality of life is taken into consideration and is a reason for taking medication. Alice has discussed taking her medications with her general practitioner.

If you want to go on living, he said, then you've got to have those things to help you whatever the consequences, but he said if you're not fussy about going on, he said, well you just don't take them. I've got it in my own hands. (Alice, Int 1: p. 24).

... because without the tablets, they are unpleasant in many many ways, but without them, you'd just peter out. And I think I would be more afraid of dying, not the fact that, everybody's got to die, but I don't like the thought of how I might. (Alice, Int 2: p. 17-18).

There is an apparent perception of choice about taking medications in order to 'keep going' as well as to promote quality of life. Participants appeared to ponder this point, and indicated the decision is very contextual. Magdeline describes that whilst medication may be taken to control symptoms, the side-effects may create other symptoms.

Yes, but the worst of it is that it [analgesia] encourages constipation. That means that I have to take some sort of laxative, you know to keep me loose. The doctor has prescribed some sort of oily stuff. (Magdeline, Int 1: p. 7-8).

Several participants have a flu vaccination each year on the advise of their doctor. Jessie has a flu vaccination twice each year as she has experienced pneumonia regularly in the past. Magdeline and Annette also have the vaccination. Influenza vaccination is congruous with a health goal for older people identified by the Ministry of Health Public Health Group, which is to protect elders from preventable infectious disease (Department of Prime Minister and Cabinet, 1997).

To summarise there is agreement that it is preferable not to take medications, but also that this is not practical for the participants. Medications are taken to control symptoms, for example pain and atrial fibrillation, and to manage their health problems, for example diabetes. They have become part of daily routines to promote health, and to improve quality and quantity of life.

### **5.3.5 Environmental determinants of health.**

In addition to the four core aspects of health promotion to which each participant subscribed there are specific individual aspects. I will comment briefly on three aspects as they illustrate determinants of health which are broader than the individual.

First, is cigarette smoking. Whilst cigarette smoking can be understood to be a health risk behaviour for which the individual is responsible, there is also a broader political interpretation in which the impact of environmental factors such as advertising are recognised. None of the participants currently smoke. Magdeline however attributed some of her current health problems to previous cigarette smoking. She commented

that she believed some of her walking difficulties have been caused by lack of circulation caused by smoking. Belle also believed that not smoking has positively contributed to her health.

Second is the effect of the immediate environment. Caroline had recently moved into a new house which she had built specifically to suit her needs. She has installed underfloor heating and double glazing which she believes promotes health as her feet are warm in winter and do not become numb with cold any more. She attributes this to living in a warmer house than previously.

C: What used to happen was that the, say, little toe would get as though it was red hot and then all of a sudden, you'd feel wetness in your stocking and it was a great blister had formed. Something to do with the circulation I think. A great blister had formed and then it had burst. And then of course you had weeks and weeks of Friars Balsam and dressings and all sorts of things, but we had none of that last year with the underfloor heating.

K: And up until then, most winters, would you have had trouble with your feet?

C: Most winters have been awful. Some days [nurse] has come in and this leg has been absolutely cold ... eventually she's massaged it and we put warm things around it and its come back. But this winter, like other winters I've had to wear great bed socks in bed, I've hardly needed to put the electric blanket on. The whole house must have been warmer. (Caroline, Int 2: p. 1-2).

The warmer house therefore has a positive effect on Caroline's health as she is not experiencing the same circulation problems from cold weather that she has regularly experienced in the past.

Third is the importance of a genetic aspect of health, which Belle recognised and attributed some of her good health to. She understood her health in the context of receiving good health via strong genes from her parents and passing these genes on to her children. Belle therefore recognised determinants of health beyond her control, which influence her health.

It has been illustrated that health is valuable and worth promoting. Health promotion incorporates the promotion of positive health and the prevention or further development of disease and complications. However it is difficult to distinguish between these activities. For example, living in a warm house may promote a sense of well being and positive health as well as preventing disease.

It is interesting at this stage to speculate on the relevance of the participants' life stage to their health promoting activities. They have described changes in their thinking about health as they have aged, as they reflect that they have taken health for granted when younger. This may have relevance to their interest in promoting their health now as health is perceived as valuable in a very immediate sense.

#### **5.4 Summary.**

In this chapter further data from the interviews has been analysed. Experiencing and promoting health have been discussed. The participants experience health in a multi-dimensional way which is inclusive of medical conditions. They understand health as an integrated concept which is valuable. They have also described changes in their thinking about health as they have aged, and this supports the suggestion that there may be different understandings of health at different life stages. Participants have also described their promotion of health through nutrition, physical and mental activity and taking medications. These four activities form core ways of promoting health. There are also specific individual actions taken. Three broader determinants of health are also referred to and are the effects of cigarette smoking, housing and genetic influence.

#### **5.5 Conclusion.**

In this chapter patterns of experiencing and promoting health, which have been identified from interview data, have been illustrated. The ways in which the participants have illustrated their understandings of health therefore include contextual independence, autonomy, experiencing health and promoting health. These four



patterns illustrate some of the commonalities of experiences of the participants in their understandings of health. There are also diversities of experiences and I would like to acknowledge that these differences are present.

In the final chapter I will discuss the positioning of the participants and of nursing in relation to the available discourses of older women's health. I will also conclude the thesis by identifying some limitations to the study and by posing some implications for nursing which have arisen from the study.

## **CHAPTER SIX: Older Women Experience Health.**

### **6.1 Introduction.**

In the previous two chapters I have demonstrated commonalities in the meanings of health to the nine participants, and described ways in which they promote their health. This final chapter will conclude the thesis by reviewing the aims of the study, examining the meaning of the results and locating them within the nursing practice context. The discourses, which provide ways of understanding older women's health, are briefly reviewed and the positions of older women and nursing are subject to critique. The relevance for nursing is explored and future directions suggested. Limitations of the study are raised. The relevance of gender to the experiences of health of the participants will then be discussed. Conclusions will address the contextual nature of health.

#### **6.1.1 Review of Aim.**

This study was commenced with the aim of exploring the meaning of health and health promotion from the perspective of women over the chronological age of 70 years. In order to promote the visibility and views of older women, feminist methodology has provided an underlying philosophy for the work. Feminist scholarship acknowledges the gendered and socio-political aspects of the context in which experiences occur. In order to explore the context in which older women experience health, the discourses which are currently prevalent and through which older women's health is known, are described.

### **6.2 Discussion of Findings.**

#### **6.2.1 Marginalisation of older women.**

Discourses have been identified through which knowledge of older women's health is generated and replicated. These discourses provide a framework for understanding how society represents the health of older women. Individuals take up a subject

position within available discourses and understand what it means to be an old woman through this positioning (Parker, 1992). Discourses have language and social constructions which represent older women's health in particular ways. The dominant discourses provide a meta-discourse which currently represents older women in negative terms and focuses on declining physical, mental and functional abilities. Within this meta-discourse, older women's aging and diseased bodies, which do not function as effectively as younger bodies, are viewed as a social problem through dependency. Subsequently older women require support and assistance from scarce resources as they become dependent financial burdens. Within the meta-discourse homogeneity is assumed due to the commonality of chronological age, and other factors which contribute to individual complexities are disprivileged by stereotypical notions of aging.

The critical review of literature has indicated that Western society in general and health professionals in particular are located within dominant discourses. The knowledge and 'truths' generated within these discourses are privileged over the 'truth' of older women located within the wellness discourse. The perception of older women, by people who are not older women, is therefore often negative. Western society has a youth oriented approach and if knowledge is generated by making comparisons then older age will be contrasted in terms reflecting reduced abilities (Sidell, 1995). Medicine also has a strong influence on Western health care systems which approach health changes of aging as deficits which need to be treated (Sidell, 1995).

The discursive construction of subjectivity is described by Parker (1992) and McNay (1992). Individuals take up the meaning of the discourse and their positioning is constituted within it. This notion of subjectivity supports exploration of older women's positioning within the discourses of older women's health. The negative representation of older women's health appears to be so pervasive that older women themselves should have few other images which represent their health. However this research has shown that older women have a different portrayal of their health. All nine participants are represented within the wellness discourse. These older women do not take up an understanding of themselves within the dominant discourses. Instead

they take up subject positions and understand themselves outside dominant discourses. This portrayal within the marginalised wellness discourse represents an image which is not commonly known, but which is distinctly present.

Conventional understandings of subject positioning within discourse do not explain the findings of this study. The participants' location in a discourse of wellness demonstrates silence and resistance to the pervasive understandings of older women's health represented within the dominant discourses. In stark contrast to dominant representations, the participants of this study provide readers with a persuasive alternative image of their health. It is only by asking older women how they understand health that it is possible to have a glimpse of their worlds, as they do not remonstrate against the dominant representations. Instead they are getting on with living their lives, using the skills they have gained over the years and coping with the challenges they face, to the best of their abilities. They face new experiences which may include health events. They continue to grow and to learn as they confront these new experiences. Whilst this study is representative of only nine women, their voice is distinctly different to the preconceived notions of aging found within society.

Most older women live in their own homes, and live independent or contextually independent and productive lives. Whilst the participants in this study do have some forms of assistance in their homes and have some frailties, they are not the 'financial burdens to society' that older women are commonly portrayed to be. They are clearly getting on with their lives in the context of knowing they have less life than when younger. The participants demonstrate an abundance of coping skills which enable them to manage the health changes which occur. They persist and remain determined and 'pigheaded' in order to promote their health. They value health, as being healthy enables them to do as they wish. They promote their independence and autonomy through doggedness. This enables them to live their lives in the ways they wish.

The participants express a realisation that their bodies are 'older' and do not work as quickly or effectively as when they were 'younger'. They have referred to changes within their physical, mental and functional abilities, which the predominant view interprets as deterioration or loss. However the women discuss these changes within a

positive frame of reference and emphasise what they continue to achieve. The participants experience health in a positive way, inclusive of the changes which have occurred. It is not the changes which define health for them, but their abilities. They do not represent their health in terms of decline and loss but focus on their achievements. Their viewpoint is divergent to the meta-discourse which speaks for them in terms of loss and decline, and does not represent their 'truth' of wellness and health.

The productive and contributory aspects of older women's lives are known within the wellness discourse, but are not recognised outside this parameter. The participants have demonstrated multiple examples of generative and productive lives. They have provided child-care for grandchildren, caring for their husbands with disabilities, participated in family lives, supported their children and grandchildren, supported their friends, taught colloquial English, taught religion, played the church organ for services, participated in local groups, and provided positive role models for younger people and each other.

These generative and contributory dimensions of older women are not well known, and are not predominant representations of them. It is interesting to postulate reasons for this omission, and to ponder why vested interests in society do not benefit from these representations. If older women's contributions became valuable and worthy, they would need to be recognised, acknowledged and possibly rewarded. This rewarding would potentially disrupt the current economic system which includes privileging of economically productive 'working' younger people (Estes, 1999).

### **6.2.2 Reasons for marginalisation of older women.**

It is not clearly evident why older women are marginalised, but I now propose several possible reasons. Elders and older women in particular have been virtually invisible in the generation of knowledge within the institution of medicine (Markson, 1997). Research findings from younger populations have been generalised to older populations (Fentiman et al., 1990; Woods, 1994) and patterns of aging specific to older women have tended to be ignored (Dimond, 1995; Kirschstein, 1991; Preski & Burnside, 1992; Ward-Griffin & Ploeg, 1997; Woods, 1994). Ignoring older women

suggests a concurrent lack of interest in their health and their understandings of health.

Knowledge of aging has developed predominantly from the interest medicine has in the physical and mental changes which occur as part of this process (Yardley, 1997). Knowledge has been generated 'on' rather than 'with' or 'for' older women. The dominance of science and medicine within the meta-discourse has limited ways in which knowledge of health and illness is developed. The reductionist approach to 'the body' which predominates within these discourses has taken precedence and the replication of knowledge reinforces this approach (Sidell, 1995).

McHoul and Grace (1993) describe the concept of power as analysed by Foucault to refer to the power of one discourse in relation to other discourses, with the potential for material and empowering effects. It is relevant to ask 'who benefits from this power?'. It is clearly not older women who benefit, as they are marginalised. Estes (1999) suggests that structural influences, which influence experiences of aging, stem from the state, the 'aging enterprise', the public, the medical-industrial complex and the organisation of financial capital. Aging experiences are therefore influenced by political, economic and social factors within society. Power is generated through complex intersections of these structural influences, and does not stem from the discourse of older women. It is therefore not older women who benefit.

Younger people have defined the health of older people. Definitions of health relevant to different life stages have been suggested by Perry and Woods (1995). This proposal is supported by the participants of this study, who suggest that they think more about health and health consequences than when they were younger. The representations of health within dominant discourses are not representative of older women's understandings and reflect the perspective of younger age groups, who have an 'outsider' interest in the health of older women. Dominant discourses continue to apply definitions of health which are developed within these discourses, whereas the wellness discourse stems from asking older women how they understand health.



Participants have illustrated that they get on with their lives and do not remonstrate against society and health professionals. Who would listen if they did? The marginalised position of the participants appears to benefit those within the dominant discourses. Older women are silenced as others speak for them, and represent their health in ways which promote particular interests. One of the participants of this study informed me that she wished to participate in order to have her voice heard, for how else would she be heard? (Louise, personal communication, November 10, 1998).

Further silencing of older women has been illustrated in this study as Jessie and Magdeline have both described their perception of not being believed by health professionals during a specific interaction (in chapter 4). They both experienced health professionals interpreting their behaviours as if they were not making the effort, when they state that they were. Magdeline felt the situation was unfair, and Jessie felt it was important that her efforts were recognised. The voice of the health professional in these situations held greater power than the participants. Again, if they were to remonstrate, who would listen?

Despite the marginalisation that they experience, the participants of this study challenge the dominant understandings of older women as they reproach stereotypes of older women's health in the ways in which they live their lives. They live their own lives being contextually independent, autonomous, experiencing health and promoting health. They define health in their own terms. Tensions are therefore present as dominant discourses define and represent older women's health in ways which are not representative of these women. The participants do not quietly acquiesce to preconceptions of their health, but quietly get on with living their lives the best way they can.

Some older women therefore resist the predominantly negative understandings and define health in their terms of wellness. These findings are not able to be explained by the theoretical understanding of subject positions within discourse. The participants have their own definitions of health which they have presented within this thesis. This study has shown that they get on with life and cope with changes. The wellness discourse is however small and does not have embedded power. It is evident that the

marginalisation of the wellness discourse disadvantages older women, but it is not immediately apparent who is advantaged due to complex social interactions.

### **6.3 Nursing and older women's health.**

The findings of this study offer a positive direction for nursing to work with older women in a distinct way. Health professionals including nurses who currently work with older women do so from positions within dominant discourses, and tend to take an illness focus. Nursing however has the opportunity to work with older women within a wellness framework. This would provide a unique focus on wellness and would ensure nurses work in ways which are synonymous with older women's understandings of health.

Tensions are present as nursing claims to take an holistic approach to client health yet fragmentation is evident (Kermode & Brown, 1995; Raftos, Mannix & Jackson, 1997). Nursing generates knowledge through reductionist and individualistic approaches and thereby favours the discursive constructions of health within the dominant medical discourses (Carrier, 1997; Delaney, 1994; Hills & Lindsey, 1994; Kermode & Brown, 1995; Perry & Woods, 1995; Raftos et al., 1997). Health is therefore defined in terms congruent with the dominant discourses. Similarly nursing also accepts representations of health which have been generated within the dominant discourses. In summary the reductionist approach of the dominant discourses is replicated within nursing, despite nursing also espousing holism (Kermode & Brown, 1995; Raftos et al., 1997).

Nursing claims to represent health, yet has been shown to be focused on illness and strongly influenced by medicine (Carrier, 1997; Kulbok & Baldwin, 1992). Nursing addresses both illness and wellness components of health (Jensen & Allen, 1993). The focus on illness has been at the expense of wellness. Much nursing literature focuses on health problems and limitations of health, yet this is not the way in which the participants understand or know their health.

Within nursing literature there is knowledge about health (Mitchell, 1995; Pender, 1996). However very little of this knowledge stems from elders, and in particular older women. It is not clear whether this reflects an expectation that elders are not healthy but are aging and diseased. The small amount of literature which focuses on wellness reflects a positive approach to aging. Perry and Woods (1995) applied a positive approach to health as they asked older women what being healthy meant to them. They did not predefine categories of health but applied content analysis and found participants identified definitions which are congruent with the wellness discourse. The definitions were inclusive of illness, and reflected a positive notion of health. There are some similarities between the findings of Perry and Woods and the participants of this study, as positive images of health are apparent in both findings. Further exploration of the concept of health from the perspective of older women would generate knowledge relevant to them.

The contextual nature of independence and the endeavour for autonomy has direct relevance for nursing, as nurses claim to promote independence of clients (Davies, Laker & Ellis, 1997; Orem, 1991; Whittle & Goldenberg, 1996). Exploration of the concept of independence to include the contextual nature would further develop understanding of this critical component of health for older women. Nursing would also benefit from the development of ethical knowledge to assist in the practical implementation of promoting independence in the context of associated risks. Elders do experience changes in health and must balance independence with risk taking. Nurses provide nursing care which intersects with independence and risk.

Nursing must develop its position within the wellness discourse, which will align nursing knowledge more closely with older women. The development of knowledge within the wellness discourse has the potential to strengthen nursing practice to incorporate the older women's perspective. Nursing may then stem from the older women's understandings of health.

Perry and Woods (1995) have also suggested the possibility of a developmentally relevant meaning of health for women. They identified that whilst there are some similarities in the definitions of health of younger and older women, there are also

differences. The findings of this study support this premise, as participants have reflected on their understandings of health from older years to mid-life. Differences appear to stem from an inclusion of health changes associated with aging or disease in older women's experiences of health. Younger women are more likely to exclude illness and symptoms from their definitions of health. The participants of this study suggested that they did not think about health as much when younger and took health for granted. They claim to be more aware of health as they have aged. However there is little research which has investigated this complex issue and it is not known whether personal definitions remain stable over life or whether they change with age. The possibility of different definitions for different life stages reflects some complexities of the term health. It also illustrates an area which would benefit from further knowledge development.

Nursing is present within the discursive field of health promotion, and has identified that elders are interested in promoting their health. Whether this interest is related to an increased awareness of health is not known. Viverais-Dresler and Richardson (1991) and Pascucci and Loving (1997) have asked elders about health promotive behaviours and found exercise and nutrition to be important. The participants of this study also claim nutrition and exercise are important ways of promoting health.

Nutrition and exercise are factors which are included in many health promotion programmes (Pascucci & Loving, 1997; Viverais-Dresler & Richardson, 1991). The criticism present within health promotion literature, in which the individual is held responsible for behaving in selected health promoting ways, is relevant for elders. Health promotion has been criticised for its focus on the individual and on selected behaviours through which individuals are believed to be able to promote their health (Antonovsky, 1996; Backett & Davison, 1992; Caraher, 1994). The promotion of healthy lifestyles however occurs within a context of contradictory evidence about what constitutes health promoting behaviours (Becker, 1993; Dean, 1996). This is important in the context of a 'blame the victim' approach, in which individuals are blamed if they do not undertake the specified behaviours for which they are subsequently held responsible. The emphasis on health promoting behaviours has

meant the broader determinants of health have been ignored (Caraher, 1994; Delaney, 1994).

In the current nursing climate the focus has been on illness, and within gerontology there is little knowledge development within the wellness discourse. As this discourse represents the understandings of older women it is important for nursing to generate knowledge which is reflective of older women (and men). In this way the interests of older women are served, and the contextual nature of health made more visible. Nurses are able to offer alternative ways of working with older women.

#### **6.4 Gender, older women and health.**

Feminist methodology has been utilised in this study. I had commenced this study with an expectation that the social expectations of "being women" would have influenced the participants' health. Their lives have been influenced by the role requirements of being women, as all participants have been married, and eight of the nine participants have had children. However the participants did not believe that having children and being a mother has had any significant effects on their health. Participants with children do receive support from them in varying amounts. Whether this support affects retrospective recollections of motherhood is totally speculative.

The participants postulated that the ways in which the men in their lives dealt with health issues differed to theirs, as men took on more of a sick role. However they did not believe that social expectations of them have affected their experiences of health. The current descriptions of the participants as contextually independent, determined and managing their lives is contrary to the dominant social construction of women in this age group. However the participants have an attitude of 'getting on with it'. They also may experience some difficulty in the process of accepting assistance of other people, and I question whether this attitude reflects an underlying social construction similar to the 'be grateful and uncomplaining' construction. Is it that older women must be either uncomplainingly independent or dependent?

## **6.5 Limitations of the study.**

This study has generated knowledge which is relevant to some older women, but is not necessarily able to be generalised to all older women. This is appropriate as the generation of prescriptive theories is not the overall aim of feminist scholarship. An aim of the study has been to raise the voice of older women in order that it is visible. Whilst the participants live in their own homes and have some assistance to do so, the findings may also be relevant to women living in rest home and hospital settings, as striving for independence has been identified as a core aspect of health. The concepts of independence, autonomy, experiencing and promoting health need further exploration in other contexts.

Participants of this study were representative of pakeha culture, and so their voice is represented in this study. No Maori or Pacific Island women participated and this was expected due to my Pakeha culture. Exploration of the contextual nature of health within cultures may be appropriate, and these explorations would enrich understandings of health from older women's perspective.

The focus of this study has been on the commonalities of the experiences of older women. However there are diversities also present and these diversities have not been explored in the same way as the commonalities. Some diversities appear to be represented by the contextual nature of health, in which each participant has specific understandings. Other differences have not been explored.

## **6.6 Concluding statement.**

This feminist study, of the meaning of health and health promotion to nine women over the age of 70 years, has illustrated that health is a contextual concept. There are several different representations of older women's health, through which understandings are generated. The nine older women who participated in this study describe their health in a way which is different to the dominant representations. There are some commonalities present amongst the participants. One such



commonality is that older women focus on current abilities and achievements, and do not use a comparative approach to past abilities. Health is therefore defined in terms of abilities and not losses. It is contextual.

Nursing has emerged as having eclectic understandings of older women's health. Within this eclecticism however is an alliance with medicine, rather than with older women. Nursing must promote independence and autonomy for older women, and in so doing will challenge the allegiances which are currently present. Independence and autonomy are clearly what the participants strive for, and for nurses to nurse older women in their terms nursing must be aligned with the older woman. This will be a challenge for nurses to undertake.

Gender concerns have not emerged strongly from this study, and are limited to the incongruence between society's past expectations of this age group of women, to be dependent on their husbands, against the participants' current aim of independence. The participants may be illustrating a social construction of older women in which there is an expectation that they will 'get on with it' and be uncomplaining. Alternatives are limited to expectations of dependence. Thus an 'uncomplainingly independent' or a 'dependent' social construction may be present. The assumptions of homogeneity of elders, held by dominant discourses, contributes to these predominant social constructions of elders. Recognition of the heterogeneity of this diverse group will contribute towards a greater range of social constructions for elders.

This study has not attempted to define health and health promotion for all older women. Clearly there will be many ways in which older women define their health, which will be reflective of their individual life patterns. Nurses are encouraged to recognise the wellness discourse and to nurse each older woman in a way which reflects her definition of health. In this way individual needs may be met so that older women are able to live their lives in the ways which they choose. A health focus would benefit older women.

Health has been discussed as a multi-dimensional concept. Some of the complexities of health are reflected in the following writing by Nietzsche.

*For there is no health as such, and all attempts to define a thing that way have been wretched failures. Even the determination of what is healthy for your **body** depends of your goal, your horizon, your energies, your impulses, your errors, and above all on the ideals and phantasms of your soul. Thus there are innumerable healths of the body; and the more we allow the unique and incomparable to raise it's head again, and the more we abjure the dogma of the "equality of men," the more must the concept of a **normal** health, along with a normal diet and the normal course of an illness, be abandoned by medical men. Only then would the time have come to reflect on the health and illness of the **soul**, and to find the peculiar virtue of each man in the health of his soul. In one person, of course, this health could look like its opposite in another person. (Nietzsche, 1887/1974, p. 176).*

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**APPENDIX I: Confidentiality form**

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**CONFIDENTIALITY AGREEMENT**

I, .....  
have accepted the task of word processing the research data collected by  
Kaye Milligan in order to complete an M. A. (Nursing) at Massey  
University.  
I understand that the data gathered for this research is confidential and I  
agree to take all necessary steps to ensure that any material on cassette  
tape or computer disk containing data from interviews relating to the  
research will be:

- a) Heard only by me, and transcribed to disk in private.
- b) Stored safely until returned to the researcher.
- c) Treated as confidential in all respects.

Signed .....  
  
Witnessed .....  
  
Date .....



**APPENDIX II: Advertisement****Nurse requires participants for study on  
Women's Health.**

\*\*\*\*\*

**I am a Registered Nurse completing a  
Master of Arts in Nursing and I  
invite women participants over 70 years  
of age.**

**This would involve you discussing with me  
your ideas about your health and what you  
do to keep healthy.**

**If you are interested in participating in this  
study please contact me by leaving a message  
for Kaye Milligan at Christchurch Polytechnic  
School of Nursing - Phone 364 9074.**

**All discussions will be treated in confidence and  
your name will not be used in any way.**

**More information will be provided and you can  
decide if you would like to participate in this  
study.**

## **APPENDIX III: Information Sheet.**

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9<sup>th</sup> September 1998

### **INFORMATION SHEET**

#### **Health and health practices of women over 70 years of age.**

##### **About The Study**

You are invited to take part in a study that explores the meaning of health to women over 70 years of age. Women's perspectives and experiences are central to the study.

My name is Kaye Milligan. I am a graduate student enrolled in a Master of Arts thesis at the School of Health Sciences at Massey University. I am a registered nurse and have been working as a nursing tutor at Christchurch Polytechnic for 7 years. Prior to that I worked in various nursing positions for 20 years.

This study has grown out of my interest in the health of older women. I would like to talk with you about your health including what you do now and in the past to help your health.

##### **Participation**

If you accept my invitation to be part of my research it will involve two or three one hour interview/discussions. In addition time will also be made available for you to discuss the research process with me. You are free to ask any questions about the study at any time during your participation.

The interview/discussions will be tape recorded if you agree and you are free to stop the tape recording at any time. You are also free to refuse to answer any questions. The tape recording will be typed up into transcripts by a typist. The transcripts will be available for you to read to confirm that they are a correct record of our discussions. The tape recordings will be either returned to you or erased after the research has been completed.

##### **Confidentiality**

Your real name will not be used anywhere. Instead you will be asked to choose a pseudonym or code name, and this will be used on the tape recording, the transcripts and the final written thesis. If you agree I will share some of the information and insights you give me with the other participants when I meet with them, but this will be done in an anonymous way and you will not be identified in any way. This sharing of information and insights with other participants is done to generate further ideas and information. The typist will not know your real name and will be bound by a signed confidentiality agreement not to discuss any details about the material on the tape recordings. All research materials will be kept in a locked metal filing cabinet.

### **Results**

I will be working with six to eight women in total and when I have completed all of the interviews the findings will be written up as a research report which may be used by nurses and other health professionals interested in the care of elderly women. The results will also be published in a professional journal. I will be happy to make this report or a summary of the report available to you either to read or to discuss with me.

### **Consent**

If after reading this information sheet you would prefer not to participate then you are free not to proceed. Deciding not to participate in this study, or withdrawing from the study will not

affect any health care, services or assistance you are receiving. Even if you agree to commence this study you are still free to withdraw at any time if you so choose. If you agree

to participate please tell me. I will then arrange a consent form for you to sign and we will arrange suitable times for us to talk.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Services Consumer Advocate, telephone (03) 377 7501.

### **Approval**

This study has received ethical approval from the Massey University Ethics Committee, the Canterbury Ethics Committee and the Christchurch Polytechnic Ethics Committee.

### **Contact names and phone numbers**

I can be contacted:

Kaye Milligan

M. A. candidate

P. O. Box 2983

Christchurch

Phone (03) 364 9074

ext 8295

My supervisor is:

Dr Jenny Carryer

Lecturer

School of Health Sciences

Massey University

Phone (06) 356 9099

ext 7719

**APPENDIX IV: Consent form**

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**Health and health practices of women  
over 70 years of age**

**CONSENT FORM**

I have read the Information Sheet dated 26<sup>th</sup> August 1998 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 that I have the right to withdraw from the study at any time and to decline to answer any particular questions. I also understand that if I choose to do withdraw from the study there will not be any effect on any services provided.

I agree to provide information to the researchers with the understanding that my name will not be used without my permission. (The information will be used only for this research and publications arising from this research project)

I agree/do not agree to the interviews being audiotaped.

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

I would like the researcher to discuss the outcomes of the study with me.    YES / NO

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

Name of researcher:    Kaye Milligan  
                                    Phone (03) 364 9074                      Ext. 8295

Signed: .....

Name: .....

Date: .....