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Qual Health Res 1999; 9; 520

DOI: 10.1177/104973299129122045

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Women's Midlife Experience of Their Changing Bodies

Elizabeth M. Banister

The purpose of the ethnographic report described in this article is to discuss midlife women's perceptions of their changing bodies within the Western cultural context and to provide a basis for health care with women. The narratives of 11 midlife women (ages 40-53) were obtained. Data were analyzed using Spradley's (1979) Developmental Research Sequence Method. Results of the study indicate that women's midlife experience of their changing bodies encompasses a broad spectrum, full of contradiction and change. Issues of loss, cultural influences that perpetuate ageism and sexism, lack of consistent information about menopause, questioning, redefining self, and self-care, all played a central role in the women's lives during this time of transition.

Midlife is a complex time of transition for women that encompasses a broad spectrum of experience that is full of contradiction and change (Levinson, 1996). Midlife often is defined by chronological age or by the condition of one's body (Lippert, 1997), which has an important influence on how one sees one's self. However, how one perceives one's self is also situated within a social, cultural, and historical context and includes one's cultural¹ knowledge of aging, gender, and social roles. The extensive physical changes that occur to a woman in midlife can interact with these cultural factors, leading her to rework her definition of her "self" (Notman, 1979). This study is about how midlife women perceive their changing bodies.

BACKGROUND CONTEXT

Women at midlife comprise approximately one sixth² of the Canadian population, and this proportion will increase in the next decade as the peak number of baby boomers reach the age of 50 (Foot, 1996). The demographics alone indicate a need for research in this underrepresented area. However, there are also other important reasons for conducting research in this area. Our knowledge of midlife women's lives not only is sparse in many areas but also is often incorrect, biased by ageism³ and sexism⁴ (Unger & Crawford, 1992; Ussher, 1989). It, therefore, works at odds with the health care needs of midlife women.

AUTHOR'S NOTE: This article is based on my doctoral dissertation completed at the University of Victoria. I wish to acknowledge the 11 women who invited me into their homes and told me about their experiences. Thanks also to Beverly Timmons, research supervisor, for her supportive and constructive suggestions.



QUALITATIVE HEALTH RESEARCH, Vol. 9 No. 4, July 1999 520-537
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The popular press has been eager to cater to the needs of this growing segment of the population by producing information about women's midlife issues, such as those related to menopause (Gullette, 1996; Sefcovic, 1996), but the research community has lagged behind, with little research into midlife women's psychological, physical, or spiritual development or into the experiences of the women themselves (Baruch & Brooks-Gunn, 1984; Fodor & Franks, 1990; Unger & Crawford, 1992).

To further complicate the task of conducting research on this time of transition in women's lives, in the past, three forms of bias in theory and research led to incorrect and stereotypic views of midlife women. First, until recently, the midlife transition has been described exclusively from the perspective of men (e.g., Erikson, 1950; Levinson, 1978; Vaillant, 1977). Second, the negative emphasis on aspects of events in the lives of midlife women, such as menopause (McKinley & Jefferys, 1974; Mishell, 1989) and "the empty nest" (Adelmann, Antonucci, Crohan, & Coleman, 1989; Cooper & Gutmann, 1987), has portrayed a narrow and often incorrect perspective of women's midlife experience (Baruch & Brooks-Gunn, 1984; Gergen, 1990). Finally, women's lives and health-related experiences have not been adequately understood through traditional, quantitative scientific approaches (Sigsworth, 1995; Stein, 1997). Such approaches, while producing some valuable findings on midlife women, do not generate an appreciation and understanding of the complexity of women's midlife experience. Instead, it is imperative that researchers acknowledge as legitimate a range of research methods: Qualitative and quantitative methods, by serving different but complementary purposes, may work cooperatively to provide unique understandings and information (Worell & Etaugh, 1994).

Other than a few recent studies that focus on issues related to menopause (e.g., Bond & Bywaters, 1998; Daly, 1995; Jarrett & Lethbridge, 1994; Kittell, Mansfield, & Voda, 1998; Woods & Mitchell, 1997), there is a gap in studies that focus on midlife issues for women. In particular, little research is available on issues such as physiological changes that have an impact on sexual functioning and the numerous losses, including loss of youthful appearance, that may precipitate changes to a woman's sense of self (Levinson, 1996).

Lippert (1997) points out the need for further research on the experiences of midlife women to help illuminate the complexity of this stage in their lives. Given the lack of consistent information and misconceptions about women's midlife period (Gergen, 1990; Hunter & Sundel, 1989; Mansfield, Theisen, & Boyer, 1992), I wanted to look at the meaning of the midlife experience as it emerges in women's own interpretations of their changing bodies. The research question that guided the study was, What are women's midlife experiences of their changing bodies? The intent was to examine the respective roles of sociocultural and physiological factors underlying their experiences from midlife women's own points of view (Geertz, 1973).

TACTICS OF INQUIRY

An ethnographic research approach (Atkinson & Hammersley, 1994) was well suited for the methodological needs of this study because of its ability to evoke rich descriptions from the participants. This research approach was chosen to seek an emic perspective of midlife women's perceptions of their physical changes. The emic perspective, or the insider's perception of reality, is at the core of most ethno-

graphic research (Agar, 1986; Fetterman, 1989). An ethnographic research approach is rooted in anthropology, wherein the researcher attempts to capture individuals' perceptions of meanings and events within specific contexts (Agar, 1986; Atkinson & Hammersley, 1994; Spradley, 1979). This research approach is primarily an inductive method grounded in empirical data (Fetterman, 1989; Glaser & Strauss, 1967) provided by participants' thick descriptions (Geertz, 1973), descriptions that represent the central elements of individuals' meanings of their experiences (Denzin, 1989).

An ethnographer tries to discover the true nature of human social experience with a holistic, contextualized approach. This perspective involves the recognition of multiple sources of reality (Fetterman, 1989; Spradley, 1979) and implies the researcher's suspension of preconceptions and his or her engagement in the world of the participants under study (Ball, 1993).

In this study, the research participants were midlife women, ages 40 through 55, who identified themselves as experiencing midlife physiological changes. The rationale for choosing the criterion of physical change within this age range was based on Rossi's (1980) recommendation that researchers abandon broad age definitions of the middle years and instead work with periods of physiological changes, such as menopause, that occur within relatively short time spans. According to Rossi (1980), this could contribute to an understanding of various psychological and social influences on women's midlife development. Even though the time span of 40 to 55 years incorporated physiological changes associated with menopause, the term *physical changes* was open-ended, so that each participant could define the meaning of this term in her own words. Each conversation began with the following question: I wonder if you could describe your experience of your changing body at this time in your life? This question invited each participant to expand on the way she understood her midlife physical changes and provided a broad range of descriptions, including perceptions of changes associated with menopause and physical attractiveness.

The overarching theoretical framework that guided data collection and analysis is ethnoscience theory (Werner & Schoepfle, 1987). Within this theoretical perspective, the concept of culture is a semiotic one (Geertz, 1973; Goodenough, 1971). A central tenet is that a social group's knowledge is reflected in its language and can be organized into categories that relate to one another. Some of this knowledge is expressed explicitly through language, but a large part is tacit or hidden from view (Spradley, 1979) and can be revealed through ethnographic interpretation. The focus is on the emic point of view, and priority is given to thick descriptions that emerge from interview data (Geertz, 1973). Thus, culture consists of "webs of significance [individuals have] spun" (Geertz, 1973, p. 5). The analysis of such webs is an interpretive act and is focused on the search for meaning (Geertz, 1973). What is relevant is the ways in which the researcher's interpretation helps negotiate two worlds of meaning: the researcher's (and audience's) and the participant's (Agar, 1986; van Maanen, 1988). To paraphrase Denzin (1994), this interpretation sets the stage for the reader to engage with the research participants.

Participants

As researchers enter into the phenomenon under study, they may gain an understanding of select cases through purposive sampling, but this understanding need

not be universally shared (Denzin, 1989; Spradley, 1979). I used a purposive sampling procedure that involved variation in cultural background, employment status, marital status, and sexual orientation. This sample allowed for as broad a range of information as possible (Lincoln & Guba, 1985) through the inclusion of women who generally are underrepresented in health-related research, contributing to a multifaceted interpretive research account. Contact was initiated soon after I placed notices at the local YMCA or YWCA, a charitable, community-based organization that is centrally located. These notices outlined the intent of the study and included the way in which confidentiality would be addressed. Three women were selected from 10 women who responded to the notice. The remaining 8 participants were accessed through introductions from third parties known to myself and to the participants and through word of mouth. When I first met with the participants, each signed a consent form and I assured each of confidentiality.

I selected 11 women (ages 40-53) as participants for the study, who identified themselves as experiencing physiological changes associated with midlife and who were willing to describe their experiences. Of the women, 9 identified themselves as White, 1 as Aboriginal, and 1 as Asian. Employment status varied. Four women were employed full-time, 2 worked part time, and 2 were unemployed; 3 women were out of the work force due to early retirement, disability, or serious illness; and 2 women were students. Regarding marital status, 5 participants were married, 1 had never married, and 5 were divorced or separated. Two members of the participant group were lesbians. With one exception, each of the women had children; 2 had experienced the death of a child. Educational level ranged from grade school to graduate school. It is worth noting that 5 of the women had hysterectomies; of the remaining 6, 3 were still menstruating.

Recruitment of participants ended when the data reached theoretical saturation or when new instances of the phenomenon did not lead to new categories (Glaser & Strauss, 1967). Before and during each individual and group interview, the emerging analysis was discussed among participants to verify and add information (Lincoln & Guba, 1985; Sandelowski, 1986).

Data Collection

Data collection through unstructured interviews was carried out in two phases. The first phase consisted of individual interviews to obtain midlife women's descriptions of their changing bodies. Phase 2 involved the gathering of the research participants in consecutive groups for verification of emerging domains, further theory development, and sharing.

Individual conversations took place in each participant's home. A total of 23 1-hour individual interviews were audiotaped and transcribed for analysis of the contents. The ethnographic interviews were conducted and the typed transcript analyzed according to the Developmental Research Sequence (DRS) Method (Spradley, 1979). The DRS Method consists of 12 specific tasks (such as gaining access to participants, engaging in domain analysis, and writing the final report), whereby dimensions of meaning in cultural experience are discovered through the study of language. Of the 12 DRS steps, 3 involve posing descriptive, structural, and contrast questions. Each form of question will be explained in turn.

Descriptive questions help to obtain participants' representation of some aspect of their world (Goetz & LeCompte, 1984) and help to collect an ongoing sample of their language. To generate descriptions from each participant, questions such as the following were used: I wonder if you could tell me about your experience of your changing body? Structural questions obtain the constructs, or domains, participants use to describe their worlds. Such questions help discover the ways in which individuals classify certain terms within a specific category of meaning. The following example illustrates a structural question: "Corinne,⁵ you said, 'I see myself getting older.' Are there other phrases you might use to describe this?" Contrast questions are used to discover the relationships among the domains that participants use. The following contrast question posed to a participant revealed valuable meaning: "Mary, how would you describe the difference between your comments, 'How others view me' and 'How I view myself?'"

Following completion of the individual interviews, the participants came together within a focus group format. Three consecutive 2-hour group interviews took place to help verify and add to the hypothetical domains that had emerged from the analysis of the individual interviews (Fontana & Frey, 1994; Morgan, 1984). The focus groups broadened the database and helped to clarify the emerging theory within a different context. A constant comparative method was used (Glaser & Strauss, 1967) whereby data obtained from the focus groups were compared to the information obtained from the individual interviews. Each group interview was audiotaped and transcribed to facilitate analysis of the data.

Group interviews were held at the YM/YWCA. During the initial focus group, I addressed the issues of confidentiality and the purpose of the group. Following these formalities, eight hypothetical domains that had emerged from the analysis of the individual conversations were presented for discussion and verification. I intended to have only one group meeting; however, as the initial meeting was ending, group members requested a second focus group to "get to the nitty-gritty of women's sexuality." In their eagerness to continue sharing stories of their changing bodies, the women repeated the request to meet for a third and final time. Each participant attended at least one focus group, with an average of 8 women attending all three.

Ethnographic Analysis

Four kinds of ethnographic analysis were used in conjunction with the various types of ethnographic questions. First, domain analysis involves a search for domains or larger categories, each made up of similar cultural symbols. The second kind of ethnographic analysis, taxonomic analysis, involves an in-depth examination of a limited number of domains through the construction of a taxonomy or visual representation of the relationships among terms (Spradley, 1979). Third, pieces of information that people use to distinguish differences between terms are called attributes. Componential analysis involves a search for attributes that reveal differences among terms in a domain. Fourth, the discovery of cultural themes requires a search for recurring ideas or several common threads of meaning among the participants' narrative accounts that relate to the topic (Fetterman, 1989; Spradley, 1979).

Rigor

The quality of an ethnographic report lies in the ability of the researcher to represent individuals' ways of life, keeping in mind that the goal of ethnography is understanding (Altheide & Johnson, 1994). Lincoln and Guba's (1985) naturalist alternative to the positivist paradigm for assessing the rigor of qualitative research was used in this study and included four criteria: credibility, transferability, dependability, and confirmability.

First, criteria used to strengthen the credibility of the results involved triangulation, peer debriefing, member checks, and keeping a reflective journal. Between-method triangulation (Denzin, 1989) was achieved by the addition of content analysis to the qualitative research process (Altheide, 1987). This form of triangulation helped to broaden the interpretive base (Denzin, 1989) and provided a means for peer debriefing.

Focusing on member checking, the researcher is responsible to obtain the "members' perspectives on the social reality of the observed setting" (Altheide & Johnson, 1994, p. 490). It is crucial that researchers return to participants with tentative results and refine them according to participants' reactions (Reason & Rowan, 1981). To assure that the analysis accurately represented the social world of midlife women, participants were invited to comment on the analyzed material throughout the research process and to suggest changes where they felt that the materials did not reflect their experiences.

Finally, as a woman at midlife, the closeness of my relationship could both enhance and threaten the truth value of this study (Sandelowski, 1986). I accounted for my reactions to the field experiences by keeping a reflective journal⁶ (Banister, 1996, 1999). The reflective journal provided a medium for reflecting on such reactions and ways in which they might influence my interpretation and representation of the women's experiences (DeVault, 1990; Harding, 1987). This act of writing and critical reflection was crucial to the cycle of data collection and analysis and became part of the analytical constructs of the study (Bogdewic, 1992).

The issue of transferability involves the "fittingness" or applicability of the descriptive account to other contexts. Transferability judgements were facilitated through the use of purposive sampling and the inclusion in the ethnographic text of extensive quotations. Dependability, the third criterion, has to do with the consistency of the research findings. I attended to the issue of dependability by using an audit trail that included keeping a research journal in which I recorded my methodological decisions. Finally, confirmability, the criterion of neutrality in qualitative research, also was ensured with the audit trail.

ETHNOGRAPHIC TEXT

Themes are sense-making markers that help to integrate the diverse meanings of individuals' experiences. Themes crystallize such experiences within contemporary social, cultural, and historical situations. Four general themes became apparent to me as I critically analyzed the women's stories: sensing incongruence, having more questions, sensing loss and longing, and caring for self. The following text is

intentionally multivoiced. I attempt to have the participants speak and present themselves, to tell their own stories of their experiences of their changing bodies in their own way (Denzin, 1994).

Sensing Incongruence

Most of the participants struggled with an uncomfortable ambiguity, or sense of incongruence, as they attempted to come to terms with a changing body that was becoming less valued in terms of societal and, to a degree, personal standards of youth and fertility. When I asked Corinne about her perception of her changing body, she spoke of two kinds of "splits": "Things are falling. Basically there's a split. My torso's fine, but I go from my face, which looks like it's all falling down." Another split was expressed in her attempt to reformulate meaning of two kinds of social messages about women's midlife experience:

On the one hand, I have books about aging and I have Gloria Steinem's book and all of those recent "pop" books. So on the one hand, I have this sense of "It's fine to begin to age and those wrinkles, or whatever, are appropriate." On the other hand, there's that split inside of me that says, "No way!" And I'm not going to let my hair grow gray because it doesn't feel good to me. So, it's not just the acceptance of "This is that natural order of things." It's like "We have to do something quick!"

Halprin (1995) suggests that women at midlife experience tremendous difficulty in adjusting to the fact that they are seen as less attractive than they were when they were younger, which is a result of physical changes during the menopausal years. Corinne's split between her desire to accept the physical manifestations of aging and her actual rejection of those manifestations may be seen as a conflict between two mutually exclusive strategies to adjust to the reality that she is viewed as less attractive. Little did Corinne know that her inner conflicts and her questions were manifestations of societal contradictions.

For many members of the participant group, cultural prescriptions that devalue aging women were tacitly and explicitly revealed as a central part of meaning, one that operates in a variety of ways. Mary expressed sensing incongruence as "being out of sync with time." She told me, "I don't have a modern body. My body was more suited to 100 years ago." When I asked her to define a modern body, she used the word *thin*: "A modern body means thin thighs, and I don't have thin thighs. Now in some ways, I am influenced by our culture about that; in other ways, I'm pretty happy with my body." Her perception both frustrated and reassured her.

As with most of the participants, Judith described her weight as the first thing she notices when she looks in a full-length mirror: "There's a bit more weight here and there, but I feel that my body looks good for being 52." Her ambiguity emerged from a thick clutter of double meanings: between appreciating her body and her perception that her body could, more adequately, fit the norm of femininity. She added, "I definitely want to be attractive within the realm of possibilities of my body." In the following excerpts, 3 participants' comments were tacitly revealed as a mirror to society:

If I look at the weight issue more in relation to how my appearance is in conjunction with my disability, I think I would feel better if I was thinner.

I think I'm mentally, emotionally, and spiritually getting riper and riper, but there is the feeling that I'm less worthwhile in terms of attractiveness.

I guess there are times when I think maybe I should get a face-lift or something.

The foregoing comments helped illuminate the social structural processes of female culture that relate to "continually being taught to see the body that reflects back to us . . . [as being] wrong, defective" (Bordo, 1993, p. 299).

When I asked Lillian about her perception of her changing body, she expressed her impressions of the impact of sexism and ageism on her experience, even though she is a lesbian. As with many of the participants, what she disliked most was the effect of such negative cultural attitudes on women's self-esteem:

I think if I were actually heterosexual, I would have a lot more feeling that I'm losing the ability to fulfill the norm of a feminine woman. Not so much in the shape of my body but in the looks, how my face looks. I think for a lot of men who are concerned to look like they're with women who are younger or youthful looking, then I would fail to fulfill that requirement. And I would feel more like I'm in battle to preserve my self-esteem instead of experiencing myself as I do.

Then, Lillian spoke of her internalization of "derogatory messages" that have to do with "misogynist attitudes amongst men." She clarified, "There's some sort of inner dialogue that goes on. As I approach older age and some of these physical things manifest in my appearance, then I have this inner dialogue: 'Oh, you look like a sexless old woman now!'" It was not comfortable for Lillian to know herself to this extent, to be aware of cultural standards that value youthfulness yet, at the same time, be concerned about her looks. The question of being "caught between cultural norms and [her] own reactions" to her aging body continued to bother her as she said,

I still grieve that I don't have that young look. And yet, I have ambivalent feelings about that too because when I compare women my own age to women who are really young the young women's faces look so bland in a sense.

Lillian continued, "Life hasn't written its story on their faces."

Because looks are personal but are defined socially, the influence of social structural factors were embodied and thematicized as sensing incongruence between the women's life stories and larger cultural processes. As the women spoke of their changing bodies, more and more questions emerged. The questions arose as a result of their ambivalence but also because of a lack of knowledge, itself the result of cultural avoidance of the issues facing midlife women.

Having More Questions

As one participant in the study said about her changing body, "All of these physical changes are happening. At first, you're unsure of your body and what it's going to do each month. Your body is unfamiliar again, like when you were 14 and just starting your period." According to feminist views of women's health (e.g., Bond & Bywaters, 1998; Dickson, 1990; Kaufert, 1994; Mitchinson, 1991; Ussher, 1989), medical discourse strongly influences women's self-definitions and experiences of

their bodies. Indeed, among the participants in this study, it did influence the way in which they structured the meaning of psychological and physical changes associated with menopause and sexuality. In the face of the devaluing "medico-cultural grip" (Gullette, 1994) that defines menopause and the sexuality of midlife women, the participants' anticipations and sense making of their changing bodies often were expressed in the form of questions derived from an uncertainty about what to expect once physical and psychological changes associated with menopause became noticeable.

Indeed, many of the participants sought medical advice to make sense of such changes; however, the information they received was at times contradictory or confusing. Referring to herself as "postmenopausal," Sandra described a number of symptoms she had experienced during the past 2 years. In trying to make sense of feeling "different," she told me, "I have gone to a number of doctors about my health. I don't know what is going on! I may have a hormone imbalance or something, but the feedback I'm getting is that I'm perfectly healthy." She was asking many questions, too many questions it seemed: "I get the feeling that it's all in my head. I find if I question the doctors, they take it as being confrontational." Sandra was not the only participant who expressed such sentiments of vulnerability in response to treatment by medical practitioners. Two women spoke of feeling powerless in the face of medical intervention:

When I went for the biopsy, my physician had a medical student with her, and she didn't even ask me if it was going to be all right if this guy was in here looking at my, you know, up on the stirrups. So, there's that feeling of invasion or something.

There were sort of little innuendoes about premenstrual syndrome, and when a problem couldn't be sorted out, he'd say, "Are you sure you're not depressed?"

These quotations illustrate that some of the women experienced comments and behavior from their doctors that they interpreted as implying a lack of respect and, it could be argued, that were "engendered by sexist and ageist discourses" (Hunter & O'Dea, 1997, p. 219). Some were "getting fed up" with having many of their physical complaints interpreted by their physicians as part of changes associated with aging and being female. Such responses were clearly inadequate for the participants who simply wanted their doctors' opinions, wanted some answers, some empathy for their concerns.

Indeed, it seemed that for the women in this study, interventionist medicine reinforced the "disease model" in which middle-aged women are seen as having "declining" bodies and, for that reason, are devalued within those contexts (Jones, 1994; Kaufert, 1994; Ussher, 1989). An example of this approach is the treatment of menopause through hormone replacement therapy, despite the questions raised by feminist critics regarding this treatment (e.g., Bond & Bywaters, 1998; Harding, 1997; Klein, 1992). Indeed, this treatment concerned many of the participants. As one participant said, "There's just not enough research, serious reliable research to look at how the various hormone replacement therapies really affect women. It makes me really angry that menopause has been turned into a disease rather than a natural process."

Because their doctors could not provide the support they wanted, many women turned to their mothers "to provide prophecies about the life course" (Gullette, 1994, p. 98). However, their mothers had been influenced by the cultural and medical

discourse of a previous era, in which they themselves had experienced midlife. And because sexuality and menopause had not been openly discussed by the previous generation, the participants had only myths and misconceptions to rely on for information. It was not surprising that an understanding of the participants' own experiences was slow to emerge from such a thick cloud of silence, from tacit messages that included "insanity" and "frigidity," from such mystery surrounding menopause and sexuality. Lillian described some of the deeply entrenched cultural narratives about menopause passed down by her mother's generation:

I think that most women from my generation have seen our mothers go through menopause with some difficulty because our mothers were even more isolated. We're taught that it's difficult for women, and you can expect that you're going to get depressed, be very emotional, have a lot of hot flashes. You know, "You may have to go on some of hormonal treatment to save yourself from this horrible mess."

Such negative attitudes helped distort many of the participants' expectations of their physical changes, leaving a noticeable gap in their knowledge.

For some, the strain of not having answers to their complaints led them to search for alternative ways of healing. Judith's following assertion was shared by most group members: "The medical profession should get into the 21st century and look not at just conventional medicine but alternate measures—at holistic treatments." Predictably, the idea of seeking alternatives for their complaints at times were discouraged by their physicians. Judith explained, "If you talk to the medical profession about a variety of alternative things, they really don't want to talk about it, so I've just been focusing on them anyway and feeling better."

For many of the women, the most useful remedies for their complaints came from dialogue with other women, in which midlife myths and misconceptions were balanced by personal accounts of their changing bodies, in which, as experts of their own experience, a wealth of knowledge and information would emerge. As one woman said, "It's peer information. It's not just an expert telling us. We're peers. We're all going through it; we have the same experience." Sharing their stories of physical change reassured some of the women that they were not losing their minds, that they had a right to question that their bodies were "feeling different." In part, having more questions indicated the women's resistance to the larger cultural discourse and its negative impact on their self-conceptualizations.

Sensing Loss and Longing

Each of the participants had a heightened awareness of less time to live. For many, this awareness was exacerbated by a loss of youthful appearance, loss of youthful energy, and loss of fertility. Furthermore, some participants experienced a sense of loss, either anticipating or experiencing their children "leaving the nest." One participant put it succinctly: "You almost feel you've been besieged in that you have all of these important losses, all at the same time." Each loss contributed to an experience of the loss of a former, younger self and therefore had an important influence on each woman's identity (Levinson, 1996; Notman, 1979). This loss of a younger self precipitated a period of transition for the women, comparable to other transitional periods in women's lifecycle (Notman, 1979). As another woman said, "I'm still in that midlife crisis of trying to find out who the hell I am."

Rossan (1987) writes that an important influence on one's identity is one's interpretation of the physical changes occurring at various points in life. The awareness of diminished youthful appearance confirmed by photographs and mirrors was at odds with most of the participants' self-images. Indeed, the observed physical changes of midlife challenged many of the participants' sense of identity and self-esteem. For example, a sudden shift in perceptions of self came for some of the women when they caught a glimpse in a mirror of what seemed to be their mothers at midlife. In the following narratives, 2 of the participants expressed surprise when mirror images seemed to reflect their mothers:

You walk by a store window and you look in the mirror in the window and there's your mother. You think, "My God!" and realize that suddenly you're older physically. You're saying, "Is this what it's all about?" You know that this is a much younger person and, "My God, I look like my mother!"

Well, the first time I saw myself as getting older I was looking in the mirror, the first time I noticed I had wrinkles and all that, I picked up a mirror and I was looking like this and I went, "Ah, that's me!" It was really weird; it was funny because I saw my mother.

As Kaufman (1986) found in her study of the continuity of self over time, aging individuals perceive their self as unchanged over time, notwithstanding the physical and social changes that occur. Some of the women related many instances in which they did not identify with their aging bodies, even though they were confronted with evidence from mirrors or contemporary photos. Two women expressed this alienation from their aging bodies in terms of an inner sense of youth that defied time and natural process:

It's an interesting feeling to look in the mirror and see someone older than how I feel. I feel almost the same or healthier in some ways than I did 15 or 20 years ago. If I look at myself, especially early in the morning [and see] all those wrinkles and saggy places, then I think, "Gosh, I guess I am getting older!"

My daughter sent me a picture that she took close up of myself and her Aunt Mary and I said, "Stay back a bit. I don't want them so close up!" And my daughter says, "Mom, you look great, you look great!" So it's what she perceives . . . and it's very different from me.

Because aging is given meaning within a socially constructed context, individuals recognize that they are aging in response to the "Other," to others' perceptions of them as being old (de Beauvoir, 1970). Stories unfolded, one after another, of others' stigmatizing (Goffman, 1963) responses that reaffirmed the culture's negative assessment of aging women:

You go into an interview and it's there. I don't know how else I can describe it. If it doesn't happen in an interview, the other time it does happen is when you are being waited on and somebody calls you "dear."

People regard me differently. I get a different response from people than when I was younger. I mean, I can go into *A & B Sound* and ruin the ambiance!

For most of the participants, this loss of youthful appearance provoked grief for the loss of the youthful self. The loss of youthful appearance may disrupt the self-esteem of women who have defined themselves through their appearance and their sexuality (Halprin, 1995). For example, the experiences that emphasized Ann's loss of youth were working to bestow on her a disquieting sense of grief and vulnerability:

I think the main thing is just losing that young appearance. Although I eschew make-up and dyed hair because I never want to pretend to myself that I'm anything other than who I am, I still grieve that I don't have a young face.

Another loss confronting the participants, which for some brought further feelings of vulnerability and forced a new definition of self, was the cessation of reproductive capacity. Suzanne told me, "Something that you were capable of doing before is gone now. It's kind of sad. That part of you as a woman you can't do anymore."

Midlife is a period when one shifts from a focus on time lived to time left to live (Jarrett & Lethbridge, 1994). As one woman told me, "You come to grips with your own mortality." Through experiencing the losses, most of the participants reassessed their lives and developed a new definition of themselves, in which they assumed an "ethic of responsibility [to themselves as] a self-chosen anchor of personal integrity and strength" (Gilligan, 1982, p. 171). As Judith put it, "There's something about the pain I've been through—it brought me up short."

Caring for Self

It's a transition period between being a young woman and being an old woman. There are a lot of things that I don't care about anymore that I used to care about a lot or worry about. They just seem irrelevant to me; they don't seem important anymore.

As this quotation from Sandra, a participant in the study, implies, caring for self is a theme of setting aside, of regeneration and emergence. As Louise said, "For me, one of the positive things about aging is that we can let go of the roles that we've been given in life. We can move outside of these roles, and we can let ourselves be."

According to Mezirow (1991), development in adulthood occurs as a person forms increasingly meaningful perspectives on life, often followed by a major challenge to the person's established perspective. This is referred to as a "perspective transformation." Events such as physical change and children leaving home provided opportunities for many of the participants to examine and question social norms and expectations on which their own perspectives were based. As some of the participants realized that the social norms were increasingly unable to provide satisfactory answers to their questions, perspective transformation became likely to occur. According to developmental theorists such as Chiriboga (1989) and Erikson (1968), changes in self-concept increase with states of conflict and instability and are a necessary component of human development. Viewing oneself as a central source of support and strength was seen as a major change in most participants' self-definition. This process is illustrated by Judith, who recently had been depressed:

I was feeling depressed, and that was a result of the inner physical and emotional changes. I just started to pay attention to myself and was learning about myself again. There were always other priorities, and so I had put things away about myself. It was hauling all of that stuff out again and looking at it and maybe thinking, "Well, that doesn't matter anymore!"

Thus, as women's roles and relationships change over time, changes in their self-understandings occur. One of the major shifts in roles that may lead to a reconceptualization of self involves relationships with children and parents. Social norms have established women's role in terms of caring for others (Gilligan, 1982). For the women in the study, 4 had lost their parents, and the remainder had not yet had to assume extra caregiving roles in such relationships. Only 2 of the women still had children living at home, all in their late teens. As Bateson (1989), Levinson (1996), and Neugarten (1968) found, for most of the women in this study, many seemed to move through a perspective transformation from the child-rearing role toward their own increased individuation and autonomy, toward caring more for self. However, this transition was difficult because they had to learn to challenge past cultural messages that require women to put others' needs first, to be self-caring in light of being considered selfish. Suzanne expressed her resentment toward these messages of selfishness:

It's kind of a bill of goods we've been sold for a long time, and that's what women are suppose to do. They're supposed to look after other people, be the caregivers. You don't do things for yourself. That's being selfish, and you don't operate that way.

Perhaps most significant, the women came to realize that as women, they have a responsibility to themselves to engage in self-care activities, with the implication that one values oneself enough to care for one's body, mind, and spirit. Judith confidently told me she had learned to take charge of things: "I value myself as a person. It's okay to say, 'No' and still feel good about it." The integrity of honoring one's body and self holds the deepest and perhaps longest-standing investment in respect to maintaining one's quality of life into old age (Bateson, 1989). Indeed, as old age grew closer, most of the participants were learning to put extra time and precious effort into taking care of their bodies. One woman said, "I'm definitely aware of cherishing my energy. Now it's like this treasure that I have, that I cherish and I nurture."

Nature was highly valued by most of the participants and an important part of their self-care, as if they knew now that it was the simplest of things in life that were meaningful, things such as "the silence at the end of the day." For some of the women, shifting responsibilities and roles provided more free time to reflect on and be a part of nature. As Mary commented, "I take time for my own interests, taking walks, sitting, looking at the tree outside my window." The tranquillity of nature helped to bestow strength and serenity on many of the women, which some could not recall having ever known.

Indeed, the crises of change in life can be seen as spiritual, in which one may turn inward and trust the movement of life itself toward wholeness (Washbourne, 1977). Perhaps Sandra's perception can help to explain this metamorphosis that occurred for some of the participants: "Maybe our bodies aren't holding out as well

as we'd like them to, but we're going on into a deeper stage of our lives, more spiritual." At midlife, with its turmoil and conflict, connecting with one's spirituality seemed to help tranquilize many of the women's concerns. As Monica put it, "I am able to be more, I think, spiritual. I can say, 'Thank you!' to the creator every day."

DISCUSSION

At a conceptual level, this study demonstrates the unique capabilities of the ethnographic method for conducting research into women's lives. Through the use of this method, this study discloses the experiential meaning of women's midlife development as more complex than has been made evident beforehand by previous researchers using other methods. It has brought to light the multifaceted layers of social, historical, and cultural influences on individuals' experiences of changes in their life course. Most important, this study explored the ways in which the interaction between women's perceptions of their changing bodies and developmental, cultural, and historical influences initiated changes in perception of self. Nearly all of the women reported significant change in their self-definitions as a result of the developmental phase of midlife. A factor that this study revealed to be a salient feature of the experience of the participants was their activity of questioning, critically reflecting, and reinterpreting. By questioning and critically reflecting on the cultural construction of their realities and interpreting their midlife physical changes for themselves, the participants started to come to terms with some of the changes.

The women's questions about their changing bodies arose as a result of ambiguity between cultural stereotypes, which they themselves may have accepted as true, and their personal experiences. Also contributing to their need to ask questions was simply their lack of knowledge, itself stemming from cultural avoidance of the issues facing midlife women. Mansfield et al. (1992) report that midlife women tend to experience substantial conflict, due in part to the lack of consistent information about midlife issues. The lack of consistent information about their physical changes prompted the women to question and challenge traditional cultural constructions of their experiences, indicating their resistance to the negative impact of this larger cultural discourse on their self-conceptualizations.

The women's questioning extended to many aspects of their lives, notably to health care. As one participant put it, "It's taking the lack of trust and doing something about it. I feel I'm being more proactive in my health care. I'm not assuming that the medical profession knows everything." For example, as the women sought out alternatives to the perceived inadequate forms of health assistance provided by the mainstream health care system, some moved toward assuming responsibility for their own well-being, not only physically but also mentally and spiritually.

As Jarrett and Lethbridge (1994) found, each participant experienced numerous changes, each one providing an opportunity for her to challenge formerly accepted cultural stereotypes and to reappraise and reassess her life's course. Furthermore, as Daniluk (1993), Levinson (1996), and Rubin (1979) report, during this time of transition, issues such as loss and changes in role functions prompted each woman to work toward redefining her identity. In particular, it is apparent that an awareness of less time to live led the participants to make more self-enhancing life

choices. As one participant put it, "I think you get in touch with the deeper values within yourself, wherever those come from, and you want to listen to those."

This research indicates that for midlife women, although physical health issues are important, it is the cultural context within which these issues are interpreted that can be problematic. This context defines the ways in which midlife women engage with their health issues, and as the participants in this study indicated, women often seek to involve health care professionals in this process. To the extent that they seek such help, it is incumbent on health care professionals to be conscious of this context and of its effects. If midlife women simply want health care facts, these could be provided in a matter-of-fact way (Jones, 1994). If, however, they want help engaging with the implications of these facts within the cultural context that devalues aging women, we can help them with this process as well.

Health professionals can first attempt to examine some of their own biases and assumptions about midlife women that could influence their treatment of and attitudes toward these women. Such professionals can engage in critically questioning the underlying structural influences embedded in their own discourse and their taken-for-granted assumptions about midlife women. Furthermore, by gaining more knowledge of midlife women's developmental issues within the cultural and historical context, health care professionals can view their clients' circumstances in a more informed manner. For example, by understanding how ageism adds to the stress of midlife women, health care professionals can develop ways to help them acknowledge and counteract the cultural stereotypes that contribute to their confusion and conflict and to their experiences of feeling powerless during this time of transition. By encouraging midlife women's critical reflection and questioning, health care professionals can help them take action individually and collectively to enhance their lives (for example, by engaging in dialogue with other women and sharing information about menopause and sexuality).

Finally, health educators need to consider implementing programs, workshops, seminars, and other educational opportunities for midlife women in order to make available consistent and reliable information about the developmental changes and challenges associated with midlife women's physical changes. This type of information often remains within the realms of academia and is not available to ordinary women. By disseminating the available knowledge, health care professionals can help midlife women to demystify midlife societal attitudes and beliefs about this transition in their lives.

This study revealed that health care professionals lack knowledge and consistent information based on research on this important stage in women's lives. The paucity of research and information suggests a need for further research into midlife women's health-related issues and that such research be made available not only to the academic community but also to ordinary women. Topics to investigate could include the following: conflict and confusion associated with role changes and physical changes, vulnerability and ambivalence in the face of middle ageism and sexism, midlife women's critical reflections and questions about their midlife experiences, and changes in self-definition. As one woman said, "What's important is getting women's experiences—not necessarily just statistical information, but just hearing what other women's experiences are and hearing the variety."

In particular, there is a need for further interdisciplinary research of women's midlife developmental issues to provide a broader, more comprehensive and balanced understanding of this important time of transition in women's lives. For

example, the use of sociological research and theory for the study of midlife women's development would help broaden my findings that women's experiences of their bodies are, in part, socially produced by illuminating the effects of social interaction on the midlife experience. As well, nursing research could help create a discourse supportive of women that reflects a holistic, health-promotion view for examining midlife women's vulnerabilities and changes. This would provide an alternative to the illness-oriented medical models that rely on the stereotypical image of midlife women as vulnerable to depression, anxiety, loss of sexual interest, and lack of confidence.

Finally, social scientists and health researchers could use focus groups to investigate the collective developmental issues and concerns of groups of individuals that represent different developmental stages in the life course. The potential for using focus groups to generate shared experiences and collective action among participants is a valuable tool that could be used to help create social change.

NOTES

1. This is referring to Western culture.

2. According to Foot (1996, p. 19), "Almost 33% of the Canadian population" are those born during the baby boom, totaling 9.8 million people in 1996. *Baby boomers* are defined as the group of individuals born between 1947 and 1966.

3. In their book titled, *Women and gender: A feminist psychology*, Unger and Crawford (1992) refer to ageism as negative attitudes toward the aged. Ageism encompasses discriminatory practices based on such attitudes.

4. Sexism refers to the belief that women are valued in terms of their physical attractiveness and usefulness to men (Unger & Crawford, 1992).

5. I use pseudonyms throughout to protect the anonymity of the participants.

6. A detailed account of my reflexive process while conducting the study about women's midlife experience of their changing bodies can be found in *Qualitative Inquiry* (1999), 5(1), 1-23.

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