

AN INTENSIFIED PRAGMATISM IN REPSONSE TO REPRODUCTIVE
EXPERIENCES AND MEDICALIZATION:
A CASE STUDY OF CAPE BRETON WOMEN

By

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REPRODUCTIVE EXPERIENCES: CAPE BRETON WOMEN'S PRAGMATISM

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Abstract

This dissertation focuses on the reproductive experiences of Cape Breton women. Using feminism and symbolic interactionism, I explore these experiences by conducting focus group and semi-structured individual interviews with 47 women from the Cape Breton Regional Municipality. Three major themes emerged from the women's stories. First, women assess their situations and make decisions to maximize their advantages. Second is what I characterize as women's "intensified" pragmatism engendered by their complex socio-cultural environment. Problems of high unemployment, severe pollution and difficult access to health care have contributed to a culture that encourages individuals to expect the worst and to trust only those closest to them. In relation to women's reproductive experiences, this translates into distrust of medical professionals, great reliance on other women, and culturally influenced understandings of *normal* reproductive processes. Third, the advantages women identify for using medical interventions and treatments are subjective, arising out of lived experiences. For those not privy to the women's experiences or those operating from a biomedical position, these advantages may seem counter-productive or paradoxical. Considering the three themes as related parts of a whole, I found the difficulties and disadvantages associated with life in Cape Breton resulted in a strengthening of women's agency. Given the constraints on access to health care and the social problems, these women had no choice but to improvise and be pragmatic. Theoretically, this research reaffirms the need to pull together the literature focusing on structural constraints and lay perspectives to understand the role of medicalization in women's lives. It also illustrates that control is an important issue not just in women's interactions with medical professionals, but also in interactions between women. Substantively, this work contributes to our understanding of women's pragmatism, the importance of the context in which it operates, and how these impact on women's definitions of *normal* reproductive experiences.

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CHAPTER 1

INTRODUCTION

In this dissertation, I examine the reproductive experiences of ordinary women living in the Cape Breton Regional Municipality (CBRM) of Nova Scotia, Canada. My interest in carrying out this research arose out of a broader interest in studying women's health and reproductive processes from both feminist and symbolic interactionist viewpoints. In society generally, there have always been elements of fascination, fear and even disgust related to women's reproductive experiences. Throughout history, interpretations of the cyclical appearance of blood in the absence of injury or sickness, the ability to grow a new life inside the body, and the ability of the body to adapt to significant hormonal changes have all been heavily influenced by various ideologies. (Grahn 1993; Buckley and Gottlieb 1988). These ideologies have not simply influenced the attitudes of the general population, they have also filtered into professional proclamations about reproductive processes.

Theoretical Issues

Numerous books and articles by researchers have been written over the years on women's reproductive health and they have tended to approach the subject from one of two viewpoints. Specifically, there are those who have focused on medicalization and related structural arrangements and those who have focused on women's lay perspectives.

This research builds on the contributions of both these bodies of literature by examining lay perspectives within the particular context of the Cape Breton Regional Municipality.

The literature focusing on *medicalization* and structural arrangements has focused on the ways in which the medical profession has been successful in mandating medical intervention and treatment for female reproductive processes. This attention to women's reproductive processes emerged with the professionalization of medicine in the 1900s. According to feminist researchers, the patriarchal structure of society at that time virtually guaranteed that these processes would be labeled abnormal, requiring medical attention. For example, Smith (1987a) and others have argued that patriarchy ensured that all things male were viewed as the norm by which everything else was judged. Thus, social scientists and feminist researchers examining reproductive experiences have focused much of their analysis on this process of medicalization.

Feminist researchers working in this area have also informed us in some detail of the *negative consequences of medicalization* for women. Structural constraints on women have been emphasized, and a conceptualization that women are treated as passive victims of a patriarchal structure has emerged. According to Walters (1994), such a theoretical focus has yielded important information about the impact of structure on women (cf. Lock and Kaufert 1998). However, while the revelations of such work were necessary and useful, many feminists also focused on a different aspect of medicalization in relation to women.

Specifically, a second approach emerged in the literature that significantly influenced the decisions I made while conducting this research. The *lay perspective*

approach emphasizes women as active interpreters of the contexts in which they find themselves (cf. Walters 1991, 1994; Aronson 1990, 1998; Fisher 1988; Shuttle and Redgrove 1986; and Riessman 1983). Feminist researchers such as Gilligan (1993), Eichler (1988), Smith (1987a), and Spender (1981) have directed researchers to the behind the scenes behaviours and roundabout ways women have developed to deal with the realities that confront them. In this regard, Walters (1994:309) has urged researchers to focus on the ways in which women themselves interpret and predict their health and illness by providing them with the opportunity to speak freely about these issues (cf. Kirby and McKenna 1989).

Feminists such as myself, focusing on women's lay perspectives, owe a great deal to symbolic interactionism. This perspective provides a particularly useful approach when one is interested in experiences that relate to the development of the self and the role of interactions in the construction of meaning. It also emphasizes the need to focus on the meanings the individual associates with her actions and experiences. In terms of women's reproductive experiences, this emphasis encourages an exploration of the complexity identified by researchers such as Walters (1994). I elaborate on my use of feminism and symbolic interactionism in this research in chapter 3.

Substantive Issues

My substantive interest in the lay interpretations of Cape Breton women about their reproductive health arose from the observation, as a resident of twenty years, that this region is experiencing unique circumstances relating to health care services, the

economy, and the environment. This research is in essence a case study of these women that furthers our general understanding of women's lay perspectives.

The area itself is predominantly a working-class, Catholic community known for its strong Celtic roots. There is a long history of large families and a high rate of teenage pregnancy, a possible lingering influence of the Catholic Church's views on birth control and abortion. Given that Cape Breton is an island, there is also a definite sense among the people that they are a distinct group and isolated from the rest of the province of Nova Scotia, in particular, and Canada in general.

The area has also been experiencing cutbacks to health care, a shortage of health care providers and services, delays in treatments and interventions, high rates of unemployment and underemployment, increased reliance on welfare and food-banks, and exposure, through the Sydney tar ponds, to serious environmental health hazards. For example, *Maclean's* recently ran a story covering the results of a national health care survey. The reporter, Danylo Hawaleshka, indicated that in relation to health care services, Cape Breton ranked 50th out of 54 communities. It was ranked 17th out of the 20 rural areas listed. Cape Breton was last in mammograms, 53rd in terms of life expectancy and 34th in pap screening (Hawaleshka 2002). Further, the official unemployment rate in the area is 20.1 percent (Statistics Canada 2001). The unofficial rate is estimated to be much higher, perhaps double the official rate. Government agencies and the Joint Action Group (JAG) have identified high levels of PCBs in the area. Many members of the public believe these pollutants may be the cause of high rates of cancers and birth defects in the area.

Given the social context, and in particular, the significant social problems, I thought it important to explore how women in Cape Breton think and feel about “normal” reproductive experiences. In this way, I would not only contribute to the theoretical literature on women as agents of knowledge (Harding 1987), I would also provide substantive insights into the ways women make sense of their reproductive experiences within a specific context informed by problematic social and environmental issues beyond their control. My belief was that investigating the reproductive experiences of women who live in this unique environment would further our understanding of, not only women’s *common* reproductive experiences, but also variations in women’s experiences and understandings based on the interactions between individuals and the socio-cultural environment. As Doyal (2000: 935) has noted, “Despite the fact that they share the same biology, it is clear that women’s reproductive health status is profoundly affected by who they are and where they live.”

Methodological Issues

The theoretical issues raised by feminists and symbolic interactionists in relation to studying women influenced my methodological approach. I developed a research design that was consistent with these approaches, using focus groups and semi-structured interviews to collect information from forty-seven women living in the Cape Breton Regional Municipality. These methods were best suited for this research because:

If women are to participate in the formulation of healthy public policy – and such lay participation has been emphasized in recent years – it is important to find ways to

articulate the experiences of those whose voice might otherwise be unheard, those who do not use the language of health and illness (Walters and Denton 1997: 57). Following the interpretive tradition adopted by many feminists, my intention in this research was to create a data collection plan that approached women as knowledgeable experts, or as Harding (1987:3) has put it, as “agents of knowledge.” I submitted my research proposal to the McMaster University Ethics Review Board and received approval for my study to proceed. In the next section, I discuss the organization of the thesis proper.

An Overview of the Thesis

To address the theoretical, substantive and methodological issues outlined above, I begin this dissertation with two chapters that discuss the two strands of literature examining women and reproductive processes: 1) that which focuses on the medical system and its attitude or approach toward women, and 2) that which focuses on women’s lay perspectives regarding their reproductive experiences.

In chapter 2, “Professionalization and Medicalization,” I explain that within the existing socio-cultural context, the health care system contributes to women’s reproductive experiences in significant ways. It is, therefore, necessary to consider the health care system and its professionals when examining women’s experiences. Accordingly, I focus on the literature that discusses the historical development of medical professionals and the patriarchal ideology and praxis that supported it. I illustrate the historical ties between professionalization and medicalization that have had ramifications for women and their reproductive experiences. I conclude this chapter by explaining that

while this research has been very beneficial, consideration of the second strand of research that focuses on lay perspectives also needs to be considered.

In chapter 3, “Lay Concerns and Departures,” I focus on the literature emphasizing the need to understand what women experience and how they interpret those experiences. I present the issues that have been addressed in the literature on lay perspectives, generally, and those focusing on women, specifically. I consider the literature that examines issues around women’s compliance versus women’s resistance to medicalization of reproductive functions. Further, I consider the more recent literature establishing women’s pragmatism in relation to health matters. I also discuss issues of failed communication between women and medical professionals and misinterpretations of women’s actions. I conclude this chapter by again pointing out that women’s reproductive experiences cannot be sufficiently understood without understanding the entirety of their lives, the socio-cultural context, and that this understanding needs to be rooted in women’s explanations. It is at this point that I describe the concepts from symbolic interactionism that influenced my approach to this research.

I present a detailed discussion of the research plan in chapter 4, “Methodology, Analysis and Sampling.” Consistent with the position in the lay perspective literature that we need to understand the socio-cultural context, I begin this chapter by discussing the Cape Breton context within which the women who spoke with me live their lives. I describe the unique circumstances in the area related to health care services, the economy and the environment. I also explain the sampling method used and provide biographical information about the 47 women who participated in this research and the community in

which they live. I then describe the methods of data collection and analysis used in this research. It becomes clear in this chapter that I made decisions regarding methods with an interactionist understanding of the interconnectedness of the steps in research and the need to keep the substantive issue of women's reproductive experiences as the touchstone in decision-making.

The three chapters that follow the description of the research methods focus specifically on the information provided by the women. The overriding theme in these chapters is that women are engaged in a complex process of filtering and selecting information guided by a pragmatic approach and available resources. I explain that this pragmatism is a direct consequence of lived experiences and the socio-cultural context in which they occurred.

I begin chapter 5, "Women Dealing with the System," by explaining that the purpose of this research was to understand what Cape Breton women thought and felt about their reproductive experiences within a socio-cultural context fraught with health care, economic and environmental problems. As I explained in chapter 2, "Professionalization and Medicalization," attempts to understand these experiences require examination of the roles that health care professionals play. Specifically, there is a need to examine their interactions with women and the ways women interpret those interactions. Accordingly, in this chapter, I present women's recollections of interactions with medical professionals and their resulting interpretations of those interactions as well as their assumptions of these professionals' intentions.

In chapter 6, “Experience and Trust: Learning and Teaching, Woman to Woman,” I discuss the importance of interactions with intimate others, specifically mothers, sisters and female friends. I illustrate that these interactions took the forms of both verbal communication and observation. I then explain the ways in which these interactions influenced women and their interpretations of their experiences. In the last section of this chapter, I explain that the role of women as teachers is a continual process. The women learned from other women and in turn are teaching others - their daughters.

In chapter 7, “Local Culture and the Pragmatic Woman,” I explore the pragmatic approach that Cape Breton women have adopted as a consequence of the Cape Breton socio-cultural context in which they live their lives. I illustrate that the women were constantly synthesizing physical experiences, accumulated information and social interactions related to reproductive experiences into something that was meaningful to them. I discuss the ways in which the general negative attitude and skepticism in Cape Breton and the small size of the community have fostered a deep reliance on family and significant others. In the final section of this chapter, I illustrate women’s pragmatism by describing their reasons for using medical interventions and treatments, reasons significantly different from those of medical professionals.

In chapter 8, “Conclusion,” I summarize the findings of this research and reiterate the pragmatic approach that the women have adopted in relation to reproductive experiences. I discuss the contributions of this research to the existing literature that focuses on women and reproductive experiences. I close this chapter by discussing suggestions for future research. I now turn to these issues.

CHAPTER 2

PROFESSIONALIZATION AND MEDICALIZATION

Introduction

The medicalization of female reproductive processes has been the focus of numerous research studies (cf. Oakley 1984; Riessman 1983). According to that research, the medicalization process has been very successful in mandating medical intervention and treatment for the reproductive processes of women. For example, medical professionals treat the pain or discomfort associated with menstruation and menopause as abnormal and at the same time, think of them as common. These processes have also been associated with mental instability. The result has been a societal belief that most women are better off with medical interventions and treatments. Similarly, hospitalized births are now the norm throughout North America.

The medicalization of women's reproductive experiences has been studied in its historical and socio-cultural contexts. In many cases, the process and the medical models that informed it were the focus of research (Lock and Kaufert 1998). The primary purpose of this research then is to explore the ways women think and feel about their own reproductive experiences. Part of this analysis includes a consideration of how they interpret and respond to processes that medicalize these reproductive experiences, particularly as these relate to the socio-cultural context in which they live.

According to Miall (1994: 393):

Sociologists, writing about Canadian health and health care, have conceptualized both health and illness definitions and behaviour as social constructions. In a review of this research, Coburn and Eakin (1993: 91-93) have observed that both illness constructs and health and illness behaviour arise out of social and cultural contexts, through interactions, and at the level of the individual.

Notably, the health care system makes up a significant part of the socio-cultural context within which women experience reproductive processes. As Miall (1994: 396) states, “Many female conditions have either been reconceptualized as illnesses or understood in ways that connote a deviation from some ideal biological standard.” Consequently, it is very unusual for women today to have reproductive experiences in the absence of interactions with the health care system and health care providers.

In order to contextualize the interactions women have with medical professionals in the health care system, I focus specifically on its historical development as a system. In this regard, I pay particular attention to feminist research examining the impact of the processes of professionalization and medicalization on the medical system that emerged.

Specifically, in the first section of this chapter, I examine the rise of the medical profession as a male institution, and consider the patriarchal ideology and praxis that supported it. In the second half of this chapter, I examine the medicalization process itself, and make note of the difficulty and confusion associated with definitions of health and illness, and the relationship this has to reproductive processes. Finally, I stress the importance of considering structural approaches in conjunction with women’s interpretations of their reproductive experiences as they relate to the socio-cultural contexts within which women live.

Medicine and Professionalization

In the literature on these topics, professionalization and medicalization are inextricably linked to one another. Numerous studies attempting to more fully ascertain and describe the professionalization process, have focused on physicians or medicine generally. Freidson's (1970) *Profession of Medicine*, cited in both the medicalization and professionalization literatures, is one of the more well-known examples of this approach. In *The System of Professions: An Essay on the Division of Expert Labor*, Abbott (1988: 15) explains that Freidson is interested in the control of work and "its effect on such social functions as healing." That issue of control over the work and its effect on the medical profession are the major themes of this chapter.

The social factors, including control, that contributed to the rise of a medical profession dominated by males contributed to the medicalization of life processes in general and to women's reproductive experiences in particular. As Miall (1994: 396) explains, "[m]edicalization... serves the interests of a medical-care system dominated by technology and a patriarchal capitalist economy." Riessman (1983: 4) makes a similar argument in her article, "Women and Medicalization: A New Perspective." She indicates that some researchers have concluded that the expansion of medicalization was the outcome of medical imperialism or an attempt to increase medical power. Others have stressed the ways in which the medical establishment wanted to create and then control economic markets. In the following pages, I outline in detail the rise of the medical profession and women's relationship to that process.

Professionalization

There has been considerable variation in how the term *professionalization* is understood and used in the literature. However, researchers studying professionalization usually agree that the following criteria characterize the movement of an occupation to a profession: (a) formal specialized education, (b) the development of associations, (c) securing formal or legal protection and (d) the development of an ethical code of conduct (cf. Croucher 1994; Abbott 1988; and Larson 1977).

One aspect of professionalization particularly relevant to the medical profession is “specialized training” required for professionals and provided almost exclusively in the form of formal education (Abbott 1988). Controlled access to the knowledge of a profession, therefore, is easier to maintain, and it is only the successful completion of this training that allows an individual to take on the socially sanctioned label of *expert*. However, not all individuals historically have had equal access to formal medical training. Indeed, some groups, such as women, were denied access. Such exclusionary practices were not, however, simply based on the beliefs and desires of group members. Rather, they were tied to what researchers such as Abbott (1988) refer to as structural and cultural controls.

Structural control consists of developing professional associations, gaining and maintaining sufficient control over access to the knowledge upon which “expertise” is based, and finally, having the professional autonomy or the ability to control definitions of the work and who does what (Croucher 1994; Abbott 1988). According to Abbott (1988: 16), “Culturally, professions legitimate their control by attaching expertise to

values with general cultural legitimacy, increasingly the values of rationality, efficiency and science.”

With the male medical profession’s success regarding structural and cultural controls, many people came to view its rise as a triumph of knowledge. According to Abbott (1988), the functional school in particular argues that professions emerge in society as the demand for specialized skills increases. In other words, professions meet a function within a society which allows it to function. Implicit in this view is the assumption of continuous progress. In *Doctors and Doctrines: The Ideology of Medical Care in Canada*, Blishen (1969:14) observes:

For their continued economic growth, modern societies depend upon the technical application of an increasing body of scientific knowledge. One of the hallmarks of modernity is the rate of increase in this corpus of knowledge but since the boundaries of the corpus are beyond any one individual’s ability to encompass, application of knowledge today requires specialization and a division of labour of which the professions are an integral part.

Many researchers today challenge and criticize such functionalist views. These researchers see the rise of professions as a sad “chronicle of monopoly and malfeasance, of unequal justice administered by servants of power, of Rockefeller medicine men” (Abbott 1988: 1). This is the view adopted by Freidson (1970), and it is also the view taken by many feminists in their analyses of women’s exclusion from medicine and the medicalization of women’s bodies. The intensity of the language used by these feminists varies from Daly’s (1978) analogy, in *Gyn/Ecology*, of the Nazi in her discussion of gynecologists, to others, such as Riessman (1983), who discuss the medical profession in terms of power and manipulation.

Whatever view one adopts, it seems clear that the professionalization process, and specifically that of medicine, would be virtually impossible without support from established, powerful institutions and systems. The following section elaborates on that support and the interdependence among medicine, religion, law and science. As these came together, they formed a network of structural and ideological control that continues today to influence individuals' thoughts and feelings related to health.

The Rise of the Medical Profession through Alliances with Those in Power

Throughout much of our history, healing was not tied to power or economic markets. Indeed, women were the most common practitioners. In *My Body: Women Speak Out about Their Health Care*, Crook (1995) explains, as others have, that women passed the necessary healing information orally from one generation to the next. They assisted in the deliveries of babies. They cared for the sick and dying and eased people's pain with their healing herbs and practices. Ehrenreich and English (1979) point out in *For Her Own Good: 150 Years of the Experts' Advice to Women*, that it was not until medieval times in Europe that male medical professionals began to emerge and take those responsibilities away from women (Crook 1995; Ehrenreich and English 1979). The ideological and structural arrangements of society at that time, coupled with the power and influence of the male medical professionals are what eventually led to the exclusion of women from healing.

As noted above, women historically performed the bulk of the healing or health care. That women were recognized as the legitimate healers in society meant that they

had a certain degree of power and control over definitions of health and illness. The fact that women lost that position of authority, it has been argued, appears to be tied to powerful institutions and the patriarchal ideology embedded in them. These fostered and molded the new medical profession as a male profession during medieval times.

Alliances and interdependencies among the old and new patriarchal institutions were formed. Numerous researchers have concluded or implied that the result was the elimination of female healers' authority within society. Women came to be viewed as inferior or incapable healers compared to men. (See Crook 1995; Rich 1986; Daly 1978).

In the early stages of the transition from female to male healers, organized religion took over the responsibility for healing by associating illness and disease with sin. Despite attempts earlier in history by individuals like Hippocrates during the classical Greek period to separate medicine from philosophy and theology, this religious control dominated society for an extended period of time (Conrad and Schneider 1980; Murphy 1954).

Interest in and acceptance of medical knowledge separate from the Church's teachings were not strong in Europe until the Renaissance. Gradually, however, the view of medicine separate from religious teaching came to dominate medical theory and practice (Conrad and Schneider 1980). By the 19th century the views of Hippocrates had "won medicine away from religion, established it as an art in its own right" (Murphy 1954: 15). This victory, however, was incomplete. While religious leaders relinquished the actual responsibility for healing, it took many years before their influence over medical practice and ideology waned. They transferred over the practice of healing to

new *male* practitioners who adopted views and practices compatible with the teachings of the Church. It was in part because religious leaders supported the emerging male medical professional that the transition to separate spheres of medicine and religion went relatively smoothly but also slowly.

Remaining firmly rooted in the traditional religious view that sin was the root cause of disease and illness, physicians used remedies that were based on little knowledge of anatomy and virtually no valid scientific research. Medicine was, throughout much of that time, primarily impressionistic. Practitioners regularly incorporated prayer and religious ritual with minimal treatment to the body. According to Conrad and Schneider (1980), there was clearly a dependent relationship between medicine and religion in those early stages.

The early alliance with a powerful institution like the Church gave the emerging medical practitioners a certain degree of credibility. This made their progression through the stages of professionalization much easier. The social influence of the Church encouraged the lay population to accept the idea that the male healers were experts and that people needed their services. This allowed male healers to gain increasing control over healing.

In order to convince the lay population of their expertise, the new male healers, with the support of the Church, highlighted the differences between themselves and traditional healers. To do this, they used the prevailing cultural and ideological views of society in order to make themselves appear superior. The new male healers or “Regulars” came from prestigious family backgrounds. This was in contrast to the poor women who

practiced “Irregular” or “folk” medicine. The “Regulars” pointed to their formal medical training as another example of their superiority in relation to “Irregular” healers.

While they initially trained in an apprentice manner similar to that of the “Irregulars,” they quickly set up schools to formally train the members of their group. This training was primarily grounded in religious teachings and involved very little hands-on training. Many of these men completed their formal education without ever examining a patient or observing an autopsy. However, the fact that they were trained in an educational institution, during a period when few individuals had access to such education, impressed many people and made the progression through the stages of professionalization easier (Conrad and Schneider 1980; Ehrenreich and English 1979; Clark 1966).

The male practitioners made progress in terms of establishing themselves as the experts in relation to healing. In order to secure their new position in society, they were impelled to clearly identify their contribution to society. They also needed to create a social dependence on and belief in the services they provided. This same issue has arisen in various medical specialties throughout the history of medicine. For example, in “The Social and Medical Construction of Lactation Pathology,” Wolf (2000: 95) discusses the pediatricians’ push for bottle-feeding in the late nineteenth century as one way they attempted “to carve a role for themselves in the medical community and concomitantly gain public respect.” This method of establishing themselves was accomplished by successfully arguing that women of the nineteenth century were somehow defective and, therefore, needed assistance to feed their babies. Many such areas of expertise were

created by male practitioners throughout their progression to professional status.

However, there was still the issue of payment for services. The practice of medicine was, after all, a means of subsistence for these professionals.

One of the tactics that male professionals used to convince the lay population that their services were worthy of payment also functioned to reinforce the differences between male professionals and “Irregulars.” The tactic was to implement the use of *heroic* medicine. Male professionals designed medical treatments to be easily observable and measurable so they could justify fees for their services. The underlying principle was that the treatment or intervention should have results that were stronger than those of the illness or disease. Whether these results were positive or negative did not matter. In many cases, heroic medicine actually resulted in a higher mortality rate than the disease would have, if left untreated (Ehrenreich and English 1979).

The purpose of heroic medicine was not only to convince the lay population that medical services were worthy of payment. It was also an attempt to win back those people who had returned to the traditional healers because they were dissatisfied with male professionals.

The Male Medical Profession versus Female Healers

During the early stages of the professionalization process, the male medical practitioners did not consider female healers to be formidable competitors. Therefore, they did not pay much attention to these women and what they did in relation to health care. Part of the reason was that much of the actual work these women performed was of

little interest to the emerging male professionals. Many of the activities performed by women were directly tied to the dominant patriarchal view of women's roles in society. A number of those activities specifically related to dealing with women's reproductive experiences (Rich 1986; Ehrenreich and English 1979; Daly 1978; Clark 1966). Male professionals did not regard those activities and related others as worthy of their attention. Indeed, this gendered work reflected more generally the predominant ideological position on women's roles and status.

In sociological terms, role is defined as the "behaviour expected of someone who holds a particular status." Status is "a recognized social position that an individual occupies" (Macionis et al. 1997: 640-1). In the case of the female healers, the roles they performed were associated with their status as women. These women were typically members of the lower classes, had no formal training or documented remedies and practices. Perceptions of female healers were intertwined with images of hearth and home. Healing was performed out of kindness, typically free of charge, primarily non-intrusive and done on a part-time basis. On the other hand, male healers were typically from the upper classes, had formal training, documented their work and protected their knowledge (Fisher 1988; Ehrenreich and English 1979). Perceptions of male healers were limited to their professional status as physicians. Further, they were connected to images of career, economic subsistence and deliberate and forceful intervention in the battle against disease (Crook 1995; Daly 1978). The practice of heroic medicine, described above, reinforced those perceptions of male professionals (Ehrenreich and English 1979).

The different meanings attached to roles and statuses for men and women help us understand the male professionals' lack of interest in the healing work of women. The two were essentially engaged in fundamentally different activities. It was that separation, in combination with the existing patriarchal ideology, which enabled male professionals to challenge female healers and convince society of their own superiority (Ehrenreich and English 1979).

Thus, these gendered divisions of power and work were used to establish a dichotomy where in male healers were validated and female healers were not. In a patriarchal society it was not difficult to promote the male agenda of an exclusively male medical profession, especially if the interdependence of medicine, religion, law and later science are taken into account (Rich 1986; Clark 1966).

The roles of religion, law and science.

As discussed above, male medical professionals emphasized the positive and socially desirable characteristics of their group and the “less” desirable, and in some cases “negative”, characteristics of female healers. Such contrasts were based on and supported by the dominant patriarchal ideology and existing institutions, such as the Church, the law and later science. Religious, legal and scientific support for the medical profession can be explained by the fact that it not only adopted a similar ideology to but also professed the legitimacy of those other institutions.

In his examination of paradigm shifts, Kuhn (1987) has argued that only those views and practices that challenge the existing ideology will have difficulty becoming

established in society. Medicine, based on a compatible ideology, functioned to reinforce existing views and, therefore, faced no significant opposition to its emergence and development. Indeed, religious and legal institutions offered both ideological and structural guidelines and support for male physicians. Religious views on women and their value in society were patriarchal, reinforcing the exclusion of women from professional medicine (Rich 1986; Ehrenreich and English 1979; Clark 1966). Religious beliefs about female reproductive processes also influenced, at least initially, the spheres of influence male medical professionals sought to control. For example, physicians, relying on their religious beliefs, had no interest in assisting women during childbirth or in offering pain relief for labour. They believed such pain had been deemed necessary by God, following Eve's betrayal in the Garden of Eden (Rich 1986; Ehrenreich and English 1979; Clark 1966). As Rich (1986: 128) explains in *Of Woman Born*:

In Judeo-Christian theology, woman's pain in childbirth is punishment from God. (The notion of birth-pain as punitive is found, as well, in other cultures.) Since the curse laid on Eve in Genesis was taken literally well into the nineteenth century, the mother in labor had to expect to suffer; but what was even more significant, it was assumed until the last three decades that she must suffer *passively*. In 1591 a midwife, Agnes Simpson, was burned at the stake for having attempted to relieve birth pangs with opium or laudanum.

The relationship between the medical profession and the legal system, however, was not as longstanding or steeped in tradition compared to religion. However, that relationship offered considerable clout to physicians by limiting the practice of medicine to those who were members of the medical profession. "About 1800, 'regular,' or educated, physicians convinced state legislators to pass laws limiting the practice of medicine to practitioners of a certain training and class (prior to this nearly anyone could

claim the title ‘doctor’ and practice medicine)” (Conrad and Schneider 1980: 10). This created a formal, structural situation in which the “Irregulars,” who included wise women and midwives, were excluded from the practice of medicine and denied the opportunity to contribute to medical meanings (Peterson 1978; Clark 1966).

The ideological and structural supports offered by religion and law were consistent with the general organization of society at that time. Women were powerless. They had no right to vote, no opportunity to become students in a formal learning environment and no legal recognition that they were even persons (Friedan 1963).

The *witch craze* is an example of views about women and the manipulation of social fears that benefited male medical professionals. Many feminists have described the *witch craze* it as the ultimate act of woman hating (Daly 1978). As such, it created an atmosphere in which the female healer was viewed by many people with fear and suspicion.

The witch hunts, from the 15th to the 17th centuries in Europe and towards the end of the 17th century in North America (Daly 1978), illustrate the importance of gender in the struggle over healing. More specifically, the witch hunts illustrate how struggles for control over women by men were characterized as struggles over good and evil. Notably, the witch-hunts were supported and carried out by the church, the law, and the male medical professionals. These institutions were the primary groups involved in the identification process as well as the administration of punishment. Identifying an individual, typically a woman, as a witch often happened if she gave a woman pain relief

during labour or provided an abortion (Rich 1986). Both those activities were condemned by the Church and outside the practices of the male medical professional.

Some researchers have argued that female healers were deliberately targeted for elimination because their competence and the respect they received from the community highlighted the incompetence of the male professionals who used heroic medicine. Such circumstances were a threat to the medical professionals' expanding control over health related issues. As a result, the professionals joined forces with religion and law to eliminate that threat (Daly 1978).

While the associations with the Church and the legal system definitely benefited the male medical professional, the power they gained from those associations was in some respects short lived. As Ehrenreich and English (1979: 68) point out, "by the late nineteenth century, patriarchal tradition was no longer in and of itself, a firm enough basis for professional power." Many of the laws dictating who could heal were overturned and the strength of religious dogma was losing ground in society. However, medicine found a new, powerful and legitimating association with science.

With the credibility of scientific methods and procedures to back it up, professional medicine solidified its power and position in society. Science was believed to be the path to truth based on facts, objectivity and value neutrality. In a sense, science was the new religion of society.

Creating a relationship between medicine and science was not difficult for a number of reasons. First, like medicine, science "is a historically determined social activity," despite its claims of objectivity. Second, both reduce complex processes to

cause-and-effect relationships (Riessman 1983: 4). Third, as Fausto-Sterling (1985) points out in *Myths of Gender: Biological Theories about Women and Men*, many scientific theories were based on the same male bias found in medicine. They, therefore, offered male medical professionals a new kind of support for the continued exclusion of women from the practice and construction of healing.

In recent years, the objectivity and superiority of science have come under attack. Consequently, the power of the medical professional has also been challenged. Critics of medicine and science have argued that their knowledge and practices are socially constructed. Many theories about women are an example of such constructions and illustrate their androcentric bias.

The theories developed and used by scientists and physicians argued that woman's normal state was to be sick, weak and inferior to men (Martin 1987; Shuttle and Redgrove 1986; Ehrenreich and English 1979; Delaney, Lupton and Toth 1976). According to Tuana (1989: 147), in *Feminism and Science*, "[f]rom Aristotle to the reproductive theories of the 1700s we can trace a pattern of deprecation of the female principle in conception originating from the assumption of woman's biological inferiority." Most, if not all, scientific theories that attempted to explain the body began with the assumption that men were the standard. Any differences between men and women were explained as illustrating the inferiority of women (Tuana 1989; Martin 1987). In her article, "Remembering Amal: On Birth and the British in Northern Sudan," Boddy (1998: 37) explains that the androcentric ideology in which the male body is the norm is in part "responsible for pathologizing women's bodies and physical process in

Western societies.” McDonough and Walters (2001: 57) point to the fact that many people still believe “that women are ‘sicker’ than men as part of the explanation for the research they conducted on gender differences in health. This view is sustained by considerable empirical research.”

Theories that argued the inferiority of women were typically based on a white, privileged version of ideal femininity. This is evidenced by the fact that the different life styles and health of poor, underprivileged women were not considered. Only privileged women were believed to be incapable of mental or physical work because they were female. Poor women were expected to carry out physically strenuous tasks on a regular basis. If considered at all, these women were viewed as if they were members of an inferior species (Ehrenreich and English 1979).

“The fact was... that society was channeling women (or at least the more affluent of them) into the ‘sex function’” (Ehrenreich and English 1979: 120). The concern was not for the women themselves but rather for the offspring they would produce and the possible benefits of these for society, or more specifically the dominant members of society. As a result, affluent women were encouraged to do to their bodies whatever was necessary to have healthy children. At that time, this meant that such women should conserve all mental and physical energy through bed rest and by minimizing excitement. Whether poor women produced healthy offspring was of little interest to the powerful institutions of society, including medicine and science. (Fausto-Sterling 1985; Oakley 1984; Ehrenreich and English 1979).

To conclude, patriarchal ideology embedded in social structures and institutions worked against women and their ability to participate in and contribute to professional medicine. The male medical profession found strength in its alliances with existing patriarchal institutions such as the Church, law and science. Existing social attitudes regarding women were used to ensure a male monopoly over medicine.

In a general sense, the professionalization of medicine was fundamentally an issue of control over knowledge and control over membership. Expounding the superiority of men and the inferiority of women by focusing on their biological and social differences was one of the medical profession's most effective methods of gaining control over health. In the following section, I illustrate that medicalization is an extension of that control, particularly in relation to women.

Medicalization

Zola (1972) first coined the term *medicalization*, defining it as a process in which more and more of everyday life becomes controlled, dominated or influenced by medicine. It has become a central feature in the literature focusing on women's reproductive experiences. As Catherine Riessman (1983: 4) has argued, this control is a major focal point in the feminist literature on medicalization:

The term medicalization refers to two interrelated processes. First, certain behaviours or conditions are given medical meaning – that is, defined in terms of health and illness. Second, medical practice becomes a vehicle for eliminating or controlling problematic experiences that are defined as deviant, for the purpose of securing adherence to social norms.

Medicalization, by its very nature, expands the domain of medical professionals. Like others, Joel Lexchin (1994) points out, in his investigation of the pharmaceutical industry in a capitalist economy, that there is a relationship between medical professionals and the pharmaceutical industry. The expansion of medicine requires new interventions and treatments that pharmaceutical companies have developed and researched. These activities also increase profit margins. The new inventions and treatments, in turn, support the medical profession's claims of control over health care.

Many researchers who discuss medicalization and control focus on the power and authority associated with the profession. They emphasize the structural constraints resulting from medicalization. This can be seen in the work of Ann Oakley (1984) and Mary Daly (1978), as well as in the research examining doctor-patient interactions (Parsons and Parsons 1997; Frankel 1994; Fisher 1988; Stoeckle 1987). Such issues of control have been well documented in relation to women and are particularly apparent in relation to reproductive experiences.

In the remainder of this section I discuss the medicalization of women's reproductive experiences. I trace the evolution of that process and explain it in terms of a social constructionist perspective.

Control and the Targeting of Women's Reproductive Functions

The medical professionals' attempts to medicalize women's reproductive experiences occurred generally over time. In "Women and Medicalization: A New Perspective," Riessman (1983: 15) outlines the reasons why those experiences were easy

targets for medicalization: (a) unlike men, women have external markers of reproductive processes, like menstruation and giving birth; (b) women's social roles within patriarchal society make them more available to medical professionals than men; (c) women have greater exposure to medical labeling because of the ways in which they deal with symptoms; and (d) the social relations within doctors' offices replicate those in the larger patriarchal society.

With time and advances in medicine, women's reproductive experiences came to be viewed by medical professionals as potentially problematic and requiring medical interventions and treatments; a sharp contrast to traditional healers' approaches which *normalized* such experiences. In "Remembering Amal: On Birth and the British in Northern Sudan," Boddy (1998) argues that changes in views of childbirth, for example, were promoted by the fact that early medical professionals dealt only with *abnormal* deliveries. These experiences biased their views about the process and became generalized as they gained more professional control.

As western culture has gravitated towards blind acceptance of scientific and technological "advances," the attention given to potential reproductive problems has led to the abandonment of traditional methods of assisting women. We have learned to be prepared for the worst and look to science and technology for assistance. Hays (1996) argues that the attention given to potential health problems continues even today and is bound up with a need for control.

The medicalization of potential problems and unusual occurrences has been filled with contradictions for women. There are those women who experience problems during

normal events like pregnancy/childbirth or menstruation, and the advances made by science and technology have improved the chances for positive outcomes. The attention that potential problems and unusual occurrences have received from medical professionals has also legitimated the claims or complaints of women who have difficulties (Riessman 1983). Labels like Premenstrual Syndrome (PMS) and Premenstrual Dysphoric Disorder (PMDD) provide medical recognition of women's problematic experiences and legitimate them. However, these labels can also be used to invalidate women's thoughts, feelings and words by characterizing them as hormonal changes. When women are angry, for example, they may encounter responses from others such as, "It must be that time of the month." In other words, as Riessman (1983: 11) states, "it invalidates the content of their protest."

In *The Captured Womb*, Oakley (1984) has argued that childbirth was the first of the reproductive experiences to be viewed as potentially problematic. By redefining obstetric mortality as a social problem, the door was then opened to the medicalization of reproductive experiences. In one of her more recent books, *Essays on Women, Medicine and Health*, Oakley (1993: 124) explains that with the redefinition of childbirth, we have come to think of it as:

An episode in women's lives and in the lives of families which is not part of everyday life, but an occasion for medical surveillance and treatment. Thus, to think about the possible normality of birth requires a deliberate refocusing of one's attention. But what is significant is that such refocusing was not necessary before birth became the province of experts....

The focus on potential problems is also documented by Wolf (2000) in her article discussing breast-feeding in the early 1900s. She cites a 1938 issue of *Parent's Magazine*

to illustrate the emphasis placed on potential problems and the implicit use of fear as a method of controlling new mothers. The advertisement in the magazine stated:

“You hope to nurse.... Of course, but there is an alarming number of young mothers today who are unable to breast-feed their babies and you may be one of them... Even if you are breast-feeding you may be ordered by your doctor to given him supplemental feedings by bottle, so it is fairly safe to count on bottles... in your scheme of things” (Apple 1987). (Wolf 2000:103).

Such views and attitudes did not end in the 1930s or 1940s. The fear instilled in women regarding their inability to breast-feed, and doctors’ claims that breast milk has no particular health benefit are still having an impact today. While physicians and many women today dismiss those views, there are still relatively few women who rely solely on breast-milk for their babies. Moreover, despite factual and rational objections to those nineteenth century views, the fear that a woman’s body will fail her and her baby still exists within society. In the mid 1990s, television and newspaper reports presented stories of children who had died of dehydration because of breast-feeding. “[T]he reports were terribly alarming, reminiscent of the late nineteenth-century warnings about the potential for breast milk to be quite harmful” (Wolf 2000: 104-5).

The idea that potential problems require medical attention also emerged in relation to menstruation. As scientific and technological advances were made in relation to women’s menstrual cycles, physicians began to explain the benefits of treating menstrual discomfort. According to Ehrenreich and English (1979), they did not propose treatments merely to benefit women but also, and perhaps more importantly, to benefit or protect the families and societies to which those women belonged. The implication was

that women with menstrual discomfort negatively affect those around them. From that perspective, the treatments were meant to benefit others, not the women concerned.

The idea of potential problems has also influenced our ideas about menopause. As more of the largest age cohort, the Baby Boomers, reach peri-menopause, menopause and post-menopause, the medical system has focused more of its attention on those experiences. Attempts to medicalize them have played a major role in the constructed image that currently exists in society. In her book, *The Menopause Industry*, Coney (1994: 19) makes that connection quite clear. She states:

The mid-life woman now has her very own disease - estrogen deficiency syndrome - specific to her sex and time of life. Medicine has determined that in her normal state, the mid-life woman is sick. The idea of normal aging has been collapsed into a definition of pathology. The menopause is no longer simply the end of periods or a life stage, rather it has been construed as an illness that no woman can escape.

The discovery of hormones broadened the reproductive territory controlled by medicine. Hormones were viewed as the link between the uterus and the brain (Kaufert and Gilbert 1987; Martin 1987; Fausto-Sterling 1985). Knowledge of hormones also allowed physicians to enter the field of women's psychology (Ehrenreich and English 1979). In line with previous social constructions of a woman's experiences as problematic because of her nature, medical professionals concluded that gynecological complaints were caused by a woman's rejection of her femininity (Ehrenreich and English 1979; Daly 1978). Similar explanations have been applied to other reproductive experiences.

Social construction is at the core of medicalization no matter what the particular issue or experience being considered. In *Deviance and Medicalization: From Badness to*

Sickness, Conrad and Schneider (1980: 30) state that the idea of the social construction of illness is that “an entity or condition is a disease or illness only if it is recognized and defined as one by the culture.” According to Miall (1998: 557-8):

The social constructionist approach... argues that social problems arise or are constructed through social explanations, or claims, about how these problems should be understood (Best, 1989; Spector and Kitsuse, 1977). The claims advanced about any particular issue reflect the social structure of society and its cultural values and beliefs (cf. Gusfield, 1966)... Claims makers may compete for the right to explain a phenomenon in a certain way and seek to influence policy making and clinical practice in a given direction (Miall 1998: 557-8).

The success of the claims making process of an interested group ultimately determines whether something is considered an illness and how it is explained. This is fundamentally an issue of who has more control and power. In relation to health issues, those with control are typically medical professionals. That women do not have that type of control and power is apparent by the examples discussed earlier that illustrated that the best interests of women are not necessarily the driving force behind medical intervention. In many cases, there are consequences that are physically or socially harmful to women.

Paradoxically, as noted earlier, male medical claims-making about women’s reproductive experiences was, to some extent, initiated by women who sought medical interventions for various complaints (Riessman 1983). Women’s claims-making about their own experiences has been less obvious in discussions of reproductive issues, however. There are two basic reasons for this situation. First, a focus by feminist researchers on structural constraints has contributed to a perception of women as passive victims of a patriarchal medical institution. Second, definitions of health and illness involve interpretations of what is normal. Women experiencing the same physiological

and structural processes interpret their actions and experiences within different socio-cultural contexts.

Feminist researchers have informed us in some detail of the negative consequences of medicalization for women. Kaufert and Gilbert (1987) point out in “Medicalization and the Menopause” that women are aware of those consequences and resent the process that caused them. “Resentment of medicalization is strongest in those areas (such as childbirth, contraception and abortion) that are integral to the experience of most women and in which medical domination and control are most intrusive” (Kaufert and Gilbert 1987: 173). As discussed above, while structural constraints have been a problem for many women, we also need to understand these experiences from the perspectives of the women themselves.

In addition, the medicalization of women’s reproductive experiences has been aided by the inconsistency found in definitions of health and illness. In the next section, I explore the nature of those inconsistencies as they specifically relate to women’s reproductive experiences. I illustrate that definitions of health and illness involve interpretations of what is *normal*. It is clear that there are multiple meanings for a single experience and this has contributed to confusion regarding women’s own meanings and actions. As Lopez (1998: 257) states in her study of Puerto Rican women and medicalization, “[d]ifferent realities can, and often do, coexist within the same context.” She explains that women’s reproductive choices can be simultaneously “sources of resistance and empowerment” and at the same time expressions of their oppression in relation to structural constraints.

Issues of Defining Health and Illness

Any discussion of women's reproductive experiences is challenging because they involve healthy processes but are usually approached by medical professionals as potential illnesses and diseases. Further, as safe reproduction of the population has become more important to society, the potential problems associated with reproductive experiences have taken on greater significance. The result has been an emphasis on these problems to the point that many medical professionals discuss all such experiences as potential health problems.

The literature focusing on health reveals that definitions tend to be so specific that they have no general application or so vague that they become meaningless in their application. The reasons for this can be found in the extreme variations of what is considered health. Attempts to include all possible scenarios have resulted in an ideal of health that no individual could reasonably be expected to reach. For example, the World Health Organization (2003) posits that health is the physical, mental, emotional and social well-being of the individual. What these criteria actually entail is subject to interpretation by individuals and medical professionals alike.

Definitions of women's reproductive experiences are also vague and inadequate. As Oakley (1993: 19) has observed, "Women's capacity to reproduce is subject to different interpretations. Biology is not destiny. But its very importance lies in the fact that it must enter in some form into the logic of every social system and every cultural ideology."

Even in cases where there is strong agreement about a definition, its relevance to everyday life is often minimal. Walters (1993), for example, has pointed out that characteristics such as gender, age and social class as well as personal experiences and those of significant others strongly influence the ways in which people think about their health regardless of medical definitions. Walters and Denton (1997) argue, therefore, that sociologists are in a position, not only to explain the social construction of definitions of health and illness, but also to illustrate the ways in which those characteristics, or the social context generally, influence what individuals regard as health problems.

In her well known study of *Health and Lifestyles*, Blaxter (1990) states that issues such as the presence or absence of pain, the duration of a “condition” and the consequences for an individual’s everyday life are part of that social context. Nowhere is the relationship between social context, pain and health definitions more apparent than in the case of women’s reproductive experiences. As Miles (1991: 49) points out in *Women, Health and Medicine*:

Women struggle to find an answer, to attach meanings to their experiences and to ascertain the socially approved and appropriate ways to behave. Ambiguity arises from the conflicting messages which reach women: from doctors and other health care professionals, from relatives and friends, and from their own bodies.

Miles (1991: 53) goes on to explain that experiences, like menstruation and childbirth, that are “both healthy and painful [are] confusing and deeply rooted in social attitudes.” Women must decide what degree of pain is normal or tolerable. “Not surprisingly, many women find it difficult to decide how much discomfort and pain should be regarded as part of normal health and at what point the threshold of illness or the abnormal is crossed” (Miles 1991: 54). In some instances, however, “[t]he irony is

that,... women may be reinforcing a second wave of medicalization and extending medicine's sphere of control to many more aspects of the social realm" (Walters and Denton 1997: 57).

Whatever a woman's decision regarding her threshold of pain, she does not have to accept the idea that her pain indicates a health problem. As Lock and Kaufert (1998: 15) explain, "[o]ne does not have to share the same explanatory system as the medical professional to procure medicine." Like others, Avotri and Walters (1999) comment, in their study of Ghanaian women's accounts of health and work, that women's definitions of health and illness arise out of their everyday lives – the social context. Medical professionals, however, often dismiss that context and as a result misunderstand the meanings women have attached to their experiences. With the experience of pain, for example, medical professionals acknowledge different kinds of pain but seem to neglect different interpretations or emotional responses to that physical experience. In "Transcending the Dualisms: Toward a Sociology of Pain," for example, Bendelow and Williams (1995) explain that the emotional components of pain are typically ignored while attention is focused on the physical sensations of pain. This

leads to a limited approach towards sufferers and a neglect of broader cultural and sociological components of pain.... A far more sophisticated model of pain is needed; one which locates individuals within their social and cultural contexts and which allows for the inclusion of feelings and emotions" (Bendelow and Williams 1995: 146).

A more sophisticated model, according to Bendelow and Williams (1995: 148), should include recognition of the pragmatic as well as the hermeneutic components of pain. "[A]t a pragmatic level, the telic demand of pain is to get rid of or to master one's

suffering.” Such a pragmatic approach has been the typical medical and scientific response to pain and has often overshadowed any attempt to understand the importance of the larger context. “At the hermeneutic level pain and suffering give rise to the quest for interpretation, understanding and meaning”, (Bendelow and Williams 1995: 148) all of which are direct consequences of the social and cultural contexts in which the painful experience occurs. Such is the case with the pains and discomforts associated with women’s reproductive experiences. “In particular, this hermeneutic moment and the quest for meaning point to the critical role which narratives of suffering and theodicies of pain play for the individual coming to terms with their situation” (Bendelow and Williams 1995: 149).

Castro’s (1995) study of the Ocuituco in Mexico illustrates the importance of making the distinction between hermeneutic and pragmatic approaches to pain and directs attention to the very different meanings underlying these. He explains:

[I]n addition to being regarded as a symptom, pain in Ocuituco may also be seen as being associated with the cause of death of certain individuals, and as the main reason to visit a doctor. Furthermore, pain is also a woman’s way of knowing her body and its disorders. For Ocuituco women, *suffering* is a form of *learning*. This is meant literally in this town: a common way in which women express that they do not know something about their body is by saying that they have not felt any pain related to it (Castro 1995: 1019).

More generally, Castro’s work illustrates the importance of considering not only meaning, but its variations as well.

In order to take variations of meanings into account, we should address the issues of individual interpretation and agency in the construction of meaning. Many feminists

and sociologists indicate that we need to:

Emphasize the actors' capacity both to attach meaning to different social situations, and to act – and not only “react” – accordingly. Sometimes, however, this is done at the cost of sacrificing, in analytical terms, the role of social structure as a determinant or at least as a factor to be seen conditioning individual freedom (Castro 1995: 1005-6).

In terms of women's reproductive experiences, this means that both individual agency and structure need to be taken into account. The reality is that women do encounter structural constraints associated with medicalization and they construct meanings about those encounters that arise from their lived experiences. Women actively interpret the constraints they encounter and creatively engage in situations. As Lock (1998: 208) explains in her study of reproductive technologies in Japan, “[r]esponses of individuals are not simply those of either compliance or resistance; indeed they need not be *responses* at all. Rather, there is abundant evidence of pragmatism in action.”

Conclusion

Generally, issues related to women's reproductive experiences are tied to social structures. Professionalization, medicalization and related definitions of health and illness operate to a great extent at that level. Many researchers have focused on these factors and as a result have made significant contributions to our understanding of the medicalization process.

In the next chapter, I elaborate on the issue of women as active agents who construct meanings that are consistent with their everyday lives. The work of Walters (1991,1994), Aronson (1990,1998), Fisher (1988), Shuttle and Redgrove (1986),

Riessman (1983) and others are examples of research that explores women's meanings in discussions about the medicalization of their bodies and other health related issues. These studies are informed by the assumption that women are interpreters of the contexts in which they find themselves, and consequently, their thoughts, feelings and actions need to be considered from their own perspectives.

CHAPTER 3

LAY CONCERNS AND DEPARTURES

Introduction

A great deal of theoretical attention has been given to understanding the medical system and its professionalization in relation to the medicalization of women's bodies (Lock and Kaufert 1998; Walters 1994). Understanding the structural and ideological aspects of the medical institution's power and social control has been extremely useful in understanding women's experiences with health care.

Researchers sought to understand how medicalization assisted medical professionals in expanding their jurisdiction and increasing their power. The exposure of such agendas was and is important as part of a feminist agenda to improve health care for women. Numerous researchers have associated that issue of control with the ever-growing number of medical procedures imposed on women. As Kabakian-Khasholian, Campbell, Shediac-Rizkallah and Ghorayeb (2000: 104) have observed in their work with Lebanese women, “[a] review of hospital policies vis-à-vis normal childbirth in Lebanon showed that many procedures and practices such as perineal shaving, enemas, induced labor, and episiotomies, are in routine use and are applied to women without indication.”

In this chapter, I explore the body of literature focusing on lay perspectives of reproductive experiences. I present a description of women's relationship to medicalization. I illustrate the different kinds of knowledge of women and medical

professionals. Relying on concepts from symbolic interactionism, I consider the consequences of failed communication between women and medical professionals and the misinterpretation of women's actions as an acceptance of medicalization. I then elucidate the major theoretical and epistemological approaches underlying this research.

Medicalization-From-Above and From-Below

Two types of medicalization have been advanced in the research literature (Cronwell 1984). Focusing on issues of structure and control, medicalization-from-above is defined as the view of reproductive experiences prescribed within the biomedical model. According to Kaufert and Gilbert (1987), in their study of medicalization and the menopause, medicalization-from-below “depends on whether this model is accepted by women and/or their physicians as shown by their acceptance of its prescription for their behaviour” (Kaufert and Gilbert 1987: 173).

Walters (1994) has argued that the distinction between these two types of medicalization force researchers to consider the degree to which medicalization has achieved its objective of redefining an experience as an illness or a disease. Such a distinction also directs attention to more than the social control aspects of the process of medicalization. It challenges the assumption that medicalization-from-above is replicated at the level of the individual (Walters 1994).

Although some researchers have acknowledged that the medicalization of women's reproductive experiences has sometimes harmed women, they also recognize

that medicalization has sometimes been beneficial for women. As Riessman (1983: 4) has observed:

Women collaborate in the medicalization process because of their own needs and motives, which in turn grow out of the class-specific nature of their subordination. In addition, other groups bring economic interests to which both physicians and women are responsive. Thus a consensus develops that a particular human problem will be understood in clinical terms. This consensus is tenuous because it is fraught with contradictions for women, since, . . . they stand both to gain and lose from this redefinition.

As discussed earlier, a number of researchers have begun to inquire into the ways in which women participate in the medicalization of their bodies and women's reasons for that participation. As Walters (1994) has indicated, that means attempting to make sense of the structural constraints that women encounter but doing so in conjunction with an examination and understanding of women's thoughts, feelings and actions. Recently, researchers like Walters have been attempting to investigate how women's understandings of their own experiences affect the decisions and courses of action they take in dealing with their reproductive experiences. I will now consider that research.

Women and Health Care Professionals: Different Kinds of Knowledge

Despite claims of medicalization-from-below, in recent years researchers have found that women's views are often quite different from the descriptions and expectations of many health care professionals (Doyal 2000; Kabakian-Khasholian et al. 2000; Walters and Denton 1997; Blaxter 1990). The most obvious reason for this is that women's knowledge is based primarily in their own experiences and the context of their

lives. The knowledge of health care professionals is based on their professional social constructions and observations.

Researchers such as Graham and Oakley (1981), in their work on pregnancy and childbirth have argued that there is a fundamental difference of meaning for women and for representatives of patriarchal institutions. In relation to childbearing, for example, they state: “It is not simply a difference of opinion about approach and procedures... Rather, we are suggesting that doctors and mothers have a qualitatively different way of looking at the nature, context and management of reproduction” (Graham and Oakley 1981: 51-52). Kabakian-Khasholian et al. (2000: 111), in their study of Lebanese women’s experiences of maternal care, also note that “what women perceived as ‘normal’ is shaped by their previous experiences or by what is described to them previously by their female relatives and friends giving birth in similar situations.” In her study, “Pain and Pain Relief in Labour: Issues of Control,” based on data collected from 10,352 participants by “The National Birthday Trust Fund (NBTF) Pain Relief in Lebanon Study,” Rajan (1996: 193) concludes that, “one of the findings that clearly emerged from the study was that women and health professionals seem to hold differing concepts of what actually constitutes methods of pain relief.” Castro (1995) further concluded, in his study of the Ocuituco in Mexico, that the meanings assigned to the experience of pain differ significantly depending on the context.

Unlike research on lay perspectives on health, it appears that medical professionals did not acknowledge or investigate those differences in meanings. The assumption seems to have been that medical meanings were sufficient for treatment.

Blaxter (1990: 13) has pointed out in *Health and Lifestyles*, “crudely, medical knowledge is seen as based on universal, generalizable science, and lay knowledge as unscientific, based on folk knowledge or individual experience.” Kitzinger (1992: 64) has also observed that medical professionals and society, in general, tend to view women’s accounts as lacking credibility:

Research on women’s attitudes to birth often also discusses them merely as patients whose lives have no context or meaning other than as patients.... we learn little about them as women, their hopes and fears, their relationships, and the values that are significant in their lives.... Women’s own accounts of birth are ignored, trivialized or pathologized when they do not match ‘objective’ facts.

As Litt (1996: 185) in her article, “Mothering, Medicalization and Jewish Identity,” has noted, medicine has a “privileged position – its invocation of the natural, the objective, and the value free – has given it particular cultural authority to represent ‘woman,’ a tendency that feminist scholars argue reinforces and reflects gender inequality.”

As discussed in Chapter 2, male medical professionals determined that women’s reproductive experiences require medical attention and intervention, sometimes at the behest of women themselves. However, it is the medical professional which publishes and publicly discusses medical concerns, not the women who are the subject matter of such discussions. The views of the medical professionals, therefore, are most often in the public forum. As a consequence, their discussions become a more obvious part of social and cultural expectations and norms. As Williams and Calnan (1996b: 1610) suggest, in

“The ‘Limits’ of Medicalization?: Modern Medicine and the Lay Populace in ‘Late’ Modernity”:

[T]he medical profession, as part of wider processes of industrialization and bureaucratization in society, has not only ‘duped’ the public into believing that they have an effective and valuable body of knowledge and skills, but have also created a dependence through the medicalization of life which has now undermined and taken away the public’s right to self determination.

In terms of women’s reproductive experiences, medical professionals often view them as pathological or potentially pathological and have worked to convince women that they are correct.

This emphasis on pathology is often apparent in doctor-patient interactions. In Graham and Oakley’s (1981: 56) study, they found that “every pregnancy and labour is treated as though it is, or could be, abnormal,. The ' as if ill' role was a recurrent feature in the observed interactions between doctors and patients.” Medical professionals also attempt to convince women that medical knowledge is superior to their own. Hays (1996), a physician, makes that point in her article, “Authority and Authoritative Knowledge in American Birth,” explaining that women are taught not to trust themselves or their bodies. She states that “[m]edicine teaches us to trust doctors and science and to place the locus of control outside of ourselves, surrendering control to technomedical authority” (Hays 1996: 294).

On the other hand, both physicians and women are experts with regard to reproductive experiences. Their expertise, however, is very different and often incompatible because they approach these experiences from different standpoints. Given the primacy of the physician, we have been losing sight of women as experts on their

own experiences. However, as Doyal (1995: 210) points out in *What Makes Women Sick*, as part of the Women's Health movement of the 1960s and 1970s,

many women began to challenge the belief that all medical knowledge was always superior to their own, whatever the circumstances. Self-help groups were a form of consumer action that involved the redefinition of the role of the 'expert' and an attempt to change the accepted view that only a doctor can define medical need.

As such groups emerged, the issue of expertise became more important and was reflected "in conflicts between doctor-as-expert and mother-as-expert. The definition and interpretation of significant symptoms were common areas of divergence" between the two groups (Graham and Oakley 1981: 59).

Recognizing the conflict between women's and medical professionals' meanings, many researchers have made a concerted effort to explore women's meanings, acknowledge their authority and encourage their expressions and representations. Such work reveals that women's meanings are more complex than biology. They are intertwined with their everyday lives and issues of control (Avis, Stellato, Crawford, Bromberger, Ganz, Cain and Kagawa-Singer 2001; Avotri and Walters 1999; Walters and Denton 1997).

Kitzinger (1992: 66) found the issue of control to be of great importance in attempting to understand women's feelings about their labour and childbirth experiences. She explains that "it is the woman's sense of control over what was done to her, or of being 'out of control', that determine how she recalls the birth, and her emotions afterward." In support of her position, Kitzinger cites a study conducted by Rosen in 1981. The finding of Rosen's study was that many women, particularly those who have caesarian sections, experience feelings of "powerlessness, loss of autonomy and resulting lower self-esteem" (Kitzinger 1992: 68). The choices of a number of the Lebanese

women in Kabakian-Khasholian's et al. (2000: 106) study illustrate the importance women place on having control over their reproductive experiences. These authors have observed that "all the women who had delivered in a clinic with the attendance of a midwife explained their choice as an attempt to avoid the dominance of the medical staff in the hospital setting." More generally, Kabakian-Khasholian et al. (2000: 104) have argued that "the involvement of women in decision-making processes concerning their pregnancy and birth, and their sense of control over the whole process is viewed as an important determinant for women's satisfaction with childbirth."

Having control over what is done to them and the outcomes are only part of reproductive experiences for women. Women interpret their experiences within the context of their lives, relying on past experiences and the advice of female relatives and friends. This appears to be the case for women from very different cultural backgrounds. For example, as already noted, Kabakian-Khasholian et al. (2000) found such behaviour in their study of Lebanese women, while Bhatti and Fikree (2002) have identified it among Pakistani women.

Women tend to be primarily concerned with the overall experience and how it makes sense in relation to the rest of their lives. According to many researchers, like Graham and Oakley (1981: 54-55):

Because of the holistic way in which women view childbearing, the notion of successful reproduction is considerably more complex than the simple measurement of mortality and morbidity. Though in almost all cases the goal of the live birth of a healthy infant is paramount, success means primarily a satisfactory personal experience.

It would appear that women's experiences are complex and multidimensional, as Walters (1994) stated, while the images presented by the medical system are not. There is, therefore, a need to acknowledge that women's processes of interpreting are situated in their personal experiences and socio-cultural contexts and are not simply cases of women adopting a medicalized view of their reproductive experiences.

With those differences in mind, it is important that I clarify that medical and lay perspectives are not being treated as completely separate from one another in this research. I agree with Blaxter's (1990: 13-14) statement in *Health and Lifestyles*, that, "[i]n western societies, an intermixing [of medical and lay] is inevitable: lay people have been taught to think, at least in part, in biomedical terms. Nor is modern medicine entirely wedded, in practice, to a narrowly-defined biomedical science." Given the position of medical professionals in our society and the interactions women have with them, inquiries into women's views would be incomplete without considering the impact medical professionals have on women's lives.

Women and Health Care Professionals: Different Ways of Knowing Collide

As indicated above, women and medical professionals are both experts in relation to reproductive experiences but in different ways. Those differences often result in problems including failed communication between women and professionals, women's feelings that physicians' interpersonal skills are lacking, and women concealing their

disagreement with and disobedience of physicians' recommendations. Such circumstances can be viewed as the collision of different ideas from different experts.

The issue of failed communication is significant, particularly in relation to patient satisfaction. In fact, researchers such as Jackson, Chamberlin and Kroenke (2001), Kabakian-Khasholian, et al. (2000), and others have found communication to be one of the primary factors in patient satisfaction and interpretations of experiences.

Failed communication is not simply a matter of women needing to talk more to their health care providers. The issue is that the language women use can be very different from that of medicine. It is a language that reflects their knowledge and expertise. The language of medicine does not include knowledge grounded in personal experiences of the body, nor does it take into account the interconnected nature of social life. A number of researchers have attempted to address this problem by conducting research in a manner that uses women's own language as the foundation of the research. For example, Walters and Denton (1997: 54) explain, in their study of women's experiences with stress and depression, that "in seeking to give voice to 'ordinary' women,... we relied on their own definitions of health problems." They also warn, however:

This is not without problems.... The language of health appears to vary by class (and probably age, sex and race, too), and unless studies are sensitive to these variations, they may be biased toward the dominant discourse of health and illness (Walters and Denton 1997: 54).

In addition to these differences, the exchanges between women and medical professionals are further complicated by the fact that medical professionals seem to expect women to bridge the gap by learning and using the language of medicine. Such an

expectation is evidenced by the fact that women are often confronted with negative reactions from physicians when they speak from their experiences. Britten's (1996) study, for example, was an analysis of qualitative data collected in 1991 and dealing with lay views of drugs and medicines in London. In this study, she commented that women have learned that in order to be heard by medical professionals they must use the vocabulary of the medical expert. She found

that patients are voicing orthodox accounts within consultation, and keeping their unorthodox accounts to themselves.... Patients are probably well aware that their unorthodox accounts lack medical legitimacy. The orthodox accounts of drugs and medicines emphasized correct behaviour in the form of cashing prescriptions and the taking of medicines as directed, often in a very taken-for-granted fashion. If this is the view doctors are presented with, then they may well perceive that patients want prescriptions most of the time. From the patients' perspective, however, their unorthodox agenda, being unvoiced, will not have been attended to (Britten 1996: 69).

The fact that women feel the need to conceal their unorthodox accounts means that interaction with medical professionals do not adequately deal with all of the needs or concerns of women.

Rajan (1996: 197) received comments from women in her study that indicated difficulties in women's interactions with medical professionals. She states that women's comments "imply that the woman's own previous experience of childbirth is not acknowledged as relevant. It is this very experience that, at the same time as enabling them to know what to expect of labour, also reminds them that the staff are failing them in some way."

Williams and Calnan (1996a), as well as others, raise another issue in relation to doctor-patient interactions. They have found that doctors' interpersonal skills are a major

issue for women. They explain that among the women in their research, “[n]ot listening was a common complaint... Having an abrupt manner or being rude was specifically referred to by the working-class women, and treating patients as if they were ‘wasting the doctor’s time’ was one specifically referred to by the middle-class women” (Williams and Calnan 1996a: 39). Interactions that result in such feelings appear to have a definite effect on how women view their overall experience – whether they are satisfied or dissatisfied with the birthing process, for example. The interpretations of the interactions also appear to be filtered through women’s social contexts, for example, in this case, socio-economic status.

A consequence of interactions with medical professionals that women perceive negatively is identified by Britten (1996) in her study of “Lay Views of Drugs and Medicines: Orthodox and Unorthodox Accounts.” She found that negative interactions can result in patients not behaving in accordance with physicians’ instructions but at the same time concealing their “disobedience.”

With repeated experiences of poor communication between women and medical professionals, and women being “frightened of the doctor’s response,” it should be expected that women will conceal any thoughts and behaviours that may receive a disapproving response from the medical professional. Britten explains:

Patients often limited the chance of dialogue and in this sense did not make it easy for their doctors.... the reason for patients’ silence was that when they did behave more openly, the consultation often became tense. After the consultation, patients often explained their silence by saying that they were frightened of the doctor’s response, felt hurried or thought that their doctor might think less well of them. Other studies have similarly documented patients’ passivity in medical consultations (Britten 1996: 69).

Kabakian-Khasholian et al. (2000) also found that women occasionally concealed certain thoughts and behaviours from their physicians. They note that one type of concealment adopted by many of the Lebanese women in their study during labour was “to wait at home until the time intervals between contractions was short. They appreciated the comfort of their own home and they delayed their arrival at the hospital as much as they perceived possible or tolerable” (Kabakian-Khasholian et al. 2000: 108). Kabakian-Khasholian et al. (2000: 111) go on to state, “women passively subverted the system by minimizing their time spent at the hospital...” At the same time, however, “[n]o woman reported that she actually challenged any procedure or aspect of care she received.”

The desire to avoid confrontation with medical professionals appears to intensify when the women involved are members of socially disadvantaged groups. Kabakian-Khasholian et al. (2000: 111) state:

The extent to which women were passive or dissatisfied varied according to their area of residence and the amount of psychosocial support they had received. Variation in the desired level of personal control over the process of childbirth could be attributed to women’s social class.... The fact that women in remote rural areas had less demanding attitudes... could be attributed to their low social class and low education level... the literature suggests that middle-class women are more likely to demand personal choice and less professional dominance... compared to low social class women.

Such situations remind us that we need to understand the role of social control in relation to individual agency. Adopting an approach similar to that of researchers such as Lewando-Hundt, Shoham-Vardi, Beckerleg, Belmaker, Kassem and Jaafar (2001), Avotri and Walters (1999), Lock and Kaufert (1998), Walters and Denton (1997), Aronson and Neysmith (1996), and Aronson (1990), I argue that considering agency and structure together is the most fruitful approach to take.

The assumption of the universality of medical definitions and meanings, and women's appearance of compliance, have, no doubt, contributed to the assumption that women believe and behave according to their doctors' worldview and medical recommendations. Some researchers, however, having looked more closely at the how and why of women's behaviours, have drawn a different picture – one of pragmatic women negotiating their world.

Women Participating and Resisting: Pragmatism at Work

“Central to the Women's Movement is the belief that control over reproductive function is foundational for control over other personal, professional, and political aspects of our lives” (Fisher 1988:5). Much of the work reflecting this view attempts to document women's lay resistance (Williams and Calnan 1996a; Annandale and Clark 1996). Despite the tremendous amount of research done, and the continuous efforts to improve women's situation in relation to reproductive experiences by feminists and the Women's Movement, the organization of women's health and the socially sanctioned power of the medical profession remains, in many ways, unchanged. In large part, this is the result of the medical system's assumptions and treatment of women. As a result, we see numerous behaviours that can be labeled as participation in or compliance with medicalization and numerous other behaviours that can be labeled as resistance. As Lock and Kaufert (1998: 16) have observed, in both situations of apparent compliance and resistance, women are attempting to make the best of the structural constraints they encounter.

The response of women to medicalization is often mixed. They rarely react to the specific technology, or simply to the manipulation of their bodies, but rather on the basis of their perceptions as to how medical surveillance and interventions might enhance or worsen their daily lives (Lock and Kaufert 1998: 16).

Accordingly, researchers such as Avotri and Walters (1999), those who contributed to Lock and Kaufert's (1998) *Pragmatic Women and Body Politics*, as well as Walters and Denton (1997) have begun to consider both types of behaviour in terms of pragmatism. These authors argue that women are aware of the power medical professionals have within society and attempt to work through and around the system in ways that will be most beneficial to them.

In this section, I elaborate on this notion of pragmatic women examining the research that describes women as active participants in medicalization but with their own agendas.

According to Crook (1995) and others, medical professionals have presented us with their views and have done this so consistently and methodically that society has come to accept, if not agree with, them. These medical professionals have moved the issue of women's reproductive experiences from the private realm, which is where women discuss their concerns, to the public realm. That move opened the door for women's private experiences to be reinterpreted and redefined as social problems or concerns. As discussed in the previous chapter, the support of other institutions, like the church, law and science, furthered the credibility of the medical profession and undermined traditional female-based knowledge of healing. However, the undermining of female-based knowledge does not mean that women are or have been powerless, passive victims within a patriarchal medical system.

Despite the lack of control women have had in many respects, it is important to recognize that from the beginning, women have also been involved in the medicalization of their reproductive experiences. They were not bystanders silently observing what was being done to their bodies. The use of physicians and surgeons was socially encouraged and women sought out their services for a variety of reasons (Oakley 1993; Riessman 1983). A number of researchers from around the world have concluded that one of the primary reasons appears to be concern that something might go wrong. For example, Kabakian-Khasholian et al. (2000:111) found that:

Women in Lebanon and other parts of the Middle East... who seek hospital care, recognize and mention the safety aspects of hospital care as reasons for choosing such a place of delivery.... A survey in England reports that women opt for hospital-based births because of the risk of any unforeseen complications that can emerge during delivery.

It is precisely that involvement on the part of women and the related thought processes that has become the focus of a great deal of research today. Lewando-Hundt et al. (2001), the contributors to Lock and Kaufert (1998), Walters and Denton (1997) and Riessman (1983) are among the many researchers who acknowledge women's use of medical treatments and interventions. The primary issue for all of them, however, is the need to understand such behaviour from the perspective of the women themselves.

Many women whose behaviour might be viewed as compliance have attempted to gain control over their reproductive health by at least superficially embracing the physicians' perspective. They have adopted the health promotion model, learned the language of the medical experts, and become "informed patients." These women began to make themselves heard at least in a limited way. This can be seen, for example, from the

types of questions pregnant women asked their health care providers in Graham and Oakley's (1981: 61-62) study:

One sign of mothers' desires to feel in control of their reproductive care is the number of questions they asked about the progress of their pregnancy. Of all questions asked in the London antenatal clinic, 20 per cent concerned the size or position of the baby, foetal heart sounds, maternal weight and blood pressure. A further 20 per cent were questions about the physiology of pregnancy and birth in general or about related medical procedures. These are serious requests but are often casually treated by doctors with resulting confusion and anxiety in the mother.

Acknowledging the use of this expert language simply means that the women, as members of a marginalized group, have interacted with others within the context of medicalization (Smith 1987a). It is clear that medical professionals have adopted a medicalized view of women's reproductive experiences. However, we need to acknowledge and understand that women, despite the behaviour they present in their interactions with those medical professionals may not agree with them. Women have their own agendas in those interactions. Smith (1987a) has indicated that behaviour is often a consequence of social expectation rather than a real reflection of the individual's thoughts and feelings. This sort of social expectation can be seen in relation to hospital births. The medicalization of childbirth involves a highly technological approach with routine hospital procedures. Safety, rather than concern for the "psychosocial aspects of pregnancy and delivery" is emphasized (Kabakian-Khasholian et al. 2000:111). Women wishing to influence the process may make use of medical terminology to access information, as Graham and Oakley (1981) have observed.

Recent research focusing on women's meanings has revealed that they selectively sift through the information they acquire from medical professionals and others. Further,

information from professionals is not accepted if it does not fit women's experiences or their models of health (Walters 1994: 314). Kabakian-Khasholian et al. (2000) and Graham and Oakley (1981) concur, explaining that women rely on their own knowledge or experience when evaluating the worth of medical recommendations. That does not mean that women are completely free to decide what information best fits their lives. "[I]ndividuals choose from among several equally legitimate sets of rules or forms of knowledge. In situations of structural inequality, however, one set of rules or form of knowledge often gains authority, devaluing and delegitimizing others (Browner and Press 1996: 142).

There is also the fact that an individual woman may have no experiences from which to evaluate her current situation. This circumstance can mean that she is initially more accepting of medical knowledge. Women with some previous experience may also turn to medical knowledge in order to prevent the reoccurrence of problems they have had in the past. For example, Browner and Press (1996: 147) state:

Women who had already borne children commonly drew on their embodied experiences in this regard. Some, for example, incorporated advice that promised to resolve physiological problems they experienced in previous pregnancies.... Others reported being particularly conscientious about following dietary recommendations because they gained excessive weight during a previous pregnancy and suffered associated physical problems as a result.

Like Kabakian-Khasholian et al. (2000), Browner and Press (1996) also point out in "The Production of Authoritative Knowledge in American Prenatal Care," that the reliance on embodied knowledge is less pronounced when the issue at hand is the use of technology. According to these authors, women tend to view technology as neutral and

providing reassurance. Such views of technology are not surprising given that the cultural emphasis placed on its use makes questioning its authority difficult.

In asking for an induction the patient is subscribing to two important norms in obstetric treatment: the idea that technological childbirth is 'good' childbirth, and the notion that while the doctor's superior expertise may be challenged by refusing medical decisions, it is confirmed by polite requests for that; 'begging for mercy' is how the doctors often described such requests (Graham and Oakley 1981: 63).

And as Browner and Press (1996) explain, the use of clinical technology also means that it will become increasingly difficult for women to question biomedical knowledge. On the other hand, open challenges to medical professionals were rare even before the common use of technology (Litt 1996; Oakley 1993).

Indeed, the research suggests that questioning or challenging medical authority is rare. Kabakian-Khasholian et al. (2000) found that Lebanese women's behaviours were not necessarily an indication of what they thought. They have observed that:

Despite their passivity, when women were asked directly, they expressed their dissatisfaction with many of the procedures during pregnancy, labor and delivery, including perineal shaving, enemas, labor induction and not being able to hold the baby directly after delivery (Kabakian-Khasholian et al. 2000: 111-12).

These authors also generalize these findings to the behaviours of women in other parts of the world.

Women's behaviours and the meanings associated with them are complex. They are not simply instances of resistance or compliance. A closer look reveals that such behaviour can be interpreted quite differently when we view women's behaviours as pragmatic. Four categories of women's pragmatic behaviour that emerged from the literature are: (a) toleration of the process in anticipation of benefits; (b) realization that

there are no alternatives; (c) compliance to avoid personal blame, for example, in high risk pregnancies; and (d) resistance not recognized as it was intended.

Toleration of Medicalization and Benefits

As indicated earlier, there are researchers who concern themselves with the benefits of medicalization for women. Many have identified this reality as a contradiction in that medical interventions in women's lives have been both detrimental and beneficial for women (Riessman 1983). Experiences like menstruation or childbirth that are "both healthy and painful [are] confusing and deeply rooted in social attitudes" (Miles 1991: 53). Women seem to be aware of this contradiction at some level and are often willing to tolerate the social consequences and misinterpretations of their behaviours in order to acquire the benefits (Riessman 1983). One example of toleration that is often misunderstood as acceptance is the adoption of the sick role. Talcott Parsons first discussed his concept of the sick role in the 1950s. According to Miles (1991: 73):

He described certain social expectations and associated sanctions affecting the sick, and defined the sick role in terms of four components:

- (i) sick persons are allowed by society to withdraw from some or all of their social obligations and responsibilities (e.g. work, family duties);
- (ii) sick persons are exempt from responsibility for their sickness and no blame is attached to them;
- (iii) they have the obligation to define their sickness as undesirable, to wish to get well and return to normal social obligations;
- (iv) they must endeavour to seek appropriate help (usually from a physician) and co-operate with professional recommendations and treatment.

There are two aspects of women's reproductive experiences that relate to this idea of the sick role. The first is that women use the sick role as a legitimate escape from the

often stressful, endless and socially unacknowledged responsibilities of child care, elder care and domestic work. Miles (1991: 75-76) notes that given such responsibilities, women would make use of the sick role even if they do not believe they are sick. Some, like Castro (1995), disagree and argue that the sick role is not available to women for such reasons. Castro explains that many of the domestic and familial responsibilities that women have actually make them feel less free to take on the sick role.

The responses of significant-others, mainly husbands, to women's experience of disease (i.e. tiredness) is also crucial: men do not tend to consider housework to be strenuous enough for women to feel tired. And as the adoption of the sick role requires the approval of others, women are indeed constrained from feeling tired (Castro 1995: 1006-7).

Despite the points raised by Castro, some women do take advantage of the sick role by withdrawing from obligations and responsibilities and the medical profession often sanctions that course of action. As a result, however, others assume that such behaviour indicates women's beliefs that the experiences are illnesses. There is a lack of consideration given to the differences between behaviours, meanings and the role of the socio-cultural context in which they occur. As discussed above, part of the reason for this lack of consideration is that women's reproductive processes are classified as both health and illness.

Lack of Alternatives to Medicalization

In addition to the idea that women tolerate medicalization in order to acquire possible benefits, there are some situations in which women behave as they do because there are no alternatives. One area illustrating this point is midwifery. Hays (1996: 292)

observes that, “Western medicine is believed to be superior to the traditional birthing knowledge... It appears that relinquishing one’s own personal power is a prerequisite for obtaining the gifts of modern medicine.” In much of Canada today, midwifery is not an option. Many women do not have access to midwives and this leaves them with hospital birth as the only option. Once in the hospital, women have little, if any, control over the process. As Oakley (1993: 23) has observed:

[T]he concept of choice as applied to users of the maternity services is nowhere in sight in the medical model of motherhood. Although many surveys of how women feel about their maternity care show that many wish to be consulted about what kinds of medical treatment they receive, the obstetrical claim to unique expertise prevents the exercise of choice by those who have babies. I am... talking here about... the majority of cases in which it is “policy” in general that determines what proportion of women receive such procedures as ultrasonic monitoring in pregnancy, electronic fetal monitoring in labour, and elective induction of labour.

Despite this apparent lack of choice, there is the underlying assumption that a woman has accepted her pregnancy as pathological and willingly passes control over to the medical professional. While the woman’s lack of control is apparent, it is not logical to assume that she freely chooses to be in such a powerless position (Rajan 1996). Indeed, it appears that many women have learned, for example, that if they want pain relief during labour, they have no alternative except to hand over control to the medical professionals. However, from their perspective handing over control within that context allows them to retain a “sense of control” over other aspects of their labour. As in the case of perceived benefits, what may appear to be simply handing over control is not so simple. There is a difference between others’ perceptions of women’s behaviours and the meanings that women themselves attach to those behaviours.

Compliance to Avoid Blame

A third type of behaviour that is often misunderstood as acceptance involves societal pressures. Women sometimes comply with medical intrusions in order to avoid personal blame. This is seen, for example, among women classified as having high risk pregnancies (Kabakian-Khasholian et al. 2000). As Browner and Press (1996: 142) have observed:

[A]s indications for “high risk” pregnancies proliferate and more links are postulated between maternal behavior and negative fetal outcomes, pregnant women find themselves expected to accept intensifying prenatal surveillance.... Yet many are ambivalent about the value of this extensive medical scrutiny.... Among patients, then, consensus is still lacking about the nature and extent of the role biomedicine should play in prenatal care.

Under such pressures, women may accept medical scrutiny to avoid being blamed if something goes wrong (Miles 1991: 46).

The use of hormone replacement therapy (HRT) in the past is another example, wherein HRT was presented to women as a necessary treatment in the prevention of osteoporosis. The implication was that women who refuse HRT will be at fault for not being appropriately active in the prevention of the condition (Coney 1994).

Unrecognized Resistance to Medicalization

The fourth and final instance of pragmatic behaviour to consider is resistance that is not recognized or visible. In her list of consciousness and resistance, Martin (1987) has outlined two types of resistance relevant to this research: nonaction and sabotage. She has

defined nonaction as “[n]ot participating in an organization, not attending a clinic or not using a term because it is perceived to be against one’s interests” (Martin 1987:185). An example of this type of resistance is a woman’s refusal to consult with a physician about the fact that she is experiencing menopause. The experience is unproblematic for her so she sees no need for intervention. Martin (1987: 186) has defined sabotage as “[a]ction or words meant to foil some process or behaviour perceived to be detrimental but intended not to be detected.” Examples of sabotage include deliberately concealing information in order to prevent or postpone medical intervention (hiding the fact that labour has begun) as well as removing monitoring devices when left alone (cf. Kabakian-Khasholian et al. 2000).

Many women appear to feel more comfortable with these types of resistance because they are not direct confrontations. “Open and visible conflicts are rare, not because women are satisfied with medical control but because they feel themselves too powerless to oppose it” (Miles 1991: 175). The training of health care workers reinforces the idea that women are incidental in the health care setting. These professionals are taught to detach themselves from the problems of the patient and apply their knowledge in a mechanistic fashion (Haas and Shaffir 1994). When this type of training is paired with the subjective perspective of the patient, conflict becomes a built-in component of interactions between professional and patient. According to Miles (1991: 173):

When conflict does arise, the professionals are the likely winners, the two participants in the interaction not being possessed of equal power... Doctors have the medical knowledge and skills and the access to medicines and services which puts them in a position of strength. Patients, by contrast, are in an inferior position; they need the doctor’s advice and may be weakened.... this is further emphasized by the symbolic significance of the consultation taking place on the

doctor's own territory (surgery), where the doctor controls the length of time that the consultation may take, the examination performed, and the outcome of the consultation,... Asymmetry in relationships is even more marked when the patients come from relatively powerless sections of society. e.g. the working class or ethnic minority groups (Miles 1991: 173).

This review of the literature has examined issues of control and women's ways of responding to medical meanings and expectations. It appears that women involved with the medical system experience constraints on their behaviour. In various ways, those who advocate a medicalized view of reproductive experiences influence the treatments women agree to accept. As we can see, however, women's behaviours do not indicate that they necessarily accept the medical perspective that informs those treatments. Nor do these behaviours necessarily mean that women are passive and without resources of their own. By considering women's behaviours as pragmatic responses to specific circumstances presented to them, we begin to see more clearly the presence of multiple meanings. Further, we are directed to pay more attention to women's strategies for dealing with these circumstances and the socio-cultural contexts within which they occur (Avotri and Walters 1999; Lock and Kaufert 1998).

In this research, therefore, I explore the meanings and strategies used by women living in the Cape Breton Regional Municipality of Nova Scotia. This is a community riddled with economic and environmental problems. The population is experiencing cutbacks in health care, a shortage of health care providers and services, and delays in treatment. There are high rates of unemployment, increased reliance on welfare and foodbanks, and serious environmental health hazards. Through this research, I hope to contribute to the research literature that seeks a comprehensive understanding of women's

reproductive experiences by exploring individualized experiences in diverse settings. In the next section, I discuss the relevant theoretical and epistemological concerns that have informed my research.

A Critical (Feminist) Approach: Theoretical and Epistemological Concerns

Over the years, feminist researchers have identified a number of problems in research involving female participants. By heeding their advice and following their work, I hoped to avoid the problems they identified. In general, these problems have revolved around one central issue – androcentrism. Androcentrism is defined as “male-centeredness. Men’s greater power to control words, and to represent and preserve in language their interests and ideologies” (Kramarae and Treichler 1985: 47). The problems that I consider in this section arise from androcentrism and include (a) the use and misuse of language; (b) ideology that assumes the naturalness of women’s oppression; and (c) the ways patriarchal society prevents women from talking from experience. As Smith (1987b: 85) has observed:

[H]ow sociology is thought – its methods, conceptual schemes, and theories – has been based on and built up within, the male social universe... There is a difficulty first then of a disjunction between how women find and experience the world beginning (though not necessarily ending up) from their place and the concepts and theoretical schemes available to think about it in.

Recognizing this androcentric bias has directed feminist researchers to conduct their own research in ways that allow women’s voices to be heard about their own experiences within their own contexts. As discussed in the previous chapter, an androcentric ideology

dominated early views on medicine. This ideology often described women and their reproductive experiences as outside the male norm and, therefore, abnormal or representing failure. Medical, or specifically gynecological, texts are one of the more common examples of these androcentric representations (Martin 1987).

According to research done on these issues, women are required to speak in a male-oriented language that describes woman as “other”. This language limits women’s ability to speak from and about their experiences and often results in misunderstandings (Spender 1981; Daly 1978). Cameron (1985: 5) has stated that some women “have noticed... that language itself does not guarantee communication, and many feel actually inhibited by the inadequacy of words.” Male-centredness is not simply a problem of description, however. It is also a problem of researcher interpretation.

Radical feminists, among other researchers, argue that the key to patriarchal success is to make androcentrism appear normal; to make the powerlessness and oppression of women appear natural. They argue that this success is achieved by the silencing or muting of women’s voices at multiple levels in society (Frye 1983). Frye (1983) has argued that the barriers confronting women are analogous to a bird cage. Each wire, which represents a micro level of interaction, does not appear to be a barrier until we step back and recognize that the whole is a cage restricting women from moving in any direction. Daly (1978) has claimed that the silencing or muting of women’s voices is achieved through the creation and use of barriers that are developed and reinforced through deception and manipulation. Daly (1978: 4) has stressed that “the barriers that

women are confronted by ‘are not mere immobile blocks, but are more like deceptive tongues that prevent us from hearing our Selves.’” She states that women

must be aware of the male methods of mystification.... First, there is *erasure* of women.... Second, there is *reversal*. (Adam gives birth to Eve).... Third, there is *false polarization*. (male defined feminism set up as opposed to male defined sexism).... Fourth, there is *divide and conquer*. (token women killing off feminists in professional occupations). As we move further... we find deeper and deeper layers of these demonic patterns embedded in the culture, implanted in our souls. These constitute mindbindings comparable to the footbindings... (Daly 1978: 8).

Wilson Schaef (1981: 69) makes similar comments but instead of barriers, she has referred to “stoppers” that she defines as:

Techniques... used to make women back off from their own perceptions... A stopper is anything that keeps us where the White Male System wants us to be... The greatest stopper of all is the implication that a woman is sick, bad, crazy, stupid, ugly or incompetent.

As argued by Wilson Schaef (1981), Frye (1983) and Daly (1978), the manipulation and control of language is one of the most effective of these barriers. Androcentric language denies the reality of women’s experiences. Feminists, long aware of the power of language, have devoted a great deal of attention to uncovering the role it plays in maintaining patriarchy.

Informed by the idea of women’s “otherness” within patriarchal society, this research builds on the work that other feminists have done on women’s reproductive experiences. As McKinnon (1995: 136) has explained, “women have been substantially deprived not only of their own experience but of terms of their own in which to view it.” Within patriarchal society, everything, including women, is understood through its relation to men (Spender 1981; Daly 1978). As a result, all social interactions are

described and understood from only one perspective – man's. This means that:

She [woman] is broken by the fact that she must enter this language in order to speak or write. As the "I" is broken, so also is the Inner Eye, the capacity for integrity of knowing/sensing. In this way the Inner Voice of the Self's integrity is silenced; the external voice babbles in alien and alienating tongues. And when the Self tries to speak out of her true depths, the pedantic peddlers of "correct" usage and style try to drown it in their babble (Daly 1978: 19).

In other words, she is forced to use a language that does not reflect her experiences.

Feminists share the view that attention must be given to the lived experiences and subjective meanings of women. The importance of these issues is seen in the work of researchers such as Avotri and Walters (1999) and Walters and Denton (1997) and in the theoretical writing of radical feminists such as Mary Daly (1978).

As discussed throughout this section, the specific epistemological problem arising out of androcentric ontology is the absence or muting of women's voices and meanings in research about women. This muting is a consequence of assumptions built into the traditional, positivistic research process that numerous feminists have exposed and challenged. It is, in large part, because research techniques have been used uncritically that Smith (1987b) has identified two major problems with the research process itself. The first, discussed above, is that sociology appears to be based on a male world view.

The second

difficulty is that the two worlds and the two bases of knowledge and experience don't stand in an equal relation. The world as it is constituted by men stands in authority over that of women....

The two difficulties are related to one another in a special way. The effect of the second interacting with the first is to impose the concepts and terms in which the world of men is thought as the concepts and terms in which women must think their world. Hence in these terms women are alienated from their experience (1987b: 85-86).

A third problem identified in the literature is that some researchers, adopting a “traditional” positivistic sociological stance, have failed to consider or have rejected the influence of external factors on women’s experiences with reproductive health issues (Walters and Denton 1997; Golub 1985). A number of researchers, such as Avotri and Walters (1999) and the contributors in Lock and Kaufert (1998), as well as many others discussed in this thesis, are concerned with identifying women’s meanings. They recognize that such an endeavour requires acknowledgement of the interconnected nature of social experiences.

Although not necessarily explicit in their writing, many feminist researchers examining lay perspectives have made use of conceptual approaches similar to those espoused by symbolic interaction theory. In this research, I make use of the interactionist approach to extend the analysis of lay perspectives, taking into consideration issues of meaning, agency and social context.

Symbolic Interaction as Theoretical Perspective: Meaning, Agency and Social Context

Symbolic interactionism is informed by numerous assumptions about the nature of reality and how it can be known. For this research, I was particularly interested in the assumptions related to meaning, interaction and the development of self and how they could help me understand Cape Breton women’s thoughts and actions in relation to the context in which they lived.

According to symbolic interactionists, interaction is based on consensus; that is, the sharing of meanings in the form of common understandings and expectations. These shared meanings are learned through socialization and involve learning gestures and ultimately, significant symbols (language). Whereas animals appear to interact using automatic and unthinking gestures, Mead (1934) argued that humans have the ability, through the evolutionary process of language acquisition, to use language consciously and intentionally. Further, language is the mechanism for the rise of the human self and the mind.

According to Blumer (1966: 535), in asserting that a human has a self, Mead was arguing that the individual is an object to herself and accordingly, may perceive herself, have conceptions of herself, communicate with herself, and act toward herself. In order to view herself as an object, the individual must internalize or learn the common meanings, definitions and attitudes of others around her. She can then apply their definitions to her own conduct in a meaningful way. This internalization necessarily implies learning the significant symbols (language) of those with whom the individual associates. According to Mead (1934: 47), gestures become significant symbols when they take on a linguistic component and “implicitly arouse in [the] individual making them, the same responses they explicitly arouse, or are supposed to arouse, in other individuals”. The ability of people to learn and interpret the meaning of their own significant symbols and to anticipate the response these symbols will produce or elicit from others is a primary assertion of symbolic interactionist theory.

Mead further argues that the existence of language which enables individuals to learn is evidence of the prior existence of society as the context within which selves arise. “The process out of which the self arises is a social process which implies interaction of individuals in the group, which implies the pre-existence of the group” (Mead 1934: 164). However, Mead did not view the self as a mere product of social conditioning or social determinism. Rather, he argued that the individual possesses agency, that she is an active actor rather than a passive recipient of external stimuli. The self, according to Mead (1934: 174-6), is not simply a structure or an organization, but an on-going process. This is illustrated by his discussion of the interaction of the two components of the self – the “I” and the “me.” The “I” is essentially the impulsive tendency of the individual. It is the initial, spontaneous and unorganized aspect of human experience. “It is because of the ‘I’ that we say that we are never fully aware of what we are, that we surprise ourselves by our own action . . . for this response of the ‘I’ is something that is more or less uncertain” (Mead 1934: 174-6). This uncertainty in the self allows for creativity and the unexpected in action. The “me”, on the other hand, is the controlling, limiting, societal side of the person and represents the internalized “other” within the individual. It is made up of the organized set of attitudes and definitions of the group, including the common understandings, expectations and meanings of the group. In any action, the “me” may be incorporating this generalized other and also a particular other.

The “I” and the “me” are constituent parts of the self, working together in responding to any social situation (Mead 1934: 176-7). As Meltzer has observed (1964: 23), “human behavior can be viewed as a perpetual series of initiations of acts by the ‘I’

and of acting-back-upon the act (that is guidance of the act) by the ‘me’. The act is a resultant of this interplay.” In other words,

the human being is seen as an active organism in his own right, facing, dealing with, and acting toward the objects he indicates. Action is seen as conduct which is constructed by the actor instead of response elicited from some kind of performed organization in him (Blumer 1966: 537).

Like the self, the mind is social in both origin and function. Developing concurrently with the self, the mind arises in the social process of communication (Mead 1934). According to Meltzer (1964: 22), when the individual internalizes the definitions of others that she has learned through significant symbols, she also learns to “assume the perspectives of others, and thereby acquires the ability to think.” The individual continually indicates to herself in the role of others and controls activity with reference to the definitions provided by others. Minded behaviour, then, is an internal conversation that inhibits overt conduct, delays action, organizes and selects responses using the standpoint of the generalized other (Meltzer 1964: 20). This implies that the individual is constructing her act. As Meltzer (1964: 21) states, “mind makes it possible for the individual purposively to control and organize his [her] responses.”

Several assumptions about the nature of social life arise from this theoretical approach. First, all human activity, other than reflex or habitual action, is constructed as it is executed. Social life, therefore, is processual and emergent, not fixed or deterministic. As Stryker (1980: 93) has observed, social life is “fluid, being continuously constructed and reconstructed and premised on definitional and interpretive processes.” As a consequence, considerable attention is given to action and meaning. As Styker (1980: 87) has explained, “human beings act toward things on the basis of the

meanings those things have for them, . . . meanings are a product of social interactions, and . . . meanings are modified and handled through an interpretive process used by persons in dealing with things each encounters.” Collins (1994: 306) has also observed that meaning arises

in the process of interaction between people. The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Their actions operate to define the thing for the person. Thus, symbolic interactionism sees meanings as social products, as creations that are formed in and through the defining activities of people as they interact.

Therefore, research using a symbolic interactionist approach must stress an understanding of actors’ meanings as these influence interpretations, actions and interactions.

Second, the self, with the “I” and “me” components, and mind, as conceptualized by Mead, allow the individual, through self-interaction, to bring about changes in herself by viewing herself in different ways. In other words, the self is not fixed and meanings can change over time. Further, an individual with a self can direct and control her behaviour, that is, she has agency to act. As discussed above, the individual is not a mere passive actor subject to all impulses and stimuli directly playing upon her. Rather, she is able to control, check, guide and organize her actions using minded behaviour (thinking). Research using a symbolic interactionist perspective must also attend, therefore, to the agency of the actor.

Third, as the “me” is based on the internalization of the attitudes of others, it is also important to consider the social context of individuals. As Mead (1934: 155) has noted, “it is only in the form of the generalized other . . . that the community exercises social control over the conduct of its individual members; for it is in this form that the

social process or community enters as a determining factor into the individual's thinking." Accordingly, any consideration of the meanings women bring to their reproductive experiences also means examining these experiences within the social contexts in which they are experienced and given meaning.

Conclusion

Drawing on lay perspectives research and symbolic interactionist theoretical principles, I have argued, in this chapter, for the importance of examining women's meanings and individual agency in the social contexts in which they find themselves. Without attention to these factors, it is all too easy to misrepresent women's interactions with medical professionals as either simple resistance to or compliance with medicalization, when the actual picture may be much more complex. Feminist researchers, for example, have already identified the pragmatic decision-making that goes into women's behaviours in issues of health and health care.

As I discussed in this and the previous chapter, there has been a considerable amount of research emphasizing structural constraints. Many researchers are now investigating women's meanings. These two bodies of literature, when considered together, provide a more comprehensive understanding of women's reproductive experiences. Indeed, a focus on the complexity of women's reproductive experiences indicates that the idea of complete medicalization of reproductive processes as presented by medical professionals is overly simplistic, incomplete and often incorrect. This criticism is grounded in the fact that women, when they are encouraged to speak from

experience, provide us with multifaceted accounts that differ from the medicalized view. They do not appear to blindly accept the medicalized model or any other singular model of their experiences. As Walters (1994: 312) has argued, “Women borrow from medicine as appropriate, transform and integrate this information with their own understandings. They are engaged in a dynamic process of constructing and reconstructing their understandings of their experiences.” They rely on experiences or embodied knowledge when assessing the value of medical definitions, technologies and treatments. This reliance is a consequence of a reflective process that is far less linear than many macro-level studies on medicalization would lead us to believe.

Feminist researchers, therefore, approach women differently, recognizing the need to avoid imposing on women the language and assumptions of medical professionals when they discuss their reproductive experiences. Researchers are also empowering their female participants by allowing their concerns and experiences to direct the research path. As Kitzinger points out in relation to childbirth:

In all cultures the birth of a child is the focus of strongly held values. The behaviour of the woman and of those who assist her at the time of birth and afterwards, together with her initial reactions to motherhood, cannot be understood without an awareness of the meanings that birth and motherhood represent. In western society, this must include understanding of the dissonance that exists between the woman’s experience and the culture of the medical system that defines the meaning of childbirth (Kitzinger 1992: 64).

Dorothy Smith (1987a) has argued that it is necessary to explore women’s phenomenological experiences. At the same time, researchers must acknowledge the role of structural inequalities in limiting and manipulating those experiences.

In order to accomplish the research goals described above, I make use of an ethnographic approach that permits the discovery and examination of women's experiences reflected in their own perspectives. In addition, I also attend to the socio-cultural contexts in which these experiences are lived (Agar 1980).

In the next chapter, I outline in detail the research design and methodology adopted in my study of Cape Breton women and their reproductive experiences. As part of this process, I discuss how the methodological decisions I made were informed by the theoretical assumptions guiding this research (cf. Smith 1987a).

CHAPTER 4

THE WOMEN, METHODOLOGY AND ANALYSIS

Introduction

As mentioned in Chapter 1, the Cape Breton Regional Municipality (CBRM) of Nova Scotia was chosen as the site for this case study because it is experiencing unique circumstances relating to health care services, the economy and the environment. Theoretically, I was guided by feminism and symbolic interactionism. Specifically, I was guided by their shared assumption that to fully understand what women think and feel and how they act, I needed to consider both the personal and socio-cultural contexts within which they interact and live. I also had, as a goal, to contribute to that body of research which seeks a comprehensive understanding of women's reproductive experiences by focusing on their lay perspectives in diverse settings. As a researcher, therefore, I needed to adopt a methodological strategy that allowed for this type of situated analysis.

The theoretical and methodological issues raised by feminists and symbolic interactionists in relation to studying women influenced my data collection and analysis methods. Sandra Harding (1987: 3), for example, points out why a researcher's methodological stance is particularly important in relation to studying women. She explains:

Feminist researchers have argued that traditional theories have been applied in ways that make it difficult to understand women's participation in social life, or to

understand men’s activities as gendered... [F]eminist versions of traditional theories.... raise questions about whether even feminist applications of these theories can succeed in producing complete and undistorted accounts of gender and of women’s activities....

... Feminists have argued that traditional epistemologies, whether intentionally or unintentionally, systematically exclude the possibility that women could be “knowers” or *agents of knowledge*.

While I agree with Harding (1987) in relation to traditional, positivistic theories, I believe the concepts of symbolic interactionism, particularly those discussed in the previous chapter, positively contribute to the goals that feminists set forth.

My intention in this research, therefore, was to follow the traditions established by feminist and interpretive qualitative researchers and create a data collection plan that approached women as active and knowledgeable experts. Once I made the decisions regarding whom I would study and how, I submitted my research proposal to the McMaster University Ethics Review Board. My research plan was approved and I traveled to Cape Breton, Nova Scotia to begin my research.

I begin this chapter by situating the research in its social context. That is followed by a discussion of how I gained access to the women and how they were selected. In the second part of the chapter, I focus on the research design and methods of analysis. I will now discuss the socio-cultural context of CBRM.

The Women, Their Backgrounds and Environment

As indicated earlier, this research is in essence a case study of Cape Breton women’s reproductive experiences. The women in this study live, work or attend university in the Cape Breton Regional Municipality (CBMR) of Nova Scotia. It is

predominantly a working- class, Catholic community that is known for its strong Celtic roots. The community also has a long history of large families and a high rate of teen pregnancy. Both may be consequences of a lingering influence of the Catholic Church's views on birth control and abortion. Given that Cape Breton is an island, there is also a definite sense among the people that they are a distinct group and isolated from the rest of the province and the country. This belief is illustrated by the common reference to areas outside Cape Breton as the "Mainland."

I selected women from the CBRM because, as mentioned, they live in an area experiencing unique circumstances relating to health, economics and the environment. The population of Cape Breton Island is experiencing cutbacks in health care, a shortage of health care providers and services, delays in treatments and interventions, high rates of unemployment and underemployment, increased reliance on welfare and food-banks, and exposure to serious environmental health hazards. I was interested in exploring what, while living with such difficulties, women think and feel about their reproductive experiences.

Within society generally, menstruation, pregnancy, childbirth and menopause are considered to be normal experiences. However, most if not all of these experiences are managed under the jurisdiction of medical professionals. The consequence is that women experiencing these reproductive processes would most likely be affected by the recent changes in the health care system. Some of the consequences of the health care crisis in Cape Breton for women's reproductive experiences are that: (a) women are resorting to emergency room services as their only institutionalized form of prenatal care and

delivery; (b) a lower than average number of women are having breast exams, approximately 21%, and Pap tests, approximately 20% (Government of Nova Scotia, 1995); and (c) there is an increased risk of car births due to the absence of maternity services in smaller hospitals in the area.

Added to these problems with the health care system is the severely depressed economic climate in which the people of Cape Breton live. The most recent indications from Statistics Canada place the unemployment rate at 20.1 percent (Statistics Canada, 2001). The unofficial rate is estimated to be much higher as those who are no longer eligible for Employment Insurance Benefits are not included in the official statistics. It is assumed that the unofficial rate combined with the underemployment rate is approximately fifty percent. This high percentage is primarily due to the closures and downsizing of, as well as imposed government restrictions on, the primary employers -- the fisheries, coal mines, and steel plant. Given that the area has historically relied heavily on these industries, other employment opportunities are affected by their fluctuations. This situation has given rise, as might be expected, to economic instability and personal anxiety.

There is also tremendous public concern over environmental health issues in this area of Nova Scotia. People are and have been concerned about the documented high rates of cancer and other health problems. According to information from the Sierra Club of/du Canada (1998: 3), "Nova Scotia has the highest rates of cancer in Canada, and within the province, Cape Breton tops the charts. It has the highest rates of lung cancer, breast cancer and stomach cancer in the province." Many believe these are a consequence

of the "Tar Ponds." The tar pond is a stream running through the center of downtown Sydney, the most populous area of Cape Breton. In the Government of Nova Scotia's 2002 Report of the Commissioner of the Environment and Sustainable Development, the Tar Ponds are described as:

Part of the Muggah Creek watershed.... The Sydney tar ponds site rests in the heart of an urban area in Sydney, Nova Scotia, where more than 25,000 people live within a four kilometer radius. Contaminants found within and surrounding the areas include heavy metals, polychlorinated biphenyls (PCBs), polycyclic aromatic hydrocarbons (PAHs), and raw sewage. This site is considered to be one of Canada's largest and most contaminated sites.

The Sierra Club adds a number of other chemicals, including: arsenic, molybdenum, benzopyrene, antimony, naphthalene, lead, toluene, tar, benzene, and kerosene. The pond was used as a dump for the waste produced by the coke ovens of the local steel plant until 2000.

Government agencies and the Joint Action Group (JAG) have conducted a number of studies aimed at identifying related health problems and finding a feasible way to clean the site. According to JAG (2001), some of the health studies completed over the years include an analysis of mortality rates, a study of reproductive outcomes, and an analysis of cancer rates in the area. In all these studies, the people of Sydney and the surrounding area fared worse than people in other parts of the country. Everyone from the locals to the federal government recognize the need to clean up the Sydney Tar Ponds site. Since the 1980s, the federal government has spent over \$66 million on environmental studies and clean-up attempts. After 20 years of studies, the site is still not cleaned up and the government has not created a plan to deal with the situation (Government of Nova Scotia's 2002 Report of the Commissioner of the Environment and

Sustainable Development). In fact, within the past year, a grocery store and a movie theatre have been built over parts of this site. While people are very concerned about the environmental hazard posed by the tar ponds and speak frequently about it, they shop at this grocery store and go to the movie theatre. Those businesses are, in fact, quite successful while others that have been part of the community for many years have closed.

As a twenty-year resident of the area, I believe that those circumstances have resulted in a unique mind-set among many of the people living in the area. Confronting economic uncertainty and the break-up of extended families due to relocation has been difficult for many people in the area. It has resulted in what appears to be a defeatist, negative undercurrent to the ways in which people understand their lives. Many people in the community give the impression that they believe most things will be a struggle and that is simply the way of life. For example, people continue to raise their concerns about the pollution from the tar pond and the extremely high unemployment rate. At the same time, however, they expect nothing to change. They have come to believe that the problems of Cape Breton are of little importance to the rest of the country, including government representatives. Such beliefs are supported by realities like the numerous health studies conducted, indicating serious problems but concluding that “follow-up studies are necessary to determine the causes” (JAG 2001) and the government’s lack of involvement in decreasing the high unemployment rate following the closures of the steel plant, coal mines and fisheries.

Given the social context, and in particular the significant social problems, I thought it important to explore how women in CBRM think and feel about their *normal*

reproductive experiences. In this way, I would not only add to the theoretical examination of women as active agents of knowledge. I would also provide new substantive insights into the ways these women make sense of their reproductive experiences within a context informed by problematic social and environmental issues beyond their control.

Getting In and Finding Participants: The Sampling Process

One of the initial concerns I had when I returned to Cape Breton was finding women who would talk to me about their reproductive experiences. Finding a sufficient number of women was a slow process. I began the search for participants in September, 1997 and continued until the final interview was arranged in December, 1998.

I hoped that the recruitment of women would be eased by the fact that I had lived in Cape Breton for twenty years. Further, my family has lived there for four generations. I was an active member of the women's network that exists in the area and I had long standing ties to the local university. I also conducted my M.A. research on women's menstrual experiences in this area and was, therefore, known in that capacity by many people in the community. My credibility and trustworthiness as an insider and a researcher were, therefore, already established among some women in this community prior to beginning this research.

Even with the advantage of being an insider, I knew that finding a significant number of women who were willing to talk to me would be difficult. For example, some women believe that reproductive experiences are personal or private and that discussion

of them is inappropriate. Indeed, a few of the women who participated indicated that this was the reason some women refused to talk with me. Others told me that some of their friends and acquaintances regarded their experiences as traumatic. Hence, they did not want to discuss them with someone they did not know. Still others felt that their experiences were completely uneventful and they, therefore, had nothing to say. Others were suspicious of me because I was a stranger to them personally, even though I was a long time resident of Cape Breton. Others were uncomfortable with getting involved in an unfamiliar activity.

Given my theoretical approach grounded in feminism and symbolic interactionism and the exploratory nature of my research problem, I made use of qualitative research strategies. According to Huberman and Miles (1994: 441), “[q]ualitative researchers must characteristically think purposively and conceptually about sampling.” For this study, the obvious starting point was to find female participants. They “are experiential experts” and the authorities about women’s reproductive experiences (Morse 1994: 228-229).

Consistent with feminism and symbolic interactionism, I made use of snowball sampling and self-selection techniques in recruiting my sample. Snowball sampling is a technique borrowed from ethnographers. The researcher relies on a member of the group with whom s/he has a relationship to recommend other appropriate participants as well as to indicate to those potential participants the trustworthiness of the researcher. This method is typically used when the researcher has no realistic way to find the people who have the information s/he needs (Berg 1998).

My familiarity with the community and other similar research led me to believe that these sampling techniques were the best approach to take. I was certain that many women would be more inclined to volunteer if they had heard of me from others they knew and trusted. I also believed that others would feel comfortable volunteering without encouragement from others. Because I wanted to maximize the size of the potential population, I decided to use this combination of qualitative sampling methods. The combination of sampling methods worked. However, virtually every woman who volunteered to participate in this research did so as a result of speaking with three women who assisted me. Only seven from a sample of forty-seven volunteered without having talked to one of these women.

I asked these three women I knew from the community to assist me with the recruitment of participants. I posted notices around the community and later asked each participant to find other women willing to talk with me. I knew the three women who assisted me for many years and our relationships were built on trust and respect. Consequently, they were happy to assist me with the research by arranging focus groups and speaking to women on my behalf. I recognized early on that the pool of potential participants would be limited to the social networks of the individuals I approached to assist me. I, therefore, gave significant thought to whom I should ask.

I selected these women because they participated in different social networks. I felt that this would maximize the number of women likely to hear about my research and my request for participants. Specifically, one of the women was a schoolteacher, near retirement. She was married, never divorced and had grown children. The second woman

was an active member of the local women's center and recently graduated from university as a mature student. She was in her mid-thirties and a divorced mother of two children who were living with her. The third woman also had a university education. She was a young, married, stay-at-home mother with one toddler. The other important factor that made these women appropriate choices is that all three had lived their entire lives in the area.

These three pivotal women also participated in the focus groups. Their participation appeared to increase my credibility in the eyes of the other women. I realized that including them in the focus groups could cause problems. The other women could have simply followed the lead of those women. There was also the possibility that women would be concerned that one of the three would tell me things about them after the meetings. However, these possibilities did not seem to materialize during the focus groups. All of the women appeared to be comfortable with each other during our meetings. The three women who assisted me did not appear to behave any differently than the other women. All the women discussed their lives and experiences. They all agreed, disagreed, and/or expanded on the comments that others in the group made. I also asked the women who later participated in individual interviews to give me their impressions of the focus group meeting and the women who participated. None of these women identified any problems with the focus group process or its participants.

In addition to considering how the assistants might influence the behaviour of the other women, there was also the possibility that they could influence the ways the participants perceived my research and me. I did, however, discuss with the three

assistants what I wanted them to tell the potential participants and gave each of them copies of the posted requests that I had circulated. Further, I introduced myself and my research to each new focus group in a standardized way that assisted participants in understanding the research and its focus. No obvious differences emerged among the women who participated in terms of which of the three women recruited them.

The addition of self-selective and snowball sampling extended the pool of potential participants by seven women. Some of these women who participated in the focus groups learned about my research by reading requests for volunteers that were posted in the Every Woman's Centre, a senior citizens apartment building, and the University College of Cape Breton. A copy of this request can be found in Appendix A, "Women's Health Experiences: Research Participants Required." Other women were recruited by women who had participated in one of the focus groups.

The same sampling techniques were used for the individual interviews with one slight variation. Many of the women who participated in a focus group volunteered to participate in the individual interviews. They did this by circling "YES" in response to the statement "I am interested in participating in a follow-up interview" on the confidentiality and release of information form. A copy of this form can be found in Appendix B, "Focus Group Confidentiality and Release of Information Form."

Requesting that the focus group participants circle whether they would be interested in participating in an interview is, perhaps, not self-selection in a strict sense. However, the request was presented in such a manner that all the women could decline without saying anything to me. In addition, I did not know whether a woman was

interested in being interviewed until the focus group meeting had ended and the women were gone.

One of the potential problems with self-selection in research is that while it ensures that those involved want to share their experiences with me, it also carries with it the possibility that those individuals will be more outgoing and articulate compared to others in the community. This did not seem to be an issue, however. Perhaps because the women viewed me as an insider, they felt comfortable talking to me even if they were not overly confident in their communication skills.

Also related to the idea of being an insider was the sense that the women were interested in helping “one of their own.” Some of the women viewed the researcher as a local girl who “made good;” someone who managed to get out and do something with her life and still came back to the community. Others felt that their knowledge about reproductive functioning was quite limited and they viewed their participation as an opportunity to acquire information from the others in the focus groups or me.

Despite all of the possible problems associated with conducting research in a familiar environment, relying on friends or acquaintances to assist in finding participants and self-selection, I found that the women who participated in the focus groups and interviews provided a wealth of valuable information.

Sample Description

In this section, I provide information on the women from Cape Breton who participated in this study and compare them to Canadian women elsewhere.

The final sample size for this research was forty-seven. The women were quite similar to one another. Most of the women were longtime residents of the Cape Breton Regional Municipality. They were all white. Most were or had been in long term relationships that involved co-habitation. They were of varying ages (20 to 64). I did not impose any limits related to age of participants with the exception that they be legal adults. These ranges are, therefore, nothing more than the ages of women interested in participating. My only expectation was that the participants had reproductive experiences about which they could talk.

Collectively the women had experienced the range of reproductive experiences from menstruation to post-menopause. Specifically, all of the forty-seven women had experience with menstruation, and forty-three had experienced at least one pregnancy and birth. Of the four women who had not, one had fertility problems, one was young and planned to have children in the future, and two were childless by choice. Of the forty-seven women in the sample, over half, or twenty-nine women were experiencing or had experienced menopause at the time of this research and nearly one third, or fifteen women were experiencing the post-menopausal phase of their lives.

Despite the similarities among the women in this case study, there were some significant differences between them and women in other parts of the country. Accordingly, I do not generalize my results beyond the context of this study. However, in Appendix C, I provide a comparison of my participants to Cape Breton, Nova Scotia and Canada in relation to age group (table 3.1), marital status (table 3.2) and level of education (table 3.3). The numbers are presented in tabular form for information purposes

only and are not intended to convey any notion of representativeness given the nature of my sampling methods.

Generally, the age groups in my research sample were similar to those in Cape Breton, Nova Scotia and Canada, although there was a slightly higher representation of women ages 25-54 in my sample. In terms of marital status, single women and widows were underrepresented in my sample and divorced women were overrepresented. The women in this sample also differed from the national population in terms of higher education. Whereas the numbers of women who had high school diplomas were relatively consistent across the geographic areas of Cape Breton, Nova Scotia and Canada, nearly forty-three percent of my sample had a university degree versus fourteen percent of Canadian women.

Apart from the obvious explanation that people with higher education are more likely to participate in research studies, the differences may be explained by the unemployment rate and the open-door admission policy at the local university. Given these circumstances, the Cape Breton community places a great deal of emphasis on education. Several of the women in this research also came from working class families. Their parents had little, if any formal education, but they had sacrificed so that their children would have more educational opportunities.

To conclude, the women in this sample were a relatively homogeneous group. At the same time they exhibited quite specific differences from others in the province and the country. As my intent was to explore women's meanings as situated in personal and socio-cultural contexts, the lack of generalizability of my sample results beyond the

CBRM was not of major concern. I will now discuss how I collected information from these women and analyzed the data that resulted.

Methodology and Research Design

According to Kirby and McKenna (1989: 16-17), “research needs are... context dependent.... research and knowledge are produced in a manner which represents the political and social interests of a particular group.” Fausto-Sterling (1985) has argued that research dealing with women’s reproduction needs to address the connections between mind, body and culture. I wanted this research to represent the interests of my participants by taking into account those connections. In order to do that, I knew that I needed to minimize my influence over the women as much as possible and the ways they described their experiences. As interpretive sociologists have pointed out for years, this meant trying to walk the fine line between maintaining focus and avoiding the exercise of power. For me, like many other feminists, this meant qualitative methods were the most appropriate methods of data collection.

I adopted an approach to data collection for this research that I thought would address those connections. Like Devault (1990: 96), I believe that the research methods I adopted for this study are firmly rooted in the tradition of interpretive qualitative sociology. However, as Devault (1990) and others indicate regarding their own approaches, my feminist stance adds a certain sensitivity that encourages the discovery of women’s meanings for their thoughts, feelings and actions.

I adopted a multiple methods approach, or methodological triangulation, for this research. The work of researchers like Reinharz (1992) lead me to believe that the use of multiple methods would increase the opportunity to collect the type of data that I needed. Methodological triangulation is simply the use of more than one method of data collection to study a single issue (Janesick 1994). In light of statements from researchers such as Devault (1990), Finch (1984) and others, I decided to use a combination of focus group interviews and individual semi-structured interviews for this research.

As Fontana and Frey (1994: 373) explain, “[A]n increasing number of researchers are using multimethod approaches to achieve broader and often better results.” Reinharz (1992) points out some of the benefits of multiple methods, particularly when studying women’s lives when she states:

Important issues concerning women’s lives can be understood in complex and thorough fashion. Researchers can then communicate this understanding to the public in a convincing manner. Multiplemethod research creates the opportunity to put texts and people in contexts, thus providing a richer and far more accurate interpretation (sic) (Reinharz 1992: 213).

Consistent with the interpretive perspective, Reinharz explains that for feminists, such an approach reflects the commitment of the researcher to a variety of issues, including thoroughness and “the desire to be responsive to the people being studied.” She goes on to state, “[b]y combining methods, feminist researchers are particularly able to illuminate previously unexamined or misunderstood experiences” (Reinharz 1992: 197).

Despite the advantages of using more than one method of data collection, the selection of the methods cannot be done haphazardly. Particular attention needs to be given to the advantages and disadvantages of each method that is adopted (Reinharz

1992). The selection of methods, therefore, should be a deliberate act in which one method is chosen because it contains elements that are missing or weak in the other. I believed that the combination of focus groups and semi-structured interviews used in this research would accomplish that objective of complimentary differences. Focus groups have the advantage of allowing for the inclusion of unanticipated information that can result from group members interacting with one another. The semi-structured interviews allow for a depth of information because they are focused on the individual and they give the researcher the opportunity to ask probing questions.

Another advantage of both focus groups and semi-structured interviews is that the flexible and fluid nature of the interactions allows for feminist concerns about language and androcentrism to be dealt with. Women can speak freely, using the language that most accurately reflects their experiences. That issue of language was particularly important in this study. As discussed in Chapters 2 and 3, the dominant medical terminology sometimes conflicts with women's lived reproductive experiences. Devault (1990), like many feminists, has explained such difficulties with language when studying women. She explains:

Presumably,... the lack of fit between women's lives and the words available for talking about experience present real difficulties for ordinary women's self-expression in their daily lives. If words often do not quite fit, then women who want to talk of their experiences must "translate," either saying things that are not quite right, or working at using language in non-standard ways (Devault 1990: 97).

By relying on my knowledge of feminism and symbolic interactionism and following the guidelines of ethnographic approaches, I attempted to deal with the issue of language in my meetings with the women. I did this by framing questions in ways that

did not direct how they discussed their concerns and ideas. The meetings themselves were flexible and the women had the freedom and the time to talk as they wished. Having encouraged such expression, I paid close attention to the ways the women talked about their experiences. I also attempted to follow their lead by asking follow-up questions using the same language. I did these things by asking an opening question that was general enough that the women could interpret it in a variety of ways. I then framed my follow-up questions using the language they had used to answer the first question. For example, when a woman used the phrase “the change” instead of “menopause,” I would follow her lead and also use the phrase the change in the remaining questions. In addition, I attempted to avoid leading the women in any particular direction. Despite the flexibility of both the focus groups and individual interviews, there were some questions that I asked all participants. They are discussed in the following sections and listed in Appendices D and E, respectively.

The theoretical issues of feminism and symbolic interactionism discussed in the previous chapter directed me to assume that in order to acquire a holistic understanding of how women view their reproductive experiences, it was necessary to consider the issue in various ways. I needed to know how women would respond to direct questions about their reproductive experiences. I also needed to understand how they contextualize and communicate their experiences. Related to these, it was important to understand how these women determined the normalcy of the reproductive experiences. I thought that knowing women’s sources of information would shed light on the ways they understand

their experiences. All these aspects needed to be considered in order to reach the type of context rich description advocated by feminists and interpretive qualitative researchers.

My predecessors in feminism and symbolic interactionism taught me to pay attention to whether certain issues emerged as important in the women's comments and at the same time remain open to any issues that I had not thought of but which the women raised during our meetings. Based on the literature discussed in Chapters 2 and 3, the issues that I thought might provide insight into women's understandings of their reproductive experiences included: the language they used to describe their experiences (whether it more closely resembled lay perspectives or medical), the ages of the women, whether women viewed particular experiences as positive or negative, and whether the women had used or rejected medical treatments and interventions that medical professionals recommended and why.

The combined use of focus groups and semi-structured interviews allowed for the exploration of complex and heterogeneous experiences. In general, both methods are flexible and allow for the collection of in-depth and unexpected information. Exactly how I designed and used those methods of data collection are the subjects of the following sections.

Focus Groups

Four focus groups were conducted during the winter of 1997. The groups consisted of three to eight women: one group included three women, two groups included five women and one group included eight women. The meetings were held in locations

comfortable and convenient for the participants. These locations included the local women's centre, my home and a local elementary school, in which some participants were employed. In each case it was the women who made the decision regarding location. I made it clear that I would meet with them in whatever setting they felt most comfortable and make any necessary arrangements.

The majority of the women within each group knew each other or had common acquaintances. They also had information about my research and me. Some of the women had had limited interactions with me in the past. They knew me through my activities in local women's groups, through my teaching at the University College of Cape Breton or through family and friends. Others were informed about my research and me by the three women described earlier. That familiarity seemed to allow the women to avoid the initial unease that is often experienced upon entering a group of strangers.

Focus group interviews are being used more today "in place of or as a supplement to one-to-one interviews" (Lofland and Lofland 1995: 21). Because there are times during this type of interview in which an individual does not have to talk, this method of data collection allows the participant time to reflect and recall experiences. In addition to the fact that this often results in more information being passed on to the researcher, this method also provides the opportunity for a participant to amend or qualify initial comments (Lofland and Lofland 1995). Many researchers, such as Fontana and Frey (1994) and Janesick (1994) state that focus group interviews also provide an additional layer of information by creating a situation in which the researcher has the opportunity to observe how participants interact with each other in relation to the topic. They allow the

researcher “to capture a richer interpretation of the participants’ perspectives” (Janesick 1994: 211). “The group dynamics that occur in focus groups very frequently bring out aspects of the topic that would not have been anticipated by the researcher and would not have emerged from interviews with individuals” (Babbie 1995: 250).

The focus group interviews for this study were designed to encourage relaxed and uninhibited interactions and, therefore, followed a semi-structured format. The format of the focus group required that I, as the researcher, confine myself more to listening than to leading the group with particular questions.

The focus group meetings were one to two hours in length. Prior to beginning, there was casual conversation, as well as questions about me and my place in the community. I also offered coffee or tea and snacks, all of which are typical of most gatherings in small communities throughout Cape Breton.

At the beginning of each focus group meeting, I briefly explained the research to the participants. I explained that the study was going to form the basis for my Ph.D. thesis in Sociology at McMaster University. I told the women that the research was designed to investigate women’s thoughts and feelings about their reproductive experiences. I made it clear that I was not looking for particular kinds of answers. I wanted them to talk about what was important to them. I also explained that I hoped the discussion would be informal, that they would feel free not to respond to anything that made them uncomfortable, and that they should also feel free to ask me questions at any time during the discussion. I then directed their attention to the forms for Researcher Confidentiality and Confidentiality and Release of Information, which are included in

Appendix F and Appendix B, respectively. They were each given “Confidentiality Forms,” signed by me in order to assure them that I would not discuss or write about them in any identifiable way. I explained that I would be the only person with access to the original data. All the participants were then given “Confidentiality Forms” that they signed, indicating that they would not discuss the other women in the group with any other people. The women were also given “Release of Information Forms.” I explained that signing indicated that they gave permission for their statements and comments to be used in the research, albeit in a non-identifying way. Once the paper work was finished, I asked for permission to use an audio tape recorder. All of the women stated that they were comfortable with the focus group discussion being recorded. At that point, I turned the recorder on.

The interview guide for the focus groups was comprised of approximately eight questions. The specific questions are listed in Appendix E. I began each focus group by asking the women to tell me what sorts of things came to their minds when they heard words like periods, pregnancy/childbirth and menopause. I then asked for details about the types of experiences they had in relation to their response to the opening question. We discussed who they talked to about their experiences and from whom or what they had received information. We also discussed their use and refusal of medical interventions and treatments. In addition, I asked the women to describe how an ideal reproductive experience would differ from their actual experiences. I asked other probing questions as necessary. At the end of each meeting, I gave the women the opportunity to add anything they wanted or to ask me questions. During the focus group meetings, the issues covered

by my interview guide often arose without me having to ask the women the actual questions.

While complete elimination of researcher influence is impossible, I attempted to minimize my influence over the flow of the focus groups by interjecting questions and comments as little as possible and allowing the women to take the interaction in the direction they wanted. I encouraged discussions among the women rather than a question-answer situation between the women and myself. I also took on the role of observer as much as possible by allowing the women to talk amongst themselves. When they began conversations about their experiences, I sat back and let them talk. When appropriate, I also encouraged them to compare and contrast their experiences with the experiences of others in the group.

At the end of the focus group, I asked the women to leave the Confidentiality and Release of Information forms on the table before leaving the room. On that form the women were asked to indicate if they would be interested in participating in a follow-up, individual interview. The majority of the women involved with the focus groups indicated that they were interested in the interview. I asked that those who were interested provide a telephone number so that a time and place for the interview could be arranged at a later date. The request to participate in an interview was done in this way so that the women would feel no pressure to say yes. I had no indication of who wanted to participate in the interviews until the focus group had ended and the women had left.

As stated above, focus groups have a number of advantages including the fact that they provide the researcher with the opportunity to observe the participants interacting

with each other, however, there are also some disadvantages. According to Berg (1998), many researchers have found that the percentage of original ideas found in focus group data is only approximately seventy per cent of what is found in individual interview data. Also, others have found that “focus group data tended to make subjects’ responses more extreme when compared to responses offered in survey questionnaires” (Berg 1998: 106). Berg further explains that focus group interviews are “concentrated interactions in a short time frame.” That means that emergent observations will not be available to the researcher. The addition of individual interviews helped to compensate for some of those weaknesses.

Interviews

The primary objective of this research was to determine what issues were important to women and whether or to what extent those issues reflected a medicalized view of reproductive experiences. That objective, with a combined feminist and symbolic interactionist standpoint, meant that I needed to give the women as much flexibility and control as possible in our meetings (cf. Kirby and McKenna 1989). Otherwise, I would only learn their views about the issues that I presented to them. Following the work of researchers like Kirby and McKenna (1989), I, therefore, decided to use a semi-structured, interactive interview format. This type of interview required the development of an interview guide and consisted of open-ended questions.

[A] guide is *not* a tightly structured set of questions to be asked verbatim as written,... Rather, *it is a list of things to be sure to ask about when talking to the person being interviewed...* You want interviewees to speak freely in their own

terms about a set of concerns you bring to the interaction, plus whatever else they might introduce. Thus, interviews might more accurately be termed *guided conversations* (Lofland and Lofland 1995: 85).

Finch states that this type of interview is particularly appropriate when research involves female participants and female researchers because it resembles the ways women tend to talk to each other in their everyday lives (Finch 1984).

The interviews for this research were conducted from the winter of 1997 to the spring of 1998. They were arranged with the women from the focus groups who were interested in participating as well as with other women who did not participate in the focus groups. Forty-one women, out of forty-seven, participated in these semi-structured interviews. Of this forty-one, sixteen had participated in one of the focus groups and twenty-five did not participate in a focus group. For those who did not participate in a focus group, the interviews dealt with the same types of questions and issues discussed in the focus groups. For those who did participate in a focus group, I used the interviews as an opportunity to discuss their experiences in greater depth. Using the interviews in this way allowed me to consider the data collection in a way that did not overemphasize the contributions of those who participated in both a focus group and an individual interview.

The interviews were scheduled at the convenience of the women and the settings varied according to the women's preferences. The interviews were conducted in the homes of participants, my home, the local women's centre, or an office provided by the Department of Social Science and Practice at the University College of Cape Breton. They ranged in length from one to two and one-half hours.

Prior to beginning the interviews, I provided the women with a brief explanation of the study which included the purpose and planned use of the research.¹ As in the case of the focus groups, I explained to the women that this research was one of the requirements for my Ph.D. in Sociology at McMaster University. I told the women that my primary interest was women's experiences with reproductive issues, particularly their perspective on those experiences. I made it clear that there were no right or wrong answers; I simply wanted to talk about what was important to them. I also told the women that I would not pressure them to answer any question they did not want to answer. In addition, I informed them of their right to end the interview at any time. I offered a further sense of security by stating that if, after the interview, they felt uncomfortable with something they said they should feel free to contact me and I would exclude that information from my research. I gave them "Confidentiality Forms" and "Release of Information Forms" and explained them. Both of these forms can be found in Appendix F and Appendix G. Finally, I asked for permission to use an audio tape recorder.²

The Interview Guide, in Appendix E, lists most of the questions that I asked the women during the interviews. It is important to note that the interviews took on individual characteristics depending on the women and their participation in my research

¹ Those who participated in focus groups already knew about the research so I simply explained the purpose of the individual interview.

² One woman was uncomfortable with the recorder so hand written notes were taken. Similar notes were taken in an interview in which the recorder was not working properly.

up to that point. As a result, not all of the questions listed in the guide were asked. Some issues were also raised by the women, eliminating the need to ask some questions.

While there was considerable similarity between the interviews with women who participated in the focus groups and those who did not participate, the manner in which the discussion was initiated differed. Those who had been involved with a focus group were asked to give their impressions of that original discussion. Those who did not participate in a focus group were asked the same question posed to the focus groups: Explain or discuss the experiences that come to mind when you think of periods, pregnancy/childbirth and menopause.

At the end of each interview, I gave the women the opportunity to add any further information and comment on the interview process and content. I invited them to contact me if they had any concerns or questions about the research or their participation in it. I told them that I would contact them when the research was completed and tell them how they could access the final report. I made that promise of access because I agreed with Kirby and McKenna (1989) it was important to make the report available to them, given the focus and intent of the research itself, and the respect I had for them and the stories they shared with me. That respect was the primary concern I kept in mind throughout my analysis of the information those women shared with me.

The Process of Analyzing the Data

While I took precautions to minimize the influence I had over the women during our interactions, my theoretical perspective did guide the way I made sense of the

information the women shared with me. As a feminist influenced by symbolic interactionism, I saw the appropriateness of using Dorothy Smith's (1987a) institutional ethnography. Smith has argued that we need to examine closely the everyday lives of women but we need to consider those lives within the structural constraints that place them in a marginalized position. Women and other marginalized groups act within structurally defined boundaries. They do not act with absolute free will but neither are they mindless puppets acting out the dictates of an all-powerful system. This reality is reflected in the two strands of literature focusing on structural arrangements and lay perspectives that I presented in Chapters 2 and 3.

Within the context of this study, it was apparent that the medical system has at least attempted to set the boundaries within which women's reproductive experiences occur. In Chapter 2, I outlined the details of that reality. However, the literature I discussed in Chapter 3 indicates that while the medical system has pushed women to adopt a medicalized view of their reproductive experiences this does not mean that all women have done so. The extent to which they have or have not, depending on institutional and/or socio-cultural contexts, remains an empirical question to be explored. This case study is meant to address that question in relation to Cape Breton women.

Recognizing from the literature the complexity of the experiences I was focusing on, I knew I needed to examine thoroughly all available information. Consequently, the analysis was an on-going process. Following the basic principles of Grounded Theory, I constantly looked for themes as well as variations and divergences in the data. The issues that appeared important as well as their connections to each other were constantly being

re-examined and always had the potential to change (Glaser and Strauss 1967). The result of this process was that my analysis went through a number of transformations as I learned more from each interview and additional literature.

As is the case for most interpretive research, my analysis involved the simultaneous examination of three bodies of information: relevant literature, the raw data from focus groups and interviews, and my observations and interpretations. Two critical issues in the research literature guided my analysis: (a) women's reproductive processes have been systematically targeted for medicalization and (b) the importance of context in women's constructions of meanings.

My process of analysis is in no way unique. Feminists and interpretive qualitative researchers developed it and have proven its usefulness. This process can be labeled Successive Approximation (Neuman 2000). Neuman (2000) describes this process as repeatedly cycling through steps toward a final analysis. This meant that I began with my research questions, assumptions and initial concepts. I examined them in order to determine how well they fit the evidence, not how well the evidence fit them. This stage of the analysis began shortly after I began the data collection, and continued until I felt I had reached theoretical saturation, that is, the point at which nothing new is appearing. Adding more information simply reinforces the existing theoretical categories and their connections (Kirby and McKenna 1989).

The process of Successive Approximation is basically the same as the Constant Comparative Method from Glaser and Strauss (1967). However, the purpose of the Constant Comparative Method is to generate theory in a systematic way by using explicit

coding and analytic procedures. There are four generic stages involved: (a) comparing incidents applicable to each category, (b) integrating categories and their properties, (c) delimiting the theory, and (d) writing the theory (Glaser and Strauss 1967).

Methods of Analysis

While analyzing qualitative data can be done in a variety of ways, the basic components common to all approaches are coding, analytic memoing, time and creativity. In this research, I relied heavily on the contributions of Kirby and McKenna (1989), Neuman (2000), Lofland and Lofland (1995), and Glaser and Strauss (1967).

Kirby and McKenna (1989) provided me with a way to begin to make sense of the data by presenting a breakdown of how to create categories and properties. This process began with an initial examination of the data and documenting my reflections about that data and the process. The second step was to create what Kirby and McKenna refer to as “bibbits.” These are small pieces of data that indicate a specific, single idea. These “bibbits” were then matched to others that contained the same idea in order to create initial categories and properties. In the early stages, I based the categories and bibbits on the questions that I had asked the women during the focus groups and interviews. Kirby and McKenna’s (1989) Hurricane Thinking was extremely useful for identifying relationships in the data that resulted in my initial categories. Hurricane Thinking is a moveable diagram of the categories found in the data. The idea is to write the research question in the centre of a piece of paper and write the categories on separate, small cards or pieces of paper. This allowed me to examine and re-adjust the organization of the

categories. However, with re-examination, I realized that my initial categorization of the data reflected my expectations more than they explained women's experiences. As I moved more deeply into the analysis, new categories emerged based on ideas (bibbits) that more accurately reflected the experiences of the women.

I reached a point in the analysis at which I felt that I needed to view the data and my initial analysis with fresh eyes; from a different position. The discussions of coding and memoing by Neuman (2000) and Lofland and Lofland (1995) provided such a fresh approach. According to Neuman (2000), a good thematic code is one that captures the qualitative richness of the phenomenon. Memoing is the creation of extended notes that the researcher writes as descriptions or explanations for the meaning of the codes.

Lofland and Lofland (1995) discuss the practice of Concept Charting. It requires that distinctions be made between the more important and less important categories by constructing a diagram using overlapping circles of different sizes. The larger circles represent the more important categories and smaller circles represent the less important categories.

Following Lofland and Lofland's Concept Charting, I created circles for the categories that had emerged to that point. The size of the circle for a particular category was based on the degree to which the participants emphasized or alluded to it in our discussions; in other words, how often it was actually reflected in the comments of the women. The use of Flow Charts, as described by Lofland and Lofland (1995) added another useful dimension to my analysis. While functioning in the same way as the Concept Chart, Flow Charts add the element of time or process in relation to how the

relationships in the data are organized. The use of those methods of analysis encouraged a continual revisiting of the data and previous ideas. The result was many transformations of my interpretations.

At every level of analysis, I attempted to retain the meanings and interpretations of the women I studied. My own theoretical conceptualizations were grounded in their understandings. As an interpretive sociologist and a feminist, I attended to the importance of the complexity of meaning construction and the relationship to context. To ensure this, I relied heavily on quotes from the women. I did this so that while my interpretations and women's words came together to tell a story, they can also be examined separately. To conclude, the women involved in this research have made a contribution to the growing body of literature on lay perspectives that help us understand women's meanings and actions within a context.

Conclusion

As this chapter has illustrated, feminists and interpretive sociologists have informed us of the numerous issues that must be addressed to ensure that the research objectives are attained. Each step in the research process requires that choices be made and those choices have consequences for the overall research project. By relying on the methodological contributions of people like Devault (1990), Reinharz (1992), Kirby and McKenna (1989) and others, I am confident that the decisions I made regarding this research were appropriate considering the research objectives. I made decisions with the

understanding of the interconnectedness of the various research steps. I made sure that the substantive issue remained the touchstone in the decision-making regarding theoretical/methodological decisions, sampling technique and data collection methods.

The following chapters represent the results of the methodological and analytic decisions I made. They are the most accurate descriptions that I could construct of the thoughts, feelings and actions of the women who spoke with me.

CHAPTER 5

WOMEN DEALING WITH THE MEDICAL SYSTEM

Introduction

The goal of this thesis research was to explore what Cape Breton women thought and felt about their reproductive experiences within a social context fraught with economic, health, and environmental problems. Although the methodological process informing this research was, for the most part, open-ended, my analysis of the data led me to organize these women's perceptions of the important issues in their lives around three general topics. First, I consider their experiences with, assessments of, and responses to medical professionals. Second, I examine the significance of mothers, sisters, other female friends and past experiences in understanding and experiencing reproductive processes. Finally, I discuss the influence of Cape Breton culture and ideology on the ways women not only thought about their reproductive experiences but also dealt with the medicalized view of these processes confronting them. These topics are discussed in chapters 5, 6 and 7 respectively.

In this chapter, I focus on women's experiences with medical professionals and the structural contexts within which they occurred. As these interactions are isolated for examination, the ways in which other sources of information influenced decision-making are not reported in this chapter. Rather, my focus is on the perceptions women had about encounters with medical professionals themselves. The overriding theme to be considered can be subsumed under the rubric: medical practices and issues of control.

Medical Behaviours and Practices: Issues of Control

The women in this study provided many examples which they felt illustrated attempts by medical professionals to exert control over them. Unless otherwise noted, the medical professionals referred to in this chapter were physicians. My analysis of the data pinpointed the following professional practices in doctor-patient interaction as contributing to this perception of control: (1) the adoption of the role of the expert; (2) the use of professional medical terminology; and (3) a reliance on diagnostic tests and technology. Other practices embedded in institutional assumptions about the medical profession included ignoring or discounting the lay knowledge women could provide about their own reproductive processes and objectifying women as specific biological processes rather than as whole persons with an integrity and dignity of their own.

The Medical “Expert” and What This Means for Women

As I discussed in chapter 3, numerous studies have focused on doctor-patient interactions and the influence physicians have on how women feel. In this study, it became clear from the women’s comments that they believed that medical professionals felt themselves more knowledgeable experts than the women they were treating. Several women felt, for example, that the medical professionals they encountered did not provide them with any information; nor did they communicate in an effective manner. These women believed that this poor communication reflected physicians’ assumptions of their own expertise and

their belief that women were not well informed and, therefore, could not understand things even if they were explained.

In the past, when some of the women in this research were young and inexperienced, they reported that they behaved as if they agreed with this perceived medical view of women. They admitted giving the situation little thought. For example, Beth explained that thirty years ago, when she was having her children, “it was umm, ah, well, you just got pregnant and you did what the doctors told you.” Women did not even consider the possibility of contributing their own ideas, at least within the context of the doctor-patient interaction. However, the behaviours, attitudes and expectations of the women reported in this research, dramatically changed with increased personal experiences. For many of them, however, the perception remained that medical professionals fail to acknowledge women’s expertise in their own reproductive experiences.

The idea that medical professionals placed no value on women’s expertise was related to the belief that medical professionals did not listen to women and dismissed the knowledge they had of their own bodies in favor of the “objective” knowledge of science. This behaviour was perceived to illustrate the medical professionals’ beliefs in their own expertise and superiority.

However, the women in this research, when talking to me, questioned and disagreed with medical professionals’ comments and actions. In this way, they indicated that they did not accept an entirely medicalized view of their experiences. Nor did they believe medical professionals had the ultimate authority or expertise in matters of

reproductive health. On the other hand, many of the women believed that medical professionals viewed themselves in that way. Many of the examples women presented to me were specifically tied to their own perceptions of what medical professionals thought. These perceptions were primarily based on verbal interactions the women had with their physicians and fell under the general themes of: (1) viewing women as a homogeneous group, (2) objectifying women and their bodies, (3) giving women a false sense of control, (4) demonstrating a lack of empathy, and (5) having an almost complete reliance on tests and technology. I will now consider in greater detail these themes.

Women as a Homogeneous Group

From the perspective of the women who spoke with me, medical professionals were perceived to deal with variables, averages and probabilities, not individuals. In essence, my participants felt that the medical system approaches women as members of only a few homogeneous groups distinguished by age and reproductive processes. Thus, menstruating women were perceived to make up one group. Pregnant women made up another group. And pre- to post-menopausal women made up a third group. Notably, this theme reflects similar observations made in health related research. For example, we see this theme in Graham and Oakley's discussion of the "as if ill" rule in their article, "Competing Ideologies of Reproduction: Medical and Maternal Perspectives on Pregnancy." In relation to pregnant women as a group, they found that doctors routinely made use of "tests and procedures such as ultrasound scanning, twenty-four hour urine collection for the measurement of placental function, and frequent internal examination"

without any real consideration of the individual woman or her circumstances (1981: 57). Sandra Coney's book, *The Menopause Industry*, also calls our attention to the idea that women are placed into homogeneous groups based on reproductive functions; that individuals' experiences within these groups are rarely the main concern of doctors. She states, in relation to the widespread recommendation of hormone replacement therapy:

The medical viewpoint is commonly biased by the ideology of medicine, which proceeds from the injunction to diagnose and treat. This is all very well when the object of interest is a sick person who has sought help; it is less appropriate when applied to populations of well people who have not asked to be treated...

A minority of women *will* experience ill health or problems related to menopause... but the majority will not. There is something essentially irrational about persuading the majority that their wellness is conditional and that they can only ensure their good health by becoming preoccupied with disease (1994: 13).

Some women in this research directly mentioned the idea of women as homogeneous groups and it also emerged as a theme during my analysis. I noticed that women felt that medical professionals were not responding to or treating them as individuals but rather as examples of the "average" woman. Women appeared to believe that medical professionals made assumptions, suggested tests are not based on their age or their particular circumstances. Jean, for example, told me about a specific interaction she had with her physician that illustrates this perception. In her forties, Jean said that she began to experience headaches, something unusual for her. She said her physician immediately assumed that she was peri-menopausal, wanted to send her for hormone tests and suggested that she begin taking HRT even before seeing the test results. Another woman who became pregnant in her forties was immediately encouraged by her physician to consider an abortion because of her age and the complications that might have resulted. In both instances, the women indicated that they felt that the medical

professionals were simply and unquestioningly applying the “most likely” scenarios for women of their ages, rather than considering the particular, and possibly unique situations of the individuals sitting in front of them.

As Marie said, one of the consequences of approaching women in this way is that “the system, it takes the humanity out of people,…” Further, the depth and detail of the individuals’ information were not considered in the physicians’ decision-making process. Another consequence of this approach was that women came to assume that their views and opinions did not count in interactions with medical professionals. They felt that they were expected to trust the “experts” despite what their bodies told them. That clearly appeared to be the case for Carla. When in her early forties, she observed:

Now I’m going into menopause and umm, I went into my doctor. I thought I was anyway [entering menopause]. I had missed a period for three months and then I had one. Then I missed for two months and I had another one. And I went in and I told her, “I think I’m in menopause.” I’d attended a menopause workshop here [Every Woman’ Centre] and ah, she said, “What makes you think that?” And I told her and she said, “Well, there could be all kinds of reasons for uterine failure.”

Carla appeared to be a woman who was fairly confident that she knew what was happening to her body. She felt the physician was being dismissive of her conclusion, however, and of the possibility that she understood her own body. Indeed, her physician went on to suggest the need for medical tests, implying that she should rely on these tests rather than her own understanding of how her body was changing. Although the context of these exchanges differed, with one group of physicians adopting a “most likely” diagnosis and another dismissing it, the common element was a dismissal and/or inattention to the woman’s point of view.

Other women discussed similar situations, many in relation to menopause. Particularly common were comments from women that they were bothered by medical professionals continued insistence that they take HRT, even after they had rejected this treatment. A number of women felt that their individual circumstances and what they wanted were being overlooked in favor of what the professionals had been taught the “average” woman needs. For many of the women, such persistence on the part of medical professionals was an indication that they placed no value on what the women themselves thought or wanted. That was definitely the case for Debra who explained:

Now my heart doctor wanted me to take it. He said that the benefits far out weighed the risks. But to me they are just statistics. He was adamant to the point that I felt uncomfortable going to his office.... It was based upon his knowledge of things he'd read. I truly felt he wasn't treating me individually.

These women felt that they were being viewed and treated as nothing more than examples of a homogeneous or average group. Their knowledge of their own bodies was being ignored. They felt that the uniqueness of their experiences was being denied or overlooked. They felt objectified.

Objectification of Women and Their Bodies

The objectification of the female body has received considerable attention from researchers for many years. While it has been an important issue in research examining the social perceptions of women's bodies, it is rarely explicitly discussed in relation to the reproductive experiences of women. The women in this research felt that they had experienced such objectification in two specific ways related to reproduction. First, some

of the women felt that medical professionals did not allow or expect them to express a sense of personal modesty during examinations or medical procedures. Second, women believed that medical professionals, rather than talking directly to them, had a tendency to talk about them with colleagues or other family members. A number of women had experiences with one or both of these situations and felt that medical professionals seemed to forget they were observing, treating or assisting a person. The experiences women recalled resembled the treatment a specimen in a petri dish might receive or a child too young to make decisions for her/himself.

A specific experience tied to the issue of modesty was described by Carry. She explained feeling uncomfortable during a medical examination in which the physician expected her to undress in front of him. It was only after she made her discomfort obvious to him that he left the room until she undressed and covered herself with the sheet. However, when he returned, his behaviour made her feel like he was mocking her modesty. She explained:

The gynecologist I went to see when ah, what was his name, I can't think. Oh [physician's name] and oh not a very nice bed-side manner and ah when he told me to get up. He said, "Ok, I'll get you to get up on the table, ok?" And he just stood there. And I went to open up my pants and he just stood there looking at me and I said to myself, "I'm shocked" and when I sort of looked at him my face must of said it all, you know, and he went "Oh" and he left the room. Now, ha, I don't know if it was just that it was routine like "Huh, get up there" like there's no big deal or whether that's how he got his jollies, I don't know but it was extremely insensitive on his part, you know. Cause that's a very sexual thing, undressing, right. When and I, I didn't catch myself right away and I started to open my pants and he well when I saw him looking at me I thought, you know, the light goes on and the flag goes up [laughter] but he moved pretty quick. Yea, didn't apologize but he did move. And then when he came back he made a big deal of it [he knocked on the door loudly she illustrated] "Are we ok in there?" so I thought then he was over-compensating for it.

Other women also addressed the issue of modesty when they commented on the many strangers in the form of medical professionals who observed them during childbirth. Carla, for example, while describing her first childbirth experience, seemed amazed at the number of individuals who went into the delivery room to observe her. She said:

With my first pregnancy they were training every student in St Rita's Hospital. And ah, I don't know what women were, men, women -- You'd look down and there'd be arms and you didn't know who's arm was [laughter] and there was this crowd [laughter] and you do you lose all sense of, you know. You just become, no, you don't become, I don't want to say, you don't become a piece of meat because you don't. It's still a whole wonderful, wonderful thing but you lose your sense of "I'm somebody"...

As in the case of Carla, it was rare that anyone asked women for their permission to observe the process. It was also unusual for any of the strangers to talk to the women or even make eye contact with them. They felt they were treated as objects or body parts.

Typically, at least in the case of childbirth, women did not question or challenge the behaviours of the medical professionals. During these experiences, the women were preoccupied with what was happening to their bodies and the child they had been waiting to see. With such priorities, modesty was not an issue in the moment. The dissatisfaction or discomfort was something women expressed after they had time to reflect on what happened. As Carla said, "you lose all sense of modesty":

[Y]ou become part of something bigger. I don't want to give you the impression that it's, you know, -- All these students and they were all terribly excited and interested and they were part of something that is happening to you. They, you weren't outside of what they were doing. But you do, by that point, you don't care [laughter] (Carla).

However, as can be seen by women's comments, the fact that they did not do or say anything in the moment did not mean that they were satisfied with the situation. That they

recalled such events as they did indicates a level of dissatisfaction with the manner in which they were treated. It was somehow tolerable, at least in childbirth, because women put the incident into the overall context of having a baby.

The experience Beth recalled, like some other women, was not related to modesty but was still experienced as objectification. She felt she was being treated as an object that others made decisions about. There were some complications during the delivery of one of her children and instead of discussing the situation with Beth, the physicians stood over her discussing what they should do to her and the consequences of their actions. It was as if she wasn't there. Beth explained:

So he went and woke up the intern and called the doctor and the gynecologist and umm they made a decision over my belly. I'm laying in the bed and there are these two men in suits over my belly and umm, you know.... But they were discussing the percentage of mental retardation if we left the pregn – left the labour or umm, "How soon can we get her to the --?" you know, "How soon can we have the section done?" And I was laying there in the bed with these men discussing 10%, 15%, you know, and ah that was horrible. That was really – now mind you it all worked out well.

Another woman, Carry, told a similar story but in her case the physician spoke to her husband rather than to her. They were going to make decisions for her. She became angry and her husband decided to support what she wanted.

Many of the women identified these objectifying situations as attempts by medical professionals to control the process and the women themselves. Further, these women felt that the medical professionals viewed themselves as experts who did not need to take women's thoughts and feelings into account.

It is apparent that these women felt uncomfortable and dissatisfied when they felt they were being treated like objects. However, some women did not recall experiences of

objectification but rather talked to me about false control. They claimed that medical professionals did not want to be accused of objectifying women and consequently made promises that the women would have control over what happened to them. The problem for the women concerned was that physicians did not follow through on those promises.

Giving Women a False Sense of Control

The medical and technological advances available for reproductive experiences have dramatically increased over the past fifty years. Typically, these advances were presented to women in this study as options or choices. In addition to these advances, many medical professionals claimed to pay more attention to the social and psychological aspects of reproductive experiences, which should have led to more options and choices for women. Indeed, relatively effective methods of birth control and HRT as well as the availability of alternative birthing procedures give women the impression that, in a medical context at least, they can choose and control what happens to their bodies. Further, freedom of choice implies that the individual has a certain degree of control over an existing situation. However, several of the women in this research felt, in relation to reproductive experiences, that this was more image than reality. They felt that medical professionals had misled them and given them a false sense of control.

Some women questioned the validity of the belief that women have any control in a medical context. Other women, who initially believed they had such control, concluded after personal experiences that there was a significant difference between what women were told and what actually happened.

Marie directly raised the question of who really has control when women use medical interventions and treatments and implied that perhaps women are being misled. She said:

It gives you a certain sense of autonomy and freedom umm to like be making your own decisions about when you want to get pregnant or ah whether you want to take hormone replacement or not. Umm in another sense it is an intervention that's controlling you and you ask to whose benefit is it really....

Several other women alluded to having such thoughts by commenting that many medications intended to alleviate symptoms also had side effects that concerned them. Situations involving such medications, therefore, were not situations in which women had control or the power to choose what was best for them. Rather, it became a process of choosing what was least harmful.

This feeling of false control was even more apparent in relation to female oriented birthing procedures. As Sue observed:

She [the doctor] like wanted to discuss how I wanted to have the baby born, like. I had to fill out this form. I think it was ridiculous now that I think about it cause it was like if you wanted the lights on like when you were having the baby or dimmed or if you wanted to like feel the baby's head when it was being born or have the father cut the cord. Now I didn't know about that part of it cause her father wasn't there but umm. So I said, "Oh, yea, I'd like it if the lights were dim" and that stuff but none of that happened cause... sixteen minutes and I had, the legs went down and bing, I had her. It's like it wasn't any time for them to say, "Ok, I'll turn the lights down cause that's what you wanted." Stupid piece of paper and the doctor had spent so much time going over it.

Clearly, attempts by medical professionals to provide Sue with choices were negated by the natural processes resulting in a quick birth. Ultimately, for Sue, this sense of control became illusory as events beyond anyone's control occurred. Sue felt she had been misled, however, by a process that had suggested that there was control to be had.

While the lack of real choice was clearly a concern for many women, equally important to some was the false impression they felt they were given that medical professionals *wanted* women to *have* control or choices. Many women viewed this as nothing more than “lip service.” That women came to such conclusions illustrates the negative undercurrent of their feelings about medical professionals and practices. Many women believed that medical professionals did not make their decisions based on what a woman thought was appropriate or what she wanted or did not want. Jane, who had given birth to her first child less than a year before she spoke with me, recalled an experience that illustrates this view. She was visibly annoyed by the experience and explained:

It's a crock! At the end of my pregnancy the [the hospital] gave me this form to fill out -- things I wanted and didn't want -- like drugs, being prepped, episiotomy, even the lighting in the room. So I filled it out. I thought it was great that they were askin'. I have friends with kids and nobody asked them. But when I went in to have my daughter it was like I'd never filled it out. They just did what they pleased. Almost like I wasn't even there.

Such experiences appear to be relatively common for women. As Oakley explains, once in the hospital women have little, if any, control over the process:

[T]he concept of choice as applied to users of the maternity services is nowhere in sight in the medical model of motherhood. Although many surveys of how women feel about their maternity care show that many wish to be consulted about what kinds of medical treatment they receive, the obstetrical claim to unique expertise prevents the exercise of choice by those who have babies (Oakley 1993: 23).

Similar statements were expressed by many women in this research. Indeed, they believed that medical professionals wanted such absolute control, a finding documented in other studies as well (cf. Oakley 1993; Crook 1995). Although it has been well established in this study and others that medical professionals appeared to want such control, this did not mean that women gave into them, however. Nor was the illusion of

control the only issue women raised in relation to medical professionals. I will now consider other methods of control indicated by the women who participated in this study.

Language Use and Empathy

Strongly tied to women's perceptions of false control and the more general idea of medical expertise were the issues of language and empathy. The way these issues played out in the experiences of women provides us with further insight into why women felt the way they did about medical professionals and the influence their words and actions had on reproductive experiences.

Language.

The issue of language was of particular interest to me when I began this research, and the women who spoke with me confirmed its importance. My initial focus was on women's use of medical terminology. I was curious to find out whether they used such terminology to describe their reproductive experiences. I thought the use of that terminology might indicate women's acceptance of a medicalized view of reproductive experiences. For the women, however, the issue of language was much more complex. Many women made it clear to me that they did not generally make use of medical terminology to describe their experiences. More important, however, were women's feelings that they were confronted with completely unfamiliar terminology that typically had a negative connotation and sometimes made them feel stupid or vulnerable.

Carla described an interaction she had with her physician in which she was confronted with unfamiliar medical terminology. She went to see her physician because she believed she had begun menopause. As noted earlier, her assumption was not only questioned but she was confronted with the medical term, “uterine failure,” which immediately affected her. She explained to her physician the body changes she was experiencing and the physician responded:

‘Well, there could be all kinds of reasons for uterine failure.’ And I thought, ‘Mmm.’ I didn’t like that [the label], like that’s a scary thought. Uterine failure, first time I ever heard that term. And when you put the ‘failure’ in, it sounds like I’m doing something wrong. What did I do wrong to cause uterine failure?

Carla’s response was typical of other women who had heard such medical terms from their physicians. The implication for these women, as Carla said, was that they had done something wrong or failed in some way. Karen, for example, had a similar experience when she was told that she was menopausal. Because she was in her thirties, however, the gynecologist labeled it “premature ovarian failure.” Like Carla, Karen described the term and the negative connotations she felt were associated with it. She said, “they call it premature ovarian failure so that really makes you feel like ha, like a big failure, you know, with that word right away.” Similarly, other women experienced feelings ranging from annoyance to anger when physicians used terms like “spontaneous abortion.”

Karen also explained that the terminology used by physicians made her feel stupid and, as a consequence, she pretended to understand. “Well, when I walked out of the doctor’s office the first day [after she found out she had “premature ovarian failure”] I felt like I was a total idiot cause he started explaining things.” Aside from the term,

premature ovarian failure, she found many of the gynecologist's questions and comments difficult to follow. She said:

When I went to the gynecologist, you know, they start asking questions about your cycle, estrogen and progesterone, you know, and I'm – and he was saying, "You following me? Right?" And I said, "yea." And I'm thinking, "I don't have a clue what you're talking about. When I get out of here I'm going to find out. I'm gonna be informed for my next visit." But it was just a lot to – he kept, you know, throwing this stuff at me and that I was really advanced menopause and I had to really get on estrogen right away cause my body had been without it for a long time and, you know, -- so with this, it's all like racing through your head and you are trying to, you know, grasp what they're saying.

It was clear that the lack of familiarity with the label for her condition made Karen feel vulnerable and more susceptible to medical control, at least during that interaction. Her experience, like so many others, illustrates the tie between language and control. As I discussed in chapter 2, controlling access to terminology is one of the characteristics of professions. For some women, the use of terminology served to heighten feelings that they were somehow inferior. It also made them feel that medical professionals were not genuinely concerned with the impact of these negative connotations on the women concerned. Paradoxically, such situations seemed to intensify women's desires to become knowledgeable about medical terminology. They felt that familiarity with the terminology was the only way to effectively interact with these professionals and make informed decisions about the medical advice they were receiving.

Lacking familiarity with medical terminology and being confronted with its negative connotations seemed to result in feelings of annoyance, inferiority or vulnerability for these women. These feelings also had the potential to keep women off balance and, therefore, hindered their ability to object to what was being said or done. As

in the case of Karen, other women pretended to understand and/or agree with medical professionals in order to avoid appearing ignorant. The consequence was that, at a superficial level, women appeared to accept or agree with a medicalized view of their reproductive experiences. However, the women explained that they actually found such terminology offensive. They only familiarized themselves with its meanings in order to present themselves as equals in their next encounters with medical professionals.

Learning the terminology became part of a process of *taking back* control. Indeed, some women who developed a familiarity with the terminology thought it gave them an advantage in their interactions with medical professionals. They felt that if they effectively used the terminology, interactions would be more successful and medical professionals would treat them as equals. Liz, for example, when she was pregnant believed her doctor reacted to her differently than other women because she was familiar with the terminology and used it:

I read a lot of stuff and I think that that really helped because umm I think it helped me to understand more things that my doctor said to me. And I think it also helped me in framing questions for my doctor because I had a basis from which to develop those questions. And I think when he realized that I was really interested and that I had umm done some reading and found out some things on my own he was very willing to go along with that and to discuss things and answer questions.

This is interesting, not only because she believed she was treated differently, but also because Liz's underlying belief was that in order to be taken seriously, she had to familiarize herself with medical language. Her own personal expertise was not sufficient to gain her the respect she sought from her doctor.

It was not just the terminology that medical professionals used that made women feel uncomfortable and dissatisfied. The women in this study discussed similar issues in

relation to the way medical professionals said things to women or the tone they used.

Despite variations in content, one of the most common themes that emerged was women's perceptions that medical professionals failed to display empathy.

Lack of Empathy.

In a number of instances, women perceived a lack of empathy on the part of medical professionals. They specifically described instances in which a medical professional's method of communication or tone of voice left them feeling much like the women confronted with unfamiliar negative terminology – uncomfortable and inferior.

While there were exceptions, a significant number of the women recounted experiences that led them to conclude that medical professionals were cold and unfeeling. Such behaviours, in relation to pregnancy, for example, were particularly upsetting to women and again help us understand women's lack of reliance on and trust in medical professionals.

Several women identified instances when they felt they were harshly criticized or were addressed with sarcastic comments that served no purpose except to make them feel badly. Early in the interview with Carla, for example, she described an experience she had with her first pregnancy:

I went in [to the hospital] and umm my water had broken at home. I was on my own. I called my husband to come from work and he took me in. And when I got there I sat on a chair. It was a cloth chair and I, still more water was coming out every now and then when I'd move a little. And I remember a nurse got angry with me and she said, "Didn't you know to put on a sanitary napkin!?" But I didn't know. I just, I was upset and excited about going to the hospital. I just got dressed not thinking more was going to come. And I was telling her, I went up in the elevator with her and I

was nervous and I remember telling her that umm, “Oh, I had two contractions at home and they were really hard.” And she said, “Well, you wait!” She said, “They’ll be, they were just tickles!” So I think that set the stage for my first delivery, that I was so uptight – and this woman had three children! I was so uptight waiting that I kept thinking, “This is going to get worse. This is going to get worse.” And it hadn’t been any worse than those first two contractions but I didn’t know that. That, that, I did find the first delivery difficult. So umm, I think you really need a lot of supportive women around you.

Beth also felt that the way the nurse responded to her during labour with her first child was unfeeling and impacted on her experience:

I was in the bed and ah umm and ah I was in the labour bed and I couldn’t believe the pain and I was hanging on to the side and I said to her [the nurse], “I didn’t think it would hurt this much,” and she said to me, this is the nurse, and she said, “That’s what they all say, dear.”

Marie made similar observations:

An amazing empowering feeling of being a woman... And that’s why it is so upsetting to me that everything that the system said I should be doing ah in regards to being pregnant was so cold and unfeeling and it took away the umm just wonderment of it all umm but like when I was away from anything I had to do regarding the system itself, it’s just, it’s such a strengthening sense to be pregnant and to be carrying a baby.

However, in her interactions with medical professionals about her pregnancy, Marie felt that they lacked empathy for her and her situation. Further, this lack of empathy was tied to her having no control over the system and how it worked:

The first thing that comes to mind is frustration with a system that doesn’t work and umm. Umm, I could not find a doctor in Cape Breton, umm, even though I was pregnant and ah through many phone calls of rude nurses and umm after six, umm sorry it was actually four months, umm going through the university here trying to find and begging with them to try to get me an appointment and more rude nurses that I finally got a doctor’s appointment.... the second time I was in, I was supposed to because of all my test results and stuff were late and I’m, I was thirty-five going on thirty-six, there were certain things and issues I needed to deal with and think about.... she had me see her intern which knew nothing about me and told me that the tests came back and they didn’t do what they were supposed to do and in order for me to make decisions I would have to go back and do more blood tests. Well,

when I went to the hospital to do more blood tests I found out that the doctor had not given them the proper information. So I went to the hospital and I said, “please, I need a new doctor. I have no faith in this doctor.” So the head nurse at the hospital phoned my doctor and said I was unhappy with her so she said, “Fine. She can go somewhere else.” I said, “That’s not what I needed you to do. I need a new doctor before I --” It took me so long to find one.... So I’m here I am now at five months with no doctor still and no tests or anything done and I’m phoning the nurse, the head nurse, saying, “Have you found anyone?” She wouldn’t return my phone calls.

Karen also described a lack of empathy but her comment was directed more specifically toward the medical system as a whole rather than toward interactions with professionals. She explained that having one medical specialist dealing with both pregnancy and menopause caused unnecessary discomfort for menopausal women, like herself who had experienced “premature ovarian failure.” As she observed:

You go sit in the gynecologist’s office and you look at other women. They’re all pregnant and you’re sitting there and it is the total opposite and I really feel for women that are menopausal. They feel crummy and eekie and kind of in the stage of their life where, you know, the change of life, that’s terrible – I think that’s awful! It’s like your life is over. When you see all these young women pregnant. It’s terrible. They should have gynecologists who deal with menopause and menopause only and it should be a real cheerful place where women go and they’re entering a new stage of their life where they’re gonna have a lot of new freedom and they need to take good care of themselves and know what’s going on with the choices they have to make and – it’s kind of – and the perception of the change of life – it’s like it’s really eekie. It’s terrible.

According to Karen, the arrangement makes menopausal women feel badly about their bodies because they were forced to sit in a waiting room with women who were doing something they could no longer do – become pregnant. The inattention of the medical system to this possibility reflected, for Karen, its lack of concern for the feelings of the people it supposedly treated or helped.

Similarly, Nina felt, when she was in the early stages of a miscarriage, that her doctor viewed her situation as nothing more than a nuisance to him. She felt that he wanted

to perform a D-and-C immediately in order to make his life easier. The lack of empathy perceived by Nina caused her extreme emotional upset. From her perspective, the physician saw his own inconvenience as more important than the emotional turmoil she was going to experience as a result of terminating her pregnancy. She explained:

It really upset me because when I was in the hospital spotting, the doctor was trying to convince me to have a D-and-C. And I think he was pushing for it because he just didn't want to get called back in the middle of the night. I really didn't think I was getting what I needed – the emotional support – because I was feeling like I hadn't done what I should to take care of myself... Emotionally, it was months, months after before I got over the loss. You can't put closure to it because you never get to see what they take out. It was a person but I never got to say goodbye....

Another dimension of lack of empathy, according to some women, was the tendency of medical professionals to think of reproductive experiences as isolated biological events. Given that reproductive experiences are normal biological functions, not illnesses or diseases. They are inseparable from the social and psychological aspects of women's lives. Women, however, felt that medical professionals failed to consider the interconnectedness of life. As Karen observed when she interacted with the doctor about premature ovarian failure:

He was really good to explain a lot of things to me and then he sent me for some tests and that and really explained a lot. But even when they explain it to you, they deal with the physical things, what's happening to your body, you have to take this medicine because at your age you desperately need estrogen and there are going to be some major complications if you don't take this medicine. But they don't really prepare you for the when they tell you that you are never going to have any children and this is it. Like , you have to deal with this and umm – It's a bit of an adjustment. It really throws you off and it doesn't matter who you – like I was never really one that was ah – I mean I've always worked and I've always thought family was important and I always knew I wanted children but it wasn't like a driving force in my life....

The negative impression that women in this study had of medical professionals was tied to this perception that they only concentrated on the physical aspects of a woman's reproductive experience. Given the social and psychological aspects of these experiences and the types of interactions described above, it is understandable that many women perceived medical professionals as cold and unfeeling.

The recollections of these women illustrate that it was not simply what women heard from medical professionals but also how they interpreted it that affected their experiences. As can be seen in Beth's memories of the nurse, her sense that the nurse was being critical and condescending served to create anxiety, fear and self-doubt in her as she was going through a new and unfamiliar experience.

It is interesting to note that in addition to their belief that medical professionals use language that intimidates women and that they do not behave in an empathetic manner, women also noted their excessive reliance on tests and technology. It might be that such reliance, at least in part, explains medical professionals' adoption of a cold and detached attitude regarding those experiences. I will now examine that reliance and how women interpret it.

Reliance on Tests and Technology

Many of the women in this study indicated that they felt that medical professionals viewed tests and technology as more valid than women's experiential knowledge. That reliance on technology was particularly relevant in relation to pregnancy and menopause.

Some women also implied that this reliance was manifest in and exacerbated by increasingly excessive testing.

For example, some women indicated to me that the average number of ultrasounds during pregnancies was four or five. As Carla said:

They started the ultrasounds just a few months after I had my last baby. Umm and they seem to have some that are going in almost every week. You hear some having another ultrasound, another ultrasound. And I wonder how, are they using us as guinea pigs or.... At least four or five [ultrasounds], really. That's the normal. That's the average, yea. And some people have many more.

According to several women, medical professionals also routinely requested other tests, like amniocentesis, for women who they assumed to be beyond the “normal” age for a “safe” pregnancy. These women felt that such tests were often ordered without serious consideration being given to whether they were necessary for the individual. Some women also told the doctor that tests were ordered even when they indicated that the results would not alter their decision to continue the pregnancy. As Carry commented, under such circumstances the tests only served to create anxiety for women because they were placed in a position of constantly wondering if anything had been found or if there was a problem. If there was a problem found, knowing made the pregnancy more difficult. In such circumstances, women did not consider medical professionals to be concerned about the impact of these tests on the individuals.

Many of the women in this research indicated that they felt that women were being subjected to too many tests, interventions and treatments. Further, it was not only the issue of over testing that was a concern for women but also whether the tests

commonly performed were of any real use. As Jean said:

I wonder if it has made a measurable difference in the health of mothers and babies. Is there a measurable difference in the health of babies? All these visits for it are relatively the same.... You know, with some kinds of conditions, I think they would know in time anyway. By the time they would, you know, they would know this, it might be too late for the person who might want to terminate the pregnancy.... But I mean people like my daughter who has two healthy children and she's pregnant again and she's due November 10th and ah she's still making all these almost the same visits, you know.

Carla made a similar comment, comparing what was done to women her age to what was done to women her grandmother's age:

Like our grandmothers' age women didn't go and have to be tested to death. It seems that we are being tested to death now with umm. It could be good but then again, I think it keeps women on the edge. You're worried. You're wondering whether they're going to find something or think they found something. And ah women years ago didn't go through all this and they seemed to live fine or the majority of them did anyway.

That attitude combined with the information she had collected regarding the accuracy of tests, like mammograms made her skeptical about their usefulness. As she pointed out:

But I don't know there's so many things happening with women today – mammograms, things like that. I've had two. I umm, my doctor said, "You should have one every two years and I don't feel confident in them. There was a study done recently that was out that said umm that the ah over 50% or 50% of them umm, they used too much radiation. The films were overdeveloped or underdeveloped and ah so I don't have the confidence going there.

Carla indicated that she carried these opinions over into her behaviour. She said that her physician wanted to send her for hormone level tests. As she explained, "she [doctor] is going to give me a blood test and see how my hormone levels are and I thought, "Well, why do that? My body knows what my levels are and it will adjust. And if I'm going to have a problem, I'll be the first to find out. Not you or the tests or whatever, you know." Jean had a similar reaction when her physician wanted to

determine her hormone levels. The physician instructed her to go to the hospital for the blood test months before she spoke with me but she had not gone and had no intention of going. The attitudes and behaviours of both Carla and Jean not only indicate skepticism about tests but also demonstrate women's resistance to the idea that medical professionals were experts who always knew best.

Several of the women in this research expressed similar attitudes regarding medical professionals and their use of technology. Marie summed up the feeling of a number of women regarding the use of tests and technology. "So it's, you know, you think with modern technology things should get better, when in actual fact we are being controlled by the systems themselves." She also added, "childbirth is, it's such a special time and the system takes that specialness away from you. They rob you of that of the joy."

Control was clearly one of the dominant themes in women's images of the medical system. In the following section – "Doing To Women," I explore this theme specifically in relation to medical professionals' actions. Whether women felt that medical professionals viewed them as members of a homogeneous group, objectified them and their bodies, gave them a false sense of control, failed to express sufficient empathy or relied too heavily on tests and technology, women appeared to be left with the sense that the professionals' intention was to maintain control over women's reproductive processes.

Medical Actions: Doing to Women

The relatively common skepticism women expressed in relation to medical professionals became even more understandable as they described their own personal experiences to me. Their examples were numerous and clear cut. They conveyed what these women were, and still are experiencing. Medical professionals appeared to be “Doing to Women.” This “Doing to Women” is most easily understandable as an extension of the issues of control and more specifically objectification of women discussed above. Women experienced objectification when physicians talked about their bodies as things and when women felt their opinions and concerns were being ignored. In the case of Doing to Women, I am focusing on the actions of physicians that seemed to result from such attitudes.

Based on the comments of women, “Doing to Women” was classified into four types of actions. The first involved medical interventions and treatments without consultation with or consent from women. The second involved the physical restraint of women in order to force compliance. The third was the control of women’s medication. The fourth was medical professionals dictating the presence or absence of women’s significant others during reproductive experiences and/or examinations.

Interventions

The use of medical interventions without consultation or consent occurred most often in circumstances related to pregnancy, but not always. Marie, for example, described

an incident when she was the birthing coach for her sister-in-law and observed the use of such a non-consensual intervention. She said that she was horrified when the physician performed an episiotomy during the delivery without asking her sister-in-law for permission or even telling her what they were about to do to her:

My sister-in-law, they didn't even ask her if it was okay to do an episiotomy or to use forceps. And because you're in -- you are so involved inside of yourself during labour, you're not actually conscious of what people are doing around you. Umm, so you don't actually know. I don't think she knew. They did not ask her. I was there. They did not ask her. And umm, I really wonder if she -- and they injected her so I am sure she didn't know why. They numbed her so she didn't know (Marie)... They hooked her up to an IV drip. They made her sit flat on the bed because of the monitoring, like electronic fetal monitoring. It slowed her labour so they had to give her more chemical inducement umm and episiotomy, forceps – all the stuff that is umm, you know, unnecessary, her baby was fine, healthy, normal. What happened was the head wasn't in position so her pushing was futile. The doctors and the nurses didn't properly detect the baby and move it, didn't even try to move it into position and it was just an automatic no questions, no. Mother was not asked or no informed consent.

There was apparently no indication from the doctor that there was any particular need for these interventions.

Jean experienced a situation similar to that of Marie's sister-in-law during one of her deliveries. An intervention was used and she was not consulted or informed. She said, "The baby was pretty well born and ah or just about. He couldn't have been born because they used forceps. I knew that they did because it was just so painful." She only knew because of the pain. There was no consultation; no discussion.

It was in part due to the experience of her sister-in-law that Marie decided she would make every attempt to minimize the medical interventions when she became pregnant. When that happened, Marie hired a midwife because she wanted a natural

birthing experience. The midwife was in the delivery room with her during labour. Marie said:

Thank God my midwife was there cause umm my cervix didn't dilate. The last quarter centimeter wasn't dilating and umm umm they [doctor and nurse] of course said I shouldn't be pushing and the midwife said to me when the nurse and doctor were out of the room, "[Marie], I can just slide my finger up there and push the cervix over the baby's head." And I said, "You go for it and you do it. Do your thing." And she did it and within five minutes I had birthed my baby.... I didn't have any, I didn't want any drugs. I didn't want to be induced. I was two weeks and a day overdue and what I did was I had acupuncture to induce me and it put me into labour within half an hour. A natural process, no chemicals, no drugs and it worked very very well.

Until the midwife moved Marie's cervix, the doctor's inclination was to intervene in the most invasive way. He was preparing to perform a cesarean section. Marie was not consulted. The doctor simply told her to stop pushing and left the room to make the arrangements for surgery. As we see in Marie's comment, she felt that the doctor would have done exactly that if it had not been for the midwife.

Carry, a woman now in her forties, also made a point of discussing an experience in which the doctor made plans to perform surgery. The experience obviously had a significant impact on her and part of the reason for that was the physician's attempt to perform surgery against her wishes:

I want to tell you this too – When I was about 36 or ah 35, I had a bad pap and I had atypical cells and ah displasia, I think it was. Anyway, I ended up having cervical cancer and they did umm – I was really lucky it didn't touch my other organs. I had to have a hysterectomy and stuff but umm. I really didn't like the treatment I got from the doctors. It was like there was no discussion at all. It was, "Well, you have to have a hysterectomy done." Like, I didn't even know the severity of it. Like, at first, they did the vinegar and laser. It didn't work anyway. And umm, so then I'd say to my doctor – he said, "You need a hysterectomy."

While the doctor did not, in the end, “Do to” Carry, she was certain that she would have endured a complete hysterectomy without knowing whether it was necessary if she had not diligently refused to do what the physician told her. She was more assertive than many other women and her experience illustrates that a woman’s passivity can be interpreted as consent, whether informed or not. It was only because she directly refused that the doctor did not proceed with his plan. Her recollection of the exchange with her physician illustrates her resistance. When she went in to discuss it with her physician:

He said, “We’ll schedule one for you.” And I thought, “Well, no. Hang on. I’d like to get another opinion.” He didn’t like the fact that I took the power. I didn’t care. I asked for, I said, “Could you get me an appointment with a doctor in Halifax?” And he did it but he didn’t have a good attitude about it. I think he thought I was second-guessing him or something.

Generally, what we see in the experiences of these women is that medical professionals appear to assert control and authority when women are in a vulnerable state. These women, with the exception of Carry, did not approach their doctors to discuss their concerns or dissatisfactions. Further, they typically formulated their conclusions about the doctors’ intentions of control from their interpretations of the doctors’ attitudes and behaviours as well as knowledge from previous experiences, both their own and those of other women.

Physical Restraint

Like the use of interventions without consent, physical restraints were sometimes part of the experiences women had, particularly with labour and childbirth. These were also used when women were in a vulnerable state. However, unlike the use of interventions in

the absence of explicit consent, medical professionals used physical restraints when women refused to comply with their expectations.

The experience of Kay was most notable in this context. Not only was she flat on her back with a fetal monitor strapped to her abdomen, like most of the women in this study who had given birth, she was also physically restrained at the wrists and ankles. She was experiencing severe pain due to the position of the baby, but until the medical professionals realized what was happening they simply thought she was a woman with a low pain threshold and a tendency toward violence and treated her accordingly. It was a traumatic experience for Kay that contributed to her later experience with clinical depression.

Other women experienced less extreme restraints, but the experiences still had an impact on their overall impressions of the experiences. A number of women like Dale, who was in a focus group, commented that they were forced to stay in bed during labour. Dale's experience most obviously illustrates the idea of medical professionals attempting to control women and their experiences. She was surprised and frustrated. She needed to go to the bathroom but the nurses would not allow her. The experience confused her because she had not experienced such restraint with the deliveries of her other children. As she pointed out:

I kept saying, "Just let me go the bathroom." And all other times they'd just let me go with the IV. But that was just... It's pressure, all pressure [physical]. And she [the nurse] put the sides up [on the bed] and I, and keep in mind it doesn't make any difference. Just remembered. What do they [male doctors] know about it! (Group 2).

Laura had a similar experience. She was also obviously annoyed by the behaviour and attitude of the nurses. In her case, the nurses did not simply raise the sides of the bed. When trying to put the fetal monitor on her they literally pushed her down on the bed.

Nothing she did or said dissuaded them, but with only two words from her physician, they stopped. She explained:

The nurses nearly drove me crazy. They wouldn't leave me alone. I had to escape to the bathroom to get away from them for a few minutes but they followed me. And it's like, "I just need to be alone for a few minutes in a cool place away from you people." They tried to put the monitor on me but I wouldn't let them. I needed to be up. I couldn't lay on my back. I just couldn't. And they tried to push me down and I was trying to get up. And they said, "We need to put this on you," and I said, "No you don't," and they said, "Yes we do." So I said, "If you can get it on and off me between contractions go ahead." Then the doctor came in and they told her I wouldn't let them put it on and she said, "So don't."

It is clear that while Laura challenged what the nurses were attempting to do to her, their behaviour indicated that they felt she had no authority over them. It was only after receiving instructions from the physician that they ended their insistence of using the fetal monitor.

Other women made similar comments about being flat on their backs with a fetal monitor during labour. This medical practice remains a common part of the experience for women in Cape Breton, and based on the comments of the women in this research it is an unpleasant and undesirable one. While in the past this was a common practice in delivery rooms throughout North America, especially if a potential problem was detected; it has become less common with the resurgence of natural child birth. It appears, however, that the hospitals in Cape Breton are either ill-equipped or unwilling to alter practices in their delivery rooms.

Controlling Medication

Medical professionals' absolute control over medication and the lack of consideration of what women wanted was another example of "Doing to Women." The issue of controlling medication in certain respects is not problematic. It is one of the functions we expect medical professionals to perform. However, there were women in this research who were quite certain that their physicians had given them medication without consent, unnecessarily over-medicated them, given medication too late or too early and/or had denied them any medication when it had been requested.

The case of Marie's sister-in-law, discussed above, is one example of a woman being drugged without her consent. Marie, her birthing coach, was in the delivery room and observed the drugs being administered. As in the case of the episiotomy, the sister-in-law was not asked or even told about the drugs. Marie was certain that those drugs contributed to the difficulties her sister-in-law later experienced. Kelly, like other women, personally experienced such circumstances. She recalled that during her labour they had given her drugs. However, the only reason she knew was because when they used the forceps she did not feel any pain. She had not requested anything, and no one indicated that they had given her anything.

Tina, during one of the focus groups, explained that while she requested medication during her delivery, she was certain that they had over medicated her, and as a result the labour took longer than it should have. She explained:

I was in labour for thirteen or fourteen hours and umm it just wasn't getting anywhere. And I was in strong labour for a long time and nothing was happening, nothing was happening. She [the doctor] broke my water which wasn't, it didn't

break entirely and she started me on a drip. She gave me morphine first and I was really out of it and then she put me on the drip and my contractions were right on top of one another, so it was too fast. The drip was too fast so they slowed it down and she gave me more morphine. And I don't remember.

Her mother, Linda, who was also a focus group participant, jumped into the discussion. She was in the delivery room with Tina. Linda explained that the “excess” morphine that Tina received virtually stopped her contractions. Linda was certain, and Tina agreed, that the morphine prolonged Tina's birthing experience and put the baby at risk.

Other women commented on receiving medication too late or too early in the delivery process. During one focus group discussion, two women described their experiences with medication. Gayle was certain that the medical professionals had waited too long before giving her the medication she had requested. As a result, she said, “it felt like someone was putting cut glass in my vein” and the labour was over before the medication took effect. Terri stated, “That's not what happened to me. I wanted the drugs and they gave them to me but too soon. By the time I was in hard labour it wore off and they couldn't give me anymore.”

In addition to medication experiences with labour, a few of the women experienced medical professionals refusing to give them medication. This was particularly an issue in relation to breast-feeding. According to these women, since breast-feeding had become the preferred choice according to medical professionals, women were encountering physicians who refused to give them medication to dry up their milk. This was an interesting twist on the idea of medical professionals pushing medicalized views of reproductive processes. It indicates that control and who has it may be the more important issue for both medical professionals and women. Carry described

the experience of her friend which related to this issue. As something similar had happened to Carry, an experience I discuss in the following chapter, that similarity is perhaps the reason she so clearly remembered her friend's experience:

They're holding back medication, I guess in the hospital, in nursing, in umm obstetrics. You know, I know this happened to a friend of mine. They held back her, you know, the pills they give you to dry up your milk. They wouldn't give them to her and she really felt -- Wouldn't, wouldn't give them! That's the truth. Dr. X, he would not give her the prescription to dry up her milk. She had to beg and at the end the only reason she got it was because another doctor on call gave them to her. And cause he's [Dr. X] a big -- they [he and his wife] have small children -- They're her breasts!! It's none of their business! I know I can make that decision myself. It's her breasts! It's her baby! There's a lot of cows out there! You can get milk. A lot of pressure. That's disturbing, isn't it? It's really disturbing. It made me angry the first time I heard it and I thought and it was a man doctor that was holding back the pills and I thought, you can have complications from, you know, when your milk swells up.

Patricia said she had heard similar stories. She felt that such experiences were more a consequence of whether the physician was inconvenienced. She felt it represented a lack of consideration for women who chose not to breast-feed. She said, "if you are in the hospital over the Christmas holidays they forget to give you the pills until a few days later when you are home and the doctor remembers and comes over to give them to you. You get a feel for what it was like [in the past]" (Group 2).

Not Letting Women Decide: Presence or Participation of Others

A lack of concern and consideration of women's wants or desires extended beyond medical interventions and treatments. Medical professionals also made decisions about who could be present during these interventions and treatments, particularly in the case of childbirth. Some women requested the presence of a spouse or family member

and others wanted no one. However, medical professionals often made these decisions without considering the wishes of these women.

A comment made by Laura illustrates some of the concerns and frustrations women had regarding this lack of control over the involvement of significant others. During her pregnancy, she wanted her husband with her when she had an ultrasound. As Laurie said:

My periods and pregnancy were all normal. But there are other things aside from that that I don't understand and I think could be different, especially with the hospital. Like when you go for your ultrasound, I think their policy is extremely inconsiderate. Your husband or partner isn't allowed in until they finish their procedures first and that includes like – I have had friends who have had miscarriages or thought they were having miscarriages and I think that that would be the time that you would really need to have that other person with you and they don't allow it here.

Laura explained that she questioned the technician about the policy and the response was that an ultrasound is “a diagnostic procedure like any other. If you were having blood work, you wouldn't invite your family in to see it.’ And I just thought, ‘I'm sure you're just a little jaded because you do this all the time’... But I don't think pregnancy is anything like anything else, you know.”

Other women commented that they did not request or want their husbands in the delivery room but their physicians decided it was a good idea and brought the husbands in without discussing it with the women. Blaire, one of the women in a focus group was extremely annoyed with both the physician and her husband and said, “If I ever was to do it again, I'd make sure neither of them were in there with me.”

Like so many other things discussed in this chapter, taking away the right to decide who participated in women's reproductive experiences was interpreted by women

as an example of medical professionals attempting to exert control over them. All of these interactions with medical professionals coloured the ways in which women thought about the overall experiences they had. There were so many examples of professionals “Doing To Women;” not allowing them to have control, it is not surprising that the women in this study became critical and informed consumers of health care. I will now examine how this process played out.

Women as Critical and Informed Consumers

Given the experiences women had with medical professionals, described in this chapter, it should not be surprising that many have made attempts to take back control of their reproductive experiences. This appears to be a general trend among the lay population. More and more in society today, patients, and women more specifically, are questioning the authority of medical professionals. That is due, in part, to greater access to information which empowers them. It is also a consequence of higher levels of education and changing social attitudes toward women’s roles and “experts,” in general. In other words, there has been a narrowing of the social distance between the medical professional and the patient, specifically women. “Consumers of health care are beginning to act like consumers of other products; they question the assertions of authority figures, request second opinions, and require that they be given information about the risks and benefits of their choices” (Frankel 1994: 193).

At one time or another during the interviews virtually all of the women in this research criticized the attitudes and actions of medical professionals dealing with their

reproductive experiences. Many of the reasons for these criticisms were discussed in earlier sections of this chapter. The issue most directly targeted for criticism by the women in this study was the status of the medical professional as *expert*.

Medical Professionals: Not the Ultimate Experts According to Women

It is clear from many of the experiences of the women discussed throughout this chapter that women believed that medical professionals saw themselves as the experts in relation to women's reproductive experiences. Their perceived lack of consultation with female patients and the hierarchical nature of the interactions reported support this assertion. Women, however, did not necessarily accept this assumption of overriding expertise. In fact, when talking with me, they often completely rejected it.

The interaction between Carry and her physician over her irregular pap result, discussed above, is an illustration of this rejection. When she went in to discuss the result with her physician, he planned to make the arrangements for a hysterectomy without any consultation. He also expected her to do what he recommended without question or a second opinion. She remembered that he became visibly annoyed with her when she insisted he refer her to another physician for a second opinion.

In this situation we can see that Carry accepted and used some of what the medical system provided. She recognized its usefulness. She went for pap tests. She saw the need for medical intervention when something considered abnormal was happening to her body. However, she was not willing to hand over complete control. She challenged

the expertise of the physician. It was only when her uncertainty was adequately dealt with that she agreed to allow the intervention. She is a strong woman and was not willing to play the role of a passive individual who hands over control to someone else. By simply demanding a second opinion, she denied the physician control over her body and resisted the idea that he was the ultimate expert.

Carry's skepticism was also apparent when she discussed her daughter's menstrual pain and her reluctance to take the daughter to the physician. She said, "I don't want to take her [daughter] to the doctor cause I know they're only going to put her on the birth control pill and I don't know if I want her having all that estrogen."

Carla also called into question the expertise of medical professionals by implying that they were not as knowledgeable as they present themselves. She was talking about menopause and the medical push for women to accept that at this time in a woman's life, hormone changes were harmful. She asked, "Like, why is estrogen dangerous when your body, it's something that you've lived with all your life. My body produced it. Why is it dangerous now?! I don't know. It's really confusing. I don't think they know enough about menopause, doctors."

The circumstances of Marie's delivery, discussed above, also lent support to Carla's perspective. It appears from her experiences that medical professionals no longer have the traditional knowledge of midwives; knowledge that Marie valued. Rather, they rely on technology and invasive interventions. Based on her observations of what the doctor did to her sister-in-law during her delivery, also discussed above, she also appears to believe that doctors just expect women to allow doctors to do whatever they want.

On the surface, many of the women appeared to treat medical professionals as a homogeneous group. However, that is not actually the case. One of the most notable issues that women raised was the gender of the medical professional. Women expected different behaviours and attitudes from male and female professionals. As can be seen in the following section, the gender of the professionals also influenced the ways in which women interpreted those behaviours and attitudes.

Women's Gender Specific Expectations of Medical Professionals

While the shortage of health care providers in the Cape Breton area may be contributing to the abrupt and impersonal interactions on the part of medical professionals, there was a definite gender issue for the women who spoke with me. They had different expectations and interpretations of medical professionals based on their gender.

A number of the women made casual reference to the gender of their physicians as a partial explanation for the positive or negative image they inspired. Female physicians were typically seen as more understanding and having their own personal experiences to draw on. That, in turn, made them preferable as caregivers. In situations where the female physician did not live up to that image, however, she was viewed much more harshly than male physicians who behaved in a similar way. Women in this study believed that, to some extent, male physicians lacked empathetic understanding because they also lacked personal experiences of the processes with which they were dealing. While that belief did not mean the women found male physicians' behaviours acceptable, it was most commonly the way they made sense of it. For example, when Carla said that physicians do not "know enough

about menopause,” she went on to point out that this made sense to her given that men still made up the majority of physicians providing care.

The same gender divisions were made by some of the women in relation to assessments of nurses and physicians, particularly in examples dealing with pregnancy. The nurses were generally thought to be more supportive and helpful while male physicians were regarded as persons who just jumped in at the last minute. Two women who participated in a focus group discussion illustrated this in an exchange. Gayle said that if she were to ever have another child, “I’d go without my first doctor,... cause I felt that the nurses brought you up to the end and the doctor just came in to catch it.” Blaire jumped in with, “they’re [the nurses] there the whole time with all the support and you’ve somewhat bonded with them and then all of a sudden this person [the doctor] comes in and says, ‘Ok, drop the baby,’ you know, or gets cross” (Group 2).

Jane offered similar praise for the female nurses who were with her after her delivery. She said:

When I had the baby they [nurses] were the most helpful people that I had ever come across in my life. And I think it was because the student nurses were there doin’ their practice and there was this one girl, she was just the sweetest thing. She’d come in every couple of hours, “Are you ok? Do you need anything?” and when I decided that I was definitely going to breast feed, she brought the TV in to me and she gave me two movies to watch... but they, they were great.

Also, in cases where the nurse was perceived in a negative light, it was typically because her behaviour did not fit with the image of being a woman who had similar reproductive experiences. Jean’s experience with a nurse who scolded her for not wearing a sanitary napkin to the hospital when she went into labour is one example. Jean found it surprising and was annoyed.

It appears that these professional women played much the same kind of role that female friends and family did in relation to women's experiences, the focus of chapter 6. Women generally assumed that these medical professionals would think and feel as they did. When that assumption was supported, their presence during reproductive experiences was often valued and when their behaviours conflicted with that image, they were judged more harshly than men.

Conclusion

In this chapter, I focused on women's experiences with medical professionals and the structural contexts within which they occurred. In general, my participants experienced these encounters as attempts by medical professionals to impose a medicalized view on reproductive experiences and control them. This was accompanied by a perceived medical disregard for their own stocks of personal knowledge about their bodily processes. It was also clear, however, that although they rarely challenged medical professionals directly, these women did not simply accept a medicalized model. Nor did they want to hand over control to medical professionals. Decisions to accept or reject treatment, for example, varied according to how a woman defined the situation and the more general social context within which it occurred. In some instances, women followed the biomedical approach while in other instances they did not. The expertise of doctors was sometimes validated and sometimes challenged. Perceptions of expertise and empathy diverged depending on the gender of the medical professional providing treatment. What a woman decided or did was influenced by what she thought

pragmatically was the best approach to follow to obtain what she wanted in the restrictive medical context within which she found herself.

To sum up, these women considered the advantages and disadvantages of medical treatments and interventions and found indirect ways to express and deal with their dissatisfaction generally without confronting the medical professionals. Specifically, those women accepting treatment although disagreeing with it, shared their feelings with intimate others who included mothers, sisters, and female friends. These interactions with others, and their impact on the thoughts and actions of women around their reproductive experiences are the focus of chapter 6.

CHAPTER 6

EXPERIENCE AND TRUST: LEARNING AND TEACHING, WOMAN TO WOMAN

Introduction

It is clear that women's images of and interactions with medical professionals had a significant impact on how they thought about their reproductive experiences and how they acted in medical contexts. It is also clear that even when appearing to accept a medicalized frame of reference through compliance, women's thoughts and feelings were often in conflict with this action. As noted in Chapter 5, these women who sometimes accepted treatment although disagreeing with it, shared their feelings with intimate others including mothers, sisters and female friends. These individuals were part of women's everyday lives and their interactions were not limited to the discussion of reproductive experiences.

Such micro level interactions are integral to processes of socialization. They instill social and cultural values and norms and prepare individuals for the various transitions they will encounter as they develop and grow. The women in this study encountered numerous lay discourses related to reproductive issues and had to find ways to make sense of and select what they would make use of in relation to their own experiences. In examining their interactions with intimate others, two major themes emerged: the importance of trust and the importance of personal experience. Trust and

lay expertise, then, were extremely important factors for women engaged in processes of filtering and selecting information about reproductive processes.

In this chapter, I discuss the interactions women had with their mothers, sisters, female friends, and male partners. These interactions took the form of verbal communication of information and/or observation of others. I then discuss the role of past personal experiences with reproductive processes in shaping understandings of new experiences as well as those of other women. That is followed by a discussion of how these women were continuing the tradition of women exchanging information and sharing experiences with their daughters.

Trust, Expertise and Other Women

The women in this study repeatedly stated that, simply put, women talk to each other, trust each other, and rely on each other to prepare for and make sense of their own reproductive experiences. As Beth explained, “We [women] discuss everything, you know,... when you’re 18 or 19 and you’re moving out... I always lived with groups of women as I was going through university so – You get to a point in your life where you discuss everything and that carries on to now.” Carla also commented on how commonly women talk about and share experiences around reproductive processes. As she observed, “Every now and then when we’re [talking]... someone will say so and so had a baby and then someone will say, ‘Oh, yes, I remember,’ and they relate and we’re all there sharing it again, listening and I think that’s therapeutic for them too, maybe.”

As noted in Chapter 4, this reliance on other women to provide trustworthy information also extended to female medical professionals. Jane, for example, talked about the confidence she had in her female physician. She implied that when she was pregnant, that confidence was due as much to the fact that the physician was a woman and had experienced pregnancy and childbirth as it was to the fact that she was a physician. As Jane said, “I think the doctor I had, well she was female which was a plus, and umm she had children of her own so umm I think I was in really good hands at that time.”

Women learned from other women things that medical professionals and informational publications did not mention. Most important, they learned from women how to make sense of and live with reproductive experiences. As other women had gone through or were going through the same experiences, there was a sense of trust and connection. Donna alluded to this when she stated, “Personally, for me,... talking to other women, a social network. I prefer that than reading cause they contradict each other. So I feel better talking to someone, you know, who has a similar background and has gone through it.” Marie also touched on this issue when she explained why there was a need for midwives. She said that during childbirth a woman needs:

... someone you have built up a bond and a relationship, a trusting relationship with. I mean, my husband, partner, was in there with me too but, you know, at that time a woman is ah – women become like a women’s network, womanly network. You can really understand one another. It’s an instantaneous bond with another woman when you’re going through something womanly and umm. How can a man really understand because they have never had the opportunity to experience it. I mean, we can’t expect them to understand.

In this study, I found similar examples of this kind of trust and connection with other women in relation not just to pregnancy, but to all reproductive experiences.

In addition to women talking to one another about their actual experiences, they also talked to one another in order to get advice, to find out what other experiences would be like and the possible problems they might encounter. Ellen illustrated this type of exchange when she explained her information gathering behaviour around PMS. She approached the local Women's Centre because:

They had workshops on things like that [PMS] and hormone replacement. And hearing other women talking. But I sort of just put it on the back burner for a while and then I just thought the hell with it and the Anaprox went out the window. It just was primarily hearing from other women. Just listening to others. I decided to try it [evening primrose] cause the Anaprox was quite expensive. But like I said it was just from listening to other women and I thought why not give it a try.

The comments from other women influenced Ellen's decision to stop taking Anaprox, a medically prescribed drug, and to try Evening Primrose. She trusted in what other women said and relied primarily on information from women who had gone through the experience and used the remedy they recommended.

Other women, like Carla, indicated that their decisions to seek out medical assistance were typically based on the advice and opinions of other women. Carla said that while she takes information from a variety of sources, she has always given priority to information from other women. She consults with a physician only when she thinks there is a problem requiring medical intervention.

But probably the first stage would be to go to other people who have gone through it and get their inputs and find out like what exactly has happened to them, you know, like what can I do to help me. And ah, that's about it. And say, 'Listen ok, tell me what do you think' and take it from there (Carla).

The information from other women was not simply transference of biological facts from one woman to another. As indicated above, the ways in which such information helped women make sense of and live with their experiences were often more important. Specifically, the information and advice other women provided functioned in the following ways: (1) as support of medical definitions of abnormality, indicated by a belief in the need for medical treatment or intervention; (2) as support for interpretations that were consistent with both medical and folk knowledge; (3) as support for undermining biomedical approaches; (4) as guidelines for assessing normalcy of experiences; (5) as a way to avoid appearing ignorant in the presence of others identified as experts; (6) as an evaluative component; and (7) to avoid repeating negative past experiences.

Of all the people who were sought out by women for information and advice, the women in this research believed that, with only a few exceptions, the most reliable were mothers, sisters and female friends. They were the people involved in the everyday lives of the women and they had relevant personal experiences. The relationship that typically existed between those women and the women in this research made them accessible and, most importantly, trustworthy. I will now discuss the interaction with these difference groups of women and the ways in which they influenced the women who participated in this research.

Processes of Learning: Mothers as Providers of Information

As primary agents of socialization, it is not surprising that mothers were considered one of the most significant sources of information for understanding and dealing with reproductive experiences. This influence persisted even after they died. Indeed, women in this study who had lost their mothers acknowledged an awareness of the role their mothers might have played if they were still alive. In general, mothers had considerable influence over their daughters. They conveyed information either directly, through conversations, or indirectly through behaviours or actions associated with reproductive processes. The absence of information from mothers was also a significant factor influencing how women viewed their own reproductive processes.

A mother was typically one of the first individuals from whom information was sought and/or acquired. However, the type of relationship a woman had with her mother was influential, particularly in terms of when and how information was imparted. Some women had discussions with their mothers in advance of actually experiencing a reproductive process. Others had no consultation with their mothers until after, or more typically, during the onset of a reproductive experience. For example, as will be discussed, several women in this study were only provided with information about menstruation after they had begun their first period. Notably, some women never engaged in a process of acquiring information from their mothers, either through conversation or observation around these issues. Given the emphasis placed in the study on the importance of mothers in general, this observation seems paradoxical. However, it demonstrates that the social context impacted on how these reproductive processes were

viewed and experienced by women. It also illustrates how the presence or absence of information shaped the kinds of attitudes that women developed toward these experiences. I will now consider in more detail, the role of mothers, including mother substitutes like grandmothers, in these processes.

Conversations as sites of learning

Childbirth. The women who spoke with me made frequent reference to conversations wherein information was provided by mothers and/or grandmothers acting as substitute mothers. My participants placed a great deal of value on information when it was imparted in these sessions and tended at least initially, to uncritically embrace the information provided. As Jean noted, when she was pregnant, she readily believed what her grandmother told her about giving birth. Her grandmother appeared to minimize the experience and urged Jean not to worry noting that, “People have babies every day.” Jean’s actual experience of birth, however, was both physically and mentally challenging. Her grandmother’s attempts to reassure Jean did not prepare her for the process itself. She recalled her reaction at the time. “They couldn’t possibly feel like this or nobody would have a baby everyday. So for a while I was thinking there’s something wrong, something’s going wrong here and nothing was going wrong at all.” Because Jean’s experience differed from the description provided by her grandmother, she thought that her experience must be abnormal. She had made this determination based solely on her grandmother’s comments. However, as she indicates at the end of this quote, she realized that her experience was normal despite the fact that it did not fit with the grandmother’s

description. Jean explained to me that she had reached this conclusion based on the behaviours of the medical professionals attending her in the delivery room and by re-evaluating the words of her grandmother. She said, “[in the delivery room] everyone acted like things were fine.... I think she [grandmother] said that because she didn’t want me to be scared and you do kind of forget the pain afterwards.”

Menstruation. While Jean talked to me about childbirth, most of the women discussed their mothers’ (or grandmothers’) role in providing information framed in terms of the onset of menstruation. It was this initial experience of reproductive processes that most specifically involved mothers and appeared to remain the sole domain of women. However, the presence of a mother or other female substitute did not necessarily ensure that they would provide information to pre-menarcheal girls through verbal communication. The absence of such information, however, seemed to have as significant an influence on young women as did the presence of information.

Often mothers who did not provide information in advance of menarche influenced their daughters’ approach to menstruation through their actions rather than words. In many cases, the absence of conversations with young women seemed to imply an acceptance of a bio-medical view of menstruation. It was as if the mothers did not think their daughters were old enough, based on the normative standards presented by medical professionals. This was implied by the fact that most of the women who did not receive information from their mothers were eleven or younger when menarche occurred. At the same time, however, the behaviours of the mothers also support folk knowledge or lay perspectives that were connected to the culture in which they live. Menstruation, like

other reproductive processes, was thought to be women's lot in life, natural and normal. There was, therefore, no reason to talk about them, they just were. It is possible, given the specific culture of the CBRM, discussed more fully in the next chapter, that there was some degree of influence from the Catholic Church. The attitudes toward women in the Church, especially related to reproductive processes, encourage the idea of shame and the need for secrecy. After all, according to traditional teachings they are punishments for Eve's sin in the Garden of Eden.

Notably, few of the women in this study recalled actually having conversations about menstruation with their mothers prior to experiencing menarche. In fact, it was typically the occurrence of menarche that resulted in mothers explaining the experience and what it would mean for their daughters. The timing of such conversations varied somewhat depending on the daughter's age at menarche. That timing also initially determined the degree to which the young woman identified her menarcheal experience as normal or abnormal.

When I asked the women if they had been informed about menstruation prior to their menarcheal experience, some of the women who experienced an early menarche at age ten or eleven said no. In such cases, the women were not referring to anything other than general information that would have allowed them to know what menstruation is and its purpose. How women dealt with such an absence of information was strongly influenced by the kind of relationship they had with their mothers up to the point at which they experienced menarche. It appears that the more comfortable and positive the relationship,

the less traumatic it was for menarcheal girls to have no information. As Jane responded:

Informed! What's that?! I remember bein' in the bathroom and "Mooommm!!!!" cause she had never told me. I had no clue. "Mom, I'm bleeding!!" And she, she's on the phone, "Ah, I'll call you back." She's like, "Oh, God." She said, "We're supposed to have this talk..." And I'm like, "What's wrong with me?!?!"

Despite the lack of verbal information from her mother, Jane felt comfortable calling out to her. She also had no sense that she should hide what was happening or that it might in some way be her "fault." Her mother's reaction reinforced those feelings. She immediately let Jane know that menstruation was something that was supposed to happen. While Jane was still somewhat scared, she quickly came to the conclusion that the experience was normal. It seems that the primary issue was not whether Jane had been informed prior to menarche, but the behaviour of her mother when menarche did occur.

That mother's tone or behaviours played a more significant role than information in influencing how menarcheal women felt, were themes that occurred frequently among many of the women. There was a sense that their mothers set the tone for their experience despite the presence or absence of information.

A comparison of Jane's experience to those of others illustrates the importance of how a mother deals with her daughter's menarcheal experience and how that daughter interpreted it. Nina, for example, similarly to Jane, said she knew nothing about menstruation prior to her menarcheal experience:

That was scary.... Nothing was ever said to me. I had no idea such a thing was going to happen to me. And the day that I started, I was terrified cause, well, I thought I cut myself. I really did and I kept searching to see where I cut myself. And I wouldn't say anything to Mom cause I figured it was something I did to myself. So, I went almost a whole day in terror cause I couldn't get this to stop bleeding or see where it was coming from. Finally, I told her that evening and she said, "This is something

that you are going to have the rest of your life.” That was all. She didn’t tell me that I needed to have this to have children or anything. That was it.

Nina apparently did not have the same kind of relationship Jane had with her mother. She hid her menarcheal experience from her mother. She did not seem to think, whatever was happening to her, that she could count on her mother. The description of her mother’s reaction seems to validate her belief. While her mother indicated that menstruation is supposed to happen, her words and tone made it sound more like a prison sentence than a normal experience. She did not explain why it would happen for the rest of Nina’s life, nor did she indicate what it meant.

Beth also discussed what it was like having her first period without any information in advance. Like Nina, she hid what was happening to her:

Umm, well, my mother never explained anything to me.... – So my experience was umm actually umm I was about eleven and a half and my mother was doing the laundry and she noticed that there was blood in my panties. And she said to me, “Oh, you started your period.” And it didn’t really mean anything to me. It just kind of went right over my head.

Beth, like Nina, did not feel comfortable going to her mother to find out what was happening. Her mother was also like Nina’s mother in that she did not offer sufficient information, according to Beth. However, her tone was nostalgic, based on Beth’s interpretation, and that appears to have set a very different stage for Beth compared to Nina. Beth seemed far less dissatisfied with her mother’s behaviour than did Nina and generally more positive about menstruation.

Unlike the women who began menstruation at a young age, those who experienced menarche later than the norm were typically very well informed about menstruation. They were also more likely to have discussed it with their mothers prior to menarche. They

seemed to be much more aware of the importance of a mother's tone and behaviours as influences over their own thoughts and experiences. As Lee said:

My mother had bought a little life encyclopedia and there were these pamphlets... I think I relied a lot on my mother for information at the time, ya. She was as good as she could be, you know. And I think at that age, it's not so much information that you need as you need emotional support.

Sarah, who was sixteen when she experienced menarche, observed, "I was very fortunate. Mom was right there. I was sixteen. Mom, from the very beginning, she told us everything... Everything we needed to know she used the correct terminology, everything from sexuality to periods and pregnancy."

Women like Lee and Sarah had a distinct advantage over those who experienced menarche at a young age – they had a positive relationship with their mothers and the medical information about the biological processes they would experience as women. While these women had those advantages, they did not completely escape negative experiences associated with reproductive processes. Most notably, many of the women who began menstruation later than is socially expected often experienced feelings that they were abnormal, particularly when there was a gap between conversations with their mothers about menstruation and the actual onset of the menarcheal experience.

Many women implied that variation in the provision of information based on age appeared to be associated with an image of what constituted normalcy around menstruation. As thirteen is the norm for menarche, according to medical knowledge, younger women were often less likely to have had conversations with their mothers because the time was not judged right for revealing this information. The women who experienced menarche at a later age, however, were more likely to have had conversations with their mothers prior to the

experience. Further, those who experienced late onset were more likely to worry about and assess their lack of periods as abnormal. Such an attitude was apparent from women's comments indicating that rather than letting others know they did not menstruate, they pretended they did. One woman who did not begin menstruation until the age of sixteen observed, "I thought for a while that one day I'd find out I was really a boy. That was scary. I was so relieved when I finally started" (Tina). The issue of normalcy was not, however, tied exclusively to age.

Women who were young and unprepared for menarche initially experienced shock and a sense that something was wrong. However, a sense of normalcy quickly set in for most women once the initial shock wore off, they saw their mothers' nonchalant reactions, and were told what was happening. At that point, these women simply saw the experience as a normal part of being female and moved on. Likewise, most of the women who were older when they experienced menarche quickly lost their feelings of anxiety and felt normal once they had the experience.

The common theme running through the menarcheal experiences of all the women appears to be that young women needed continuity among their mothers' tone and behaviours, information from their mothers and the actual onset of menarche. When these three come together, women seemed to have more positive memories of the experience compared to those who felt that there was no continuity.

It is necessary at this point to explain that typically when women talked of having no information, they were in fact speaking solely about the absence of information provided through verbal communication. It was only after talking with them for a while that they

began to allude to observational information and the role that it played in helping them make sense of and live with their own experiences.

The fact that Nina and Beth “had no clue” about what was happening when they began to menstruate, indicates that in addition to having no information resulting from verbal communication or formal instructions, they also had no obvious information based on observation. They recalled being truly shocked that such a thing was happening to their bodies. This means that they had no idea that other women, like their mothers, experienced it. Among the women in this research, however, such situations were rare.

Many of the women who did not have information resulting from verbal communication, did have observations of their mothers that helped them make sense of what was happening. Even if they did not initially understand the experience, they were aware that it was something that their mothers also experienced which tended to make them more comfortable. They had grown up seeing menstrual products and their pregnant mothers. They knew there was something “female” even if they were not sure of exactly what it was. Jane, for example, recalled using one of her mother’s menstrual pads as a diaper for her doll. When she brought the doll into the room where her mother was talking to a male visitor, her mother became embarrassed and told her to put the pad back where she found it. Later, after the man left, her mother simply said, “those are for grown-up women, not dolls. You’ll understand when you get older.” So even though her mother did not explain menstruation to her prior to the experience, she knew from this event that something requiring these pads happens to all women and that it was private. This and similar comments from other mothers appears to provide young girls with a sense that, however vague the comment, this

will happen and it is normal. Such experiences prevented some women from being shocked by the things happening to their bodies.

As noted, the presence of a mother or female role model did not necessarily ensure that information would be passed through verbal communication. However, women often observed the experiences of their mothers even when they did not talk to one another. Notably, the silence and secrecy that sometimes surrounded the reproductive experiences of their mothers also sent messages to women that were as important or powerful as any other information. Some women learn from such situations that reproductive experiences were natural and normal and there really was no need to discuss them. Others, while agreeing with that, also relied on their observations of their mothers to evaluate and anticipate their own experiences. Still others were left with a sense that such experiences needed to be private because they were potential sources of embarrassment. I will now consider this process.

Observations as sites of learning

The importance of observing mothers became apparent to me when all of the women who had grown up without a mother made comments about what they had missed. Carla, for example, said, “you do miss a lot when you don’t have a mother... Sometimes you feel too stupid to ask some things that you’d get from your mother.” The other women without mothers made similar comments. They also alluded to the fact that it was the mere presence of a mother that was significant because the facts can be found anywhere. Being able to watch what mothers did with information was the thing that was missing for these women. It

was not only women who grew up without mothers who lead me to recognize the significance of observing them.

As stated above, some of the women in this research claimed that they had little or no information regarding reproductive processes based on verbal communication with their mothers prior to an experience. However, most of these women claimed they were comfortable with that and made no attempts to change the situation. Patricia noted, “I wasn’t prepared. Most of us weren’t but we all got through fine. So maybe there is no need to talk about it. We find out what we need to know.” The implication of this comment is that these women had access to information other than through conversations.

Women, then, appeared to make a distinction between verbal and observational information. Discussions about a lack of information invariably referred to the absence of conversations. At the same time, some women, like Patricia, alluded to the fact that they had access to information. As she said, “We find out what we need to know.” As a result of that belief, some women felt deliberate discussions were unnecessary and indicated that they had not participated in any such discussions about menstruation. During their youth, they felt satisfied with the knowledge they had accumulated through observations of their mothers. Observation seemed to give women a general attitude in favor of or in opposition to what they saw as medical definitions of *normal* and *abnormal*. Verbal information appears to have been most helpful to women in relation to specific reproductive process.

In this context, it is important to note that observation does not typically refer to direct observation. What the women described were observations of their mothers living with reproductive processes – whether their mothers continued with their everyday lives or

made alterations to their routines in response to those processes, the enlargement of their mothers' abdomens before a new sibling appeared in the family, the presence of menstrual products in the bathroom, etc. Such behaviours and products, and their connections to everyday life were always under the watchful eyes of daughters.

There was a definite sense among many of the women that they had learned about reproductive experiences specifically through observations of their mothers (or grandmothers). There was also a definite sense of trust in those observations. This was indicated by the fact that many women evaluated their own experiences by comparing them to what they knew about their mothers' experiences. Others looked to their mothers' experiences in order to reach some conclusions about what their future experiences might be like. This evaluation process was used by a number of women to determine whether or not their own experiences were *normal* as well as whether their experiences merited medical interventions. Likewise, in cases in which the women used the experiences of others to anticipate their own future experiences, there was the sense that the experiences of others were used as a measuring stick, particularly those of mothers. While mentioned in relation to all reproductive experiences, such comparison was particularly true in relation to menopause.

Menopause. Women used their observations of others to make decisions about how to evaluate their own experiences. Terri explained that although her mother never told her, she knew her mother did not need HRT because she displayed no negative symptoms. Terri, therefore, saw no reason to think that she would need it when she reached menopause. She was fairly certain that she was beginning menopause but felt fine, like her mother, and had,

therefore, “deliberately forgotten” to mention what was happening to her doctor. She had a clear sense that what was happening to her was *normal* and required no medical intervention. At least in part, that evaluation was the result of knowing that her experience was similar to her mother’s and that her mother had reacted to the experience as natural and normal and saw no need for medical intervention. That Terri did not mention her perimenopause to her physician reinforces the idea that she saw her experience as normal. It may also have indicated that she held the opinion that medical professionals did not share that view. On the other hand, she may have thought there was no need to discuss it because it was normal. It was not that she simply forgot to mention the change to her physician. It was a deliberate act on her part to conceal information. She said, “I didn’t see any reason to say anything. There was nothing wrong. I didn’t need to do anything about it, you know hormones. So why say something?”

Other women claimed that their mothers’ experiences were unproblematic and they had not taken HRT. They, therefore, expected to have no problems with menopause when the time came. This can be seen in a comment made by Nina who explained that her mother was “the type to just go with the flow.” Her mother, at 72, had never taken HRT and continued to have the occasional period but it was not an issue for her. Nina saw her own experience as very similar to her mother’s. She said, “Things like that are just the natural flow so I don’t worry about it.” Similarly, women like Donna, Patricia and Terri believed that we make too much of the negative aspects of menopause and of other things generally. There was a sense among these women and others that people today are too willing to adopt a medical interpretation; they want the magic bullet that will make things perfect. These

women believed that people are generally “soft” today; that they complain about every little thing that, according to these women, is simply part of life. In other words they think that people should just “get over it.” Donna claimed that she focused less on the negative aspects of experiences because of her mother. For her, the result was a less *self-indulgent* mindset than she saw in many people around her. Such an attitude is understandable given the history of Cape Breton. The families in this area, as I noted in chapter 3, have historically had a difficult life. Complaining over little things or small aches and pains seems absurd in the face of the severe hardships many families have experienced over the years. Reproductive experiences are part of life, not interferences that justify whining or failing to get things done. She explained:

I really try not to give in to things too easily. You know, like if a child stubs his toe and, you know, your going to hear about it for two days and the mother comes in and it's like, ‘Why didn't you call me. He's obviously hurting.’ And another child does the same thing and doesn't say a word. I think that's what menopause is like.... sometimes people get a little carried away.... It's like everything is a big deal. Those people have too much time on their hands. Other things in life are much more important to people than menopause.

Donna pushed the idea that reproductive processes are *normal* – “just part of being a woman” – and from her comments there was also a clear sense that she opposed or even resented the medicalized approach to such normal life processes.

Women who were raised by their grandmothers looked to them in the same ways others looked to their mothers. They also implied that the experiences of their grandmothers influenced their attitude toward their own experiences. Jean, for example, mentioned her grandmother's behaviour regarding pap tests in an admiring tone:

Well, I think of my grandmother, I mean, not that I'm, she was probably 70 before she went for a pap smear and she didn't even realize then why she was going and

she got really angry with one of the doctors afterwards because they went into the doctor's office and he said, "This is what's going to happen."

Jean agreed with her grandmother's anger and thought that there was no need for such things to be done, especially when the woman was 70 years old. More generally, it was apparent that Jean had adopted the anti-medicalization attitude that she had observed in her grandmother's behaviour.

Marie had also given considerable thought to her mother's menopausal experience: why it was as it was and how her own experience in the future might compare. She mentioned that her mother was taking HRT but not for the reasons advocated by medical professionals. According to Marie, her mother was taking HRT because she felt the demands of her various roles made it impossible for her to do otherwise. Her mother was in the workforce and had a young child at home. Marie explained that her mother's experiences with menopause were not really problematic. However, they were disruptive in the sense that they made it difficult for her to live up to the demands that society placed on her as an employed, single mother. Marie noted that the nine to five, Monday to Friday work week is often in conflict with a woman's body rhythms. She said that the organization of our society does not allow women to have down-time when they need it. Added to that situation, Marie explained the stresses of being an employed single parent: the lack of time for her mother to take care of herself and the twenty-four hour schedule. According to Marie, all these factors encourage women to reach out for something not for menopause but to make life a little easier. While the issue is really the difficult lives that many women have to endure, Marie believes that taking HRT is socially acceptable and easier than trying to eliminate or change social roles. She saw medical intervention as a response to society more than a response to

the body. More than anything, this most clearly illustrates the significance of the socio-cultural environment when examining women's reproductive experiences. Marie clearly saw definitions of *abnormal* as social products, even more specifically as patriarchal products. Therefore, the definitions did not always reflect the experiences or needs of those affected. She said, "I think our society puts a lot of pressure on women because it doesn't allow for them to have their own down-time... Life, society, our system doesn't allow for you to have that little bit of down-time. The only thing they will allow for is for you to take some pain-killers and get on with your day. But I'm sure women throughout history have been dealing with that." With that understanding of the situation, Marie believed that it might be difficult for her to avoid taking HRT but she had not made up her mind. She explained, "it is an intervention that is controlling you and you ask to whose benefit is it really. They're developing a cultural norm umm to ah take these hormone replacement drugs so that women say, 'oh, yea, that's what you do' without really understanding the repercussions."

Whether it was a mother or grandmother who was present in their lives, the opportunity to observe was crucial for these women. In many cases it was more important than any verbal communication. Verbal communication seemed to be significant to women only after they were adults, able to engage in conversations rather than question and answer sessions. Typically, these conversations were not with mothers. It is interesting to note, and I provide details later in this chapter, that the daughters of the women in this research seem, according to their mothers, to be following the same pattern of behaviour.

Sister and Friends as Providers of Information

Women sought out other women for specific advice. Sisters and female friends were the most commonly mentioned individuals when women told me about conversations, discussions or exchanges they had regarding reproductive experiences. Who they approached, and why, tended to be guided by the general attitude they had developed over time, partly through the conversations with and observations of their mothers as well as their own experiences. Specifically, they turned to women whom they believed had similar attitudes to their own. Lee, for example, turned to a female friend for advice when she was pregnant. That friend was someone with whom Lee had taken a “sociology of medicine” course. Both Lee and her friend agreed with the instructor’s criticisms of medicalization and the medical system generally. In addition, women turned to others who had gone through the experience of interest or concern. They used the advice and information from these women in much the same way that they used information and observations of their mothers. Based on what they learned from these women, they evaluated the normalcy of their own experiences and how to incorporate it into their everyday lives.

What made this information different from that of mothers was that the information and advice was much more specific. It was almost always in relation to particular aspects of a reproductive process, rather than general information about those processes and was often sought out because they thought there was something unusual or abnormal happening. As Claire said:

With myself, I think you would ask someone who was ahead of you. Like, I know with myself, most of my friends had kids before I did so it wasn’t hard to get information on something. I wouldn’t go to my mother because I found she would

worry. She was older than most, probably twenty years so I hesitated to ask her anything (Group 2).

Claire was clearly concerned about worrying her mother and felt more comfortable talking to another woman who had gone through the experience. She had confidence in her friends and felt that they could provide her with the information and advice that she needed to prepare her for pregnancy and childbirth. Unlike many of the comments women made about mothers and menstruation, it appears that Claire believed her mother would view certain things as *abnormal* – she would worry, while Claire did not seem to believe that her friends would make the same assumption. She wanted to use the experiences of her friends to evaluate her own experience rather than her mother in part because of age. It seems that she felt her mothers' older age meant that she would have a different, more negative interpretation of the things Claire experienced during her pregnancy.

Carry indicated a reliance on her sister that was similar to Claire's reliance on friends. When describing discussions with her older sister, Claire stated:

I would confide in my sister... she had a baby,... at the time [Carry was pregnant], a small child so we sort of shared experiences. You know, I'd say how I was feeling and "Oh, look at the stretch marks"... I kept thinking throughout the pregnancy, I was really scared of the pain part; going into labour and that and I thought, "I can't handle it." And my sister kept saying, "It's not as bad as you think." And it wasn't.

In addition to Carry's initial reliance on her sister, we can also see in this comment the reason such reliance continues for many women – the information the other women provided was reinforced by the woman's actual experience. This is a consistent theme from the section about mothers. When information and experience came together, women

were much more likely to evaluate their experience as *normal* and more easily incorporated it into their lay knowledge and everyday lives.

Jane engaged in similar conversations with her mother-in-law, whom she identified as a good friend. When Jane experienced certain changes during her pregnancy, she would talk to her. When her breasts began to leak, for example, she spoke to her mother-in-law, who told her, “Well that just means it’s time for you to be going into labour soon.” Jane had no idea that would happen but she trusted her mother-in-law and accepted her information. Jane used that information to assess the normalcy of what was happening to her body. And, Jane added, “she was right. It was only a few days later and I had the baby.” Again we can see the comfort that women felt when information and experience come together.

These conversations with sisters and friends generally took place because one of the individuals involved was having the experience. That was the case for Carry when her sisters attempted to pressure her to breast-feed. As she explained, her sisters had all breast-fed:

I really felt the pressure to nurse. “All the milk you have!” And I didn’t cave in but it was hard. It was hard because the expectation was there to do it... there was a lot of pressure because I knew nursing was the right thing to do but I just didn’t feel comfortable with it. And I kept having to justify, like even now when I talk about it, I guess because it’s family.

Carry’s comments reveal an interesting point connected to reliance on other women. She talked of the pressure she felt from her sisters to nurse. It is significant to recognize that with the kind of strong reliance I have been discussing also comes the idea that these other women have a certain degree of power over these women. Because their advice and

information is so valued by these women, there is at least the potential for them to act as agents of social control. One only needs to remember Berger's (1963) Circles of Social Control to recognize this relationship. With both the need for approval and feelings of guilt that Berger discussed, we can see the potential for women to be far more influenced by other women than any other group involved with their reproductive experiences. In most cases, women were pressured to conform to a non-medicalized approach to reproductive experiences. In rare cases, like Carry's, the pressure to conform was consistent with both folk and medical definitions of what is best.

Debra experienced pressure to adopt a medicalized view from some female friends when they realized she was going through menopause. They reacted as if she were ill but Debra did not agree. She said that when she had a hot flash, they asked, "'Oh, are you ok? Do you need anything' and it's like it makes it worse. It's frustrating cause there's nothing wrong with me." She already had a clear sense that menopause was a *normal* process, although sometimes annoying. However, because she placed some value on what they thought, their comments made her feel uncomfortable about what was happening.

While Carry and Debra did not hear what they wanted from others in those instances, they continued to engaged in conversations with other women and obviously valued their opinion. That value was suggested by the fact that Carry had additional conversations with them and her sister-in-law. Other women also indicated that they did not always hear what they wanted to hear from women but continued to value their opinions.

It was Carry's sisters and sister-in-law who suggested that her experience of being prepped for childbirth was unnecessary. She had been prepped for her first delivery and

half-prepped for the second. When she discussed these experiences with her sisters, “They were floored cause my sister-in-law,... said we don’t even get prepped. She said, ‘We never even think about it. Why would you prep the body?’ I mean, it’s not like there is surgery being done here, you’re delivering a baby” (Carry). Despite what was done to Carry during her deliveries, her attitude was very much like that of her sisters – anti-medicalization. Their reaction to the preps that Carry experienced served as reinforcement and intensification of her own anti-medicalized attitude. Their shared response and reinforcement seemed to be responsible for Carry’s level of annoyance when she recalled the procedure.

Unlike Carry and Debra, Karen’s friends had no advice regarding the “premature ovarian failure” she was experiencing. She felt that was because of their ages. The friends were all in their thirties and had not begun to think or ask questions about menopause. She explained:

[W]e discovered we knew very little about a lot of women’s, about the women’s reproductive system. Cause, you know, when things are going right, you don’t ask, you know. You basically know what’s going on and it’s when something goes wrong that you start thinkin “Oh my God,” and that’s when you realize that you really know very little (Karen).

Realizing their lack of preparedness, Karen and her friends began to collect information from books, magazines and the Internet and discuss what they had learned with each other. Given their lack of personal experiences to draw on, they seemed to rely on impersonal sources. They did, however, share their thoughts and feelings with Karen and these exchanges seemed to help her adapt to and accept the unexpected experience of “premature ovarian failure.” Karen continued to believe the timing of the experience was *abnormal*. However, with their help, she began to learn how to make it part of her life. As many other

women stated, it is not necessarily information that is important but rather emotional support.

Once women had discussed things with their sisters and/or friends, they tended to filter and sift through the information obtained. A primary aspect of the filtering process was comparing what other women said to their own experiences. Through this comparative process, women decided what information they would accept and used it to assess the normalcy of their own reproductive experiences. If the acquisition of information was in anticipation of an experience, women were much more likely to accept what others told them. However, if the experience differed from the information they had received, the women often felt torn and confused. If it was advice with which they disagreed, they felt pressured to conform when the other women were significant to them.

When involved in this filtering process, some women concentrated on the differences between their experiences and what they had learned from other women. Jean's comments about menstruation illustrated this kind of evaluation. She explained that she had no problems or pain associated with menstruation unlike many of her friends. She said, "I remember hearing people complaining about pain and what not. And I remember I found it really hard to relate to my friends and others. What it was for me, it was just a bother, just a real bother... That was the only thing, you know. I never had a pain." Jean also pretended. She felt social pressure to accept the idea that menstruation was unpleasant or even *abnormal*.

Jane, when discussing her unplanned pregnancy, similarly compared her experience to those of her mother-in-law and sister-in-law. She stated that her mother-in-law “was on the Pill with [her husband].... And then his younger sister was on the IUD, so you know. Sometimes it’s just meant to be. That’s like I told [Jane’s husband], if we were to try to get pregnant, it will probably take us a while [laughter].” She was using birth control and it was as if knowing about her mother-in-law and sister-in-law’s experiences made her view her own unplanned pregnancy as less unusual or *abnormal*. She rationalized from their anecdotal experiences that her pregnancy was “just meant to be,” like their experiences and no form of birth control could have prevented it. She also seemed to explain her pregnancy using a religious or cultural view that her child was destined to be.

Mary also compared her pregnancy experience to those of other women she knew. In her case, however, she and many of her friends were pregnant at the same time. As she recalled, “They would say things like, ‘I feel the arm moving’ and I couldn’t understand how they could tell because I felt movement all over. I was having twins and didn’t know. So I would say, ‘Oh, ya, I have felt that too,’ because I didn’t want them to think I was stupid.” She used the comments of the other women to evaluate the normalcy of her own pregnancy. She pretended to have similar experiences in order to avoid appearing ignorant about her body and what was happening. She felt pressured to claim the same experiences. At the time, she was, however, unaware that she was having twins. Once she realized this, she seemed to use it as an explanation for why her experience differed from those of her friends.

In addition to these types of comparisons, many women used what they knew of others' experiences in order to actively ensure that their own experiences would be different. As discussed earlier, Marie, for example, was the birthing coach for her sister-in-law before becoming pregnant herself. She was horrified by the way her sister-in-law was treated and the way in which she was stripped of any control over her birthing experience. She said, "I knew at that point that I needed to take control of my birth [laughter]. Cause if you don't, someone else will. So, umm, ya. At the same time I will say that I appreciate having the technology... It does serve a purpose but we need to control it, not it control us."

Similarly, when Jane compared her experience to her sister-in-law, she decided her birth experience would be different. She said, "with [Jane's husband's] sister we made seven trips to Sydney with false labour and I figured I'm not doin' that. When my water breaks, I'll go to the hospital. When my contractions get too close, I'll go to the hospital." She implied that her sister-in-law was much too eager to hand herself over to medical professionals rather than listening to her own body, which is what Jane wanted to do.

To conclude, women for the most part trusted other women, particularly those who were intimate others and had experienced the reproductive processes they were concerned with at any given time. They took the information and experiences of other women and used them in whatever manner was most useful. The role of men, when present, was very different. I will now consider the influence men did have in relation to women's reproductive experiences.

**“Father’s Day is for the birds”:
Male Influences on Interpretations of Experiences**

Although the majority of women in this research were married and had children, men were rarely mentioned as sources of information. Men were not invisible in relation to women’s experiences and views of reproduction, however. They were extremely prominent as medical professionals involved with women’s reproductive experiences. Men as spouses, partners, boyfriends and fathers, however, were far less significant than any other group of people in women’s lives. Such lack of discussion about men reinforces the idea that it was other women who played a significant role in helping women determine their views about reproductive experiences. Despite the minimal attention given to men, in general, they did influence the reproductive experiences of the women with whom they were involved but often in a paradoxical way.

In instances in which men were mentioned, their behaviours were almost always interpreted negatively by women. The women described situations in which men were problematic, lacking sufficient understanding and empathy, and uninvolved in the experiences. In these situations, women seemed to believe these things happened because men were men and they gave it little thought beyond that. In interactions with women these issues were rarely mentioned. When they were, the other women were not assumed to be the source of the problem. They had credibility. It was assumed that their information, advice and assistance were based on personal experience.

A few of the women who mentioned the involvement of the men in their reproductive experiences implied that their presence or behaviours actually made those

experiences more problematic or annoying. As Gayle, for example, explained, during her delivery “the doctor decided that my husband should help. I’m telling you, by the time the baby came out, I was ready to divorce him. If he had put that cold cloth on me anywhere else... ‘damn it, let go of me!’ And he thought he did so well.” She was certain that his intentions were good. He wanted to help. However, either because he did not know what she wanted or did not ask, his attempts only frustrated her.

Anna indicated a different kind of problem with her husband. He was not at all open to discussing reproductive issues or sexuality. Anna indicated that his discomfort with such topics was shared by his mother. She had learned this early in their marriage and so when she was pregnant, she said, “I never talked to my husband, my mother or my mother-in-law when I was pregnant.” Nor did they ever attempt to initiate such a conversation with her. Her husband’s behaviour seemed to have left her with the feeling that they, as a couple, had missed out on something. It appears that at some level, Anna also felt discomfort with such discussions because despite her feeling that they should take place, she did not initiate them, not even with other women. When she needed information, she relied on written material. Her husband’s behaviour served to reinforce her discomfort but not sufficiently enough that she was willing to allow her children to be ignorant. She said, “When my children were older I did talk to them, gave them information. My husband wouldn’t talk to the children about such things. So I did a lot of reading so I could tell them what they needed to know. I didn’t want them to be ignorant.” I sensed from her comments that Anna saw such discussions with the children as part of parental responsibility. That her husband was

unwilling to participate left her feeling totally responsible for something that she felt they should have shared.

The issues of lack of understanding and empathy also came up in women's comments about men. Some of these instances were relatively minor as in the case of Debra. She recalled a conversation with her husband about her dissatisfaction with her physician. She explained to her husband that the physician had been pressuring her to take HRT and was dismissive of her concerns. She said she was no longer comfortable seeing the physician. Rather than suggesting that she take some kind of direct action like confronting the physician or finding another, as she was inclined to do, her husband said that she should lie to the physician. His response to her was "Why don't you just take half of it or just get the prescription filled and not tell him [that she was not taking it]?" This suggestion from her husband is a common tactic that women have used for many years in order to avoid medical interventions. It seems, therefore, not that she was annoyed with the actual suggestion but rather with his seeming lack of support for what she wanted to do. Debra was visibly annoyed with her husband's suggestion

Barb, while talking in one of the focus groups, recalled how annoying her husband was during one of her deliveries. Her memory implied that he was behaving as if the experience was nothing special. She said, "I remember my husband said, 'Well, the intern and I are ordering pizza.' And I said, 'Don't you dare!'" Her tone indicated that just thinking about that comment still annoyed her years later. It appears that her husband's behaviour made Barb feel like he had no real understanding or empathy for what she was going through or the significance of the event.

Carla had a similar memory of her husband during the delivery of her first child. She explained, “my husband was with me but he gave me a magazine to read, [laughter] during contractions, [laughter] and I remember looking at it,... and the words were jumping off the page, like I couldn’t even focus on the words with the contractions.” Although she told me this with laughter, she seemed to think of his behaviour as demonstrating a lack support. Later during the delivery of their child, her husband left the room. She appeared to resent his absence. She remembered saying to one of the nurses, ““Father’s Day is for the birds’And I thought there he was standing out in the hallway, even afraid to come into the room with me. I was delivering and he was going to have a Father’s Day! There should have been two Mother’s Days, [laughter].” Other women had similar feelings about the role their husbands did or did not play in the delivery room. The idea of equal recognition of fathers, given the differences in experiences, was for many women a source of bemusement and annoyance.

As can be seen, the comments made by these women were quite negative. There were a few women, however, who made comments that were less critical. They tended to be somewhat neutral in the sense of simply mentioning the presence or absence of men in relation to an experience, particularly childbirth. In a few instances, rather than being critical of men, women were critical of the medical system and its exclusion of men in relation to pregnancy and childbirth. Laura, for example, criticized the local hospital for denying male partners the opportunity to be present during ultrasounds that are routinely done during pregnancy. She claimed it took two to make the baby and he should have the right to be part

of the process – a very different attitude than that of women who had unwelcome or unhelpful participation of their husbands.

Whether the role of men was real or desired, annoying or appreciated, it was still minimal compared to the role of other women and medical professionals in shaping the interpretations of reproductive experiences. Experience and trust were consistently important factors for women in assessing information. As men obviously do not have personal experiences with women's reproductive processes, women were less likely to trust their advice on these issues and certainly not more than they trusted or relied on women who had these experiences.

Men's lack of experience aside, it appears that women had actually learned to keep their reproductive experience hidden from men. This is consistent with the lack of male involvement. For example, women learn early on to conceal the physical reality of menstruation from men. Carla's menarcheal experience was an example. When she began to menstruate, she was at home with her grandmother and young uncle. In the bathroom she discovered the blood and yelled to her grandmother. The uncle heard the yelling, ran to the bathroom door and started to walk in. Carla immediately said, "No, not you. You can't come in, only grandma." She would not let him into the bathroom, nor would she tell him why she was yelling. That Carla had the sense that she should conceal the experience from her uncle and the fact that it was a very clear memory for her illustrates that her bodily processes were embarrassing in the presence of men.

While women's comments about men's involvement in reproductive experiences were limited, they did have an effect on women. These interactions with men, like those

with other women and medical professionals influenced women's perceptions of their experiences and were part of their accumulated knowledge. Men's presence or absence, what they did or did not do were part of what made women's experiences what they were. In addition to those interactions with others, however, significant consideration was also given to past personal experiences. It is to these personal experiences that I now turn.

Upon reflection of these interactions women had with men, it is not clear whether women's attitudes and interpretations were truly in response to the things men said or did. Because many of these instances, like that with Debra's husband, were comparable to those involving other women, it may be that women entered into interactions with men assuming they were potentially problematic, lacking empathy, understanding or involvement – a message many seemed to get from the fact that mothers, not fathers, were the ones who talked to them if anyone did. In schools in which information was provided, girls and boys were separated until recently. Male partners of many of the women were not allowed to be in the delivery room. Laura's comments, discussed above, about men not being allowed in the room when ultrasounds were being conducted is another example of men's exclusion from women's reproductive processes.

The Role of Personal Past Experiences in Understanding Reproductive Processes

There are ample opportunities for the accumulation of personal experiences simply because of the biological reality of reproductive functions. Menstruation recurs monthly for much of a woman's life. Many women experience more than one pregnancy over the course of their lives. And, menopause is a gradual process typically spanning years. With each of

these functions, women experience consistencies and variations that either reinforce or call into question previous views.

All of the women in this research spent a considerable amount of time talking about the physical dimensions of their reproductive experiences. They often discussed their reproductive experiences as if they were somehow separate from everything and everyone in their lives. They, like medical professionals, focused on the biological aspects of their reproductive experiences. It was at that level that many of the women began their discussion when asked to talk about their experiences. In addition to issues like pain and body changes, there were two themes that emerged from women's comments. They were concerned with issues of *normalcy* and the use of past experiences to evaluate and understand present experiences. They also made use of information grounded in a medicalized approach and information grounded in folk knowledge/understanding within their socio-cultural context to determine the normalcy of their experiences.

A number of the women, when discussing such physical aspects, talked specifically about menstrual experiences. In response to my opening question, "What do you think of when you hear words like periods, pregnancy and menopause?" Carry replied:

Pretty much started off [pain] when I first started having a period. I was probably around 13. They were really severe. I was umm, I'd vomit, go into hot and cold sweats. Once a month I always got sent home from school. Literally go into hot and cold sweats. It'd pour off me. I'd be sweating and shivering at the same time and they'd just keep putting blankets on me and but that lasted probably until I was about 16 and then it stopped, not stopped but it eased off and it got better.

While she spoke of the physical pain and vomiting, the role of the social context is also apparent and seemed to have influenced the way she interpreted her experience as abnormal. She was sent home from school by teachers or nurses, sending her the message that she wasn't well. At home she was sent to bed – reinforcing the message that something was problematic about her experience.

Becky, who participated in one of the focus group discussions, made similar comments about her menstrual experiences. She stated, “I was physically ill in bed with my periods when they started and I mean I can remember being in the cafeteria at school and the feeling would just sweep over me and Bang, I'd throw-up in front of everybody.”

While both Carry and Becky described in great detail the physical aspects of their menstrual experiences and implied/indicated that these aspects were the intended focus, they like other women, placed those discussions within the social context. Carry was kept home from school, an indication that her experience was not normal. Becky was also kept home and she implied the embarrassment she felt about others observing her physical discomfort.

In discussing pregnancy and menopause, rather than menstruation, women also began by focusing on the physical aspects. Jane, for example, commented on her weight changes during pregnancy, saying that she only gained three pounds in the first five months of her pregnancy. Then in the last three months of the pregnancy, she gained 44 pounds. Jane seemed to accept the medical definition that this was abnormal. Other women had similar weight experiences but did not accept such a definition. Carry for example, saw her pregnancy as a time when it was acceptable to gain as much weight as

you wanted. She referred to the folk saying that “you are eating for two.” She said it was a time to eat what you wanted and as much as you wanted without feeling guilty. Carry gained more weight with each successive pregnancy and exclaimed that she thoroughly enjoyed each one. Her doctor did not agree with her view on weight gain but she did not seem to care and she had support from friends and family.

Jean also initially concentrated on physical changes when she spoke to me about going through menopause. She had only recently gone through menopause when we talked which meant that her memories were quite clear. She explained that her menstrual cycle had become irregular in terms of both occurrence and length of time. Because these changes were unexpected, she initially thought she was pregnant.

In general, the views these women had about the physical aspects of their reproductive functions tended to be expressed in terms of what was believed to be *normal* and where their experiences fell in relation to that definition. It was in that respect I realized that even though women initially presented information as factual and absent of any social influence, what they paid attention to and how they evaluated these things was a consequence of interpretation and lived experiences.

It is necessary to point out that where *normal* fell on the continuum of health and illness for women was not indicative of a dichotomous view. As other researchers who have examined lay perspectives on health generally have explained, women’s perspectives vary depending on a number of factors (Blaxter, 1990). The women in this research developed their own perspectives by bringing together considerations of

physical aspects and interactions with others. This process was coloured by reality of life in Cape Breton and demographic factors such as age.

If women viewed their experiences as *normal*, those experiences were generally given little thought. Normal seemed to be anything that did not alter a woman's daily routine or require specific attention. Women's comments were limited to things like, "generally, it was uneventful [pregnancy]," or as Sarah said when discussing her pregnancy, "I didn't have a hard pregnancy. It was pretty easy except that the baby was really long... besides that I had a normal pregnancy."

While not using the word *normal* specifically, some post-menopausal women assessed their experiences in much the same way. They explained that they were now post-menopausal but never really thought much about what was happening at the time. At some point they recognized what was happening but assumed it was normal and continued on with their lives. A few of the women in one of the focus groups made comments like, "My periods changed and I had a few hot flashes but I didn't think 'menopause' until it stopped." (Group 2).

It is important to note that in evaluating experiences, normal did not necessarily mean painless. Several women indicated that their experiences with menstruation and pregnancy were normal but also talked about the pain of menstrual cramps and labour. Similar to Castro's (1995) explanation of pain for the women in Mexico, these women interpreted the pain they experienced as a normal part of being a woman.

Typically, whether an experience was normal became an issue only when a woman viewed her experience as something that required specific attention. Women

came to this conclusion if, in relation to what they learned from other's experiences, their own were significantly different. Also, specifically in relation to labour and delivery, women more readily accepted "abnormal" labels applied by physicians and allowed medical interventions to be performed. As was stated in other contexts, women were not willing to take the risks associated with rejection of such medical advice.

When describing her delivery experience, Lee, for example, explained that marconium was present. She described it as a chemical that is sometimes present in a woman's body that can result in the baby needing a blood transfusion. "They weren't a hundred percent sure that it was marconium but they didn't want to take any risks but, you know, there are other babies that it's a very threatening situation, so-." Similarly, Karen was experiencing early menopause, or what her physician called "premature ovarian failure." Early menopause was something that she viewed as abnormal, problematic and somewhat traumatic. She accepted the advice of her doctor that because she was only in her thirties, the physical changes in her body required medical attention. She did not have access to any folk knowledge because of her age. However, folk knowledge regarding the appropriate age for women to begin menopause supported the idea that her experience was *abnormal* and perhaps influenced Karen's willingness to accept a medicalized approach.

Unlike experiences that women discussed as normal and requiring no serious thought, abnormal experiences were given considerable thought that typically included attempts to assign blame for what was happening; a tendency that again illustrates the importance of the social context in helping women make sense of their experiences.

In many cases, women tended to see the medical establishment or themselves as responsible for the abnormal experience. Jean explained, for example, that when her water broke during her first pregnancy, she did not go into labour. This despite the fact she was not induced for two days. While there were no serious complications and she did not initially view it as *abnormal*, she later learned through stories that other women told her, of the potential dangers of such a delay and was extremely upset with the physician. She blamed him for placing her and her baby at risk. Other women talked about being over medicated during labour. Such conclusions were generally based on the ways experiences changed following the medication. In relation to pregnancy, the result was a long and unpleasant experience for which many women blamed their physicians. This was the case for Tina. She and her mother both agreed on this interpretation.

While blame for what was considered an abnormal experience was typically placed on medical professionals, particularly in relation to pregnancy and childbirth, there were some women who blamed themselves. These women typically based such blame on their lifestyles. They mentioned things like the negative consequence of not taking proper care of themselves, of stress and workload. A few women also anticipated blaming themselves for things that had not happened yet. They commented about future events that might be abnormal because of something they did or did not do in the past. Often that anticipation was expressed in the form of questioning whether they had done and avoided everything they should in order to ensure a normal outcome. For example, Sarah explained her concerns as she gets closer to menopause:

I'm concerned with osteoporosis and whether I'm getting enough calcium in my diet. Ah, my lack of drinking milk when I was young and how that is going to ah

influence the way I grow older. How my bones are going to retain their strength. Ah, how much exercise I should be doing now to guard against it? Ah, can I get enough calcium now to make up for the lack of it when I was growing up?

Other women made similar comments about how their lifestyle and diet might affect their menopausal experiences later in life. Others also talked about their childbirth experiences and that they had been told by both medical professionals and other women that attending Lamaze classes would have made the experience less problematic.

A few of the women discussed abnormal experiences in which they had come to the conclusion that no one was responsible. The experiences were viewed as flukes that were outside the control of anyone. Jean's menarcheal experience is one example. She explained, "I started my period when I was eleven years old, which is quite young. Um, I had been in a major car accident the year before and I've often wondered myself 'was there something to do with the car accident that caused me to start really soon.'" Liz, similarly, attempted to identify a reason for her abnormal experience. She had a great deal of difficulty getting pregnant. There was no obvious explanation but she seemed to need to blame someone or something. She explained, "I've often wondered, and no one in my family seems to know, but I wondered if there was some environmental influence about which we know nothing." That became the most plausible explanation for Liz because all of her sisters also had problems with pregnancy. It allowed her to make sense of her experience.

Thus, while interactions with others played a significant role in what women thought of as *normal*, past personal experiences were also essential. Women used those experiences as a basis for comparison and evaluation. Women's conclusions about

particular experiences depended upon what they knew, how much they knew and from whom they acquired the information. Reliance on past experiences gave women more options in terms of how to make sense of a present experience. Some women, for example, recalled comparing menstrual pain to childbirth. Carry remembered that her painful menstrual experiences were “probably why I was so scared about having a baby. The Pain!” Her menstrual experiences made her anticipate a similar childbirth experience. Once she had the experience of childbirth, however, she realized that it was not that bad. She came to see her menstrual experiences as abnormal and the birth experience as normal. With that experience, she was far less concerned about the delivery of her second child. She expected it to be similar to the birth of her first child and no longer anticipated the pain associated with menstruation. And according to what she told me about the second birth, she felt she had been correct.

Carla also made comments comparing her first and second deliveries. She stated:

Well, the second time, I went in for my second delivery, it didn't really matter too much who was around me because I knew then that I could do this whereas the first time you're kind of doubting, “Is this, is there really a baby in there, is this ---” You know you kind of can't picture yourself doing it but the second time I knew I could do it... I could go in and have the baby without too much kerfuffle because I knew I could do it and it could happen.

Other women, who also recognized the importance of past personal experiences, attempted to piece them together and use them to predict what would happen in the future. Jane did that when discussing her desire to have another child in the near future. She said, “it's like everyone is so different but I mean, whenever we have our next one, I'll know even though it could be different, at least, you know, I'll have information of my own to rely on instead of everyone else's.” Sarah more specifically examined current

experiences and considered the possibility that they might intensify with menopause. She raised the question, “Is that [menopause] going to change my attitude, you know, ah, the way I look at things or - - Ah I’m usually a pretty level type person. As I have little times now that I feel apprehensive, that I don’t know why, and I think that might be a little bit of the Change so, you know, that concerns me.”

We can see from the comments of the women that there was particular consideration given to the physical aspects of their own reproductive experiences which impacted on decisions about the normalcy of those experiences. We can also see that women tended to evaluate their own experiences from a holistic and pragmatic standpoint. The entirety of who the women were, what they had experienced, what they knew and the context within which it occurred guided the evaluation process they went through. Women’s pragmatism was made evident by the fact that they not only made sense of reproductive experiences within the context of their lives but also acted in accordance with that context. The women accumulated information, compared and contrasted their own and others experiences. The result was that the women seemed more confident in their ability to evaluate their experiences and their ability to replicate the things that resulted in *normal* experiences. One example of this was Ellen’s decision to stop taking the prescription drug Anaprox in favor of Evening Primrose because other women told her this herbal remedy was more effective and less problematic in terms of side-effects.

The women in this research alluded to such thoughts and actions as “using my common sense.” Carry explicitly made the connection. She explained, “I guess you just

use your common sense. Just, ya, you filter in so much... like walking or any kind of physical activity – that makes sense to look after your body and to nourish your body, right?” That common sense approach to understanding and living with reproductive experiences was also carried forward by the women in relation to their dealing with the next generation. This common sense often included aspects of both medical and folk knowledge – like many prevention strategies (drink milk and exercise for healthy menopause), and like breast feeding.

Such sharing was not so much to impart information as it was to help the girls feel comfortable with their bodies and help them put reproductive experiences into context. The sharing would add to the kind of observational information they had had and no doubt their daughters also had.

**Women Thinking About The Next Generation:
“I think that they will learn their own rhythms and patterns”**

Despite the specifics of their own experiences, the women in this research revealed a sense of responsibility to make things better for the next generation of women. This was mentioned earlier in relation to Anna’s desire to ensure that her children were knowledgeable about reproductive processes. In order to fulfill that responsibility, women felt the need to pass on their own knowledge and personal experiences. Many of the women acknowledged the limitations of their knowledge but seemed to feel that what knowledge they had combined with their experiences needed to be shared with their daughters. There was a sense among these women that this sharing would place their

daughters in a better position than they had been in as young women. They used that information to prepare their daughters (and other young women) through conversations and observations. They also relied on their own experiences to evaluate the experiences of their daughters.

It was primarily women with teenage children who talked about sharing with their daughters, perhaps because their daughters' experiences were more of a concern than to those with adult children who were responsible for themselves. However, women who had small children or planned to have children in the future also mentioned their intentions to be open with their children and discuss such issues.

Carla felt a sense of responsibility to younger women. She also seemed keenly aware of the impact her behaviour might have on less experienced women. She said that during her second delivery she was more concerned about other women around her who were having their first child. She said:

I wanted to make sure that when I was in the delivery room that I wouldn't make a sound cause I didn't want to frighten them because I remember hearing at my – When I was in the first time, hearing women making, screaming and thinking “Oh, my God! This isn't a good idea. I'm leaving this.” But I, so I was really concerned that umm that I wouldn't do that to someone.

Other women made a point of telling me that they at least attempted to discuss every aspect of reproductive experiences with their daughters. Anna, for example, said that she talked to her daughter about everything. She believed that as a result of those discussions, “today my daughter is like an open book. She has no problem with her body. She is also better with her children than I was with her and her brother.”

Some women in the focus groups said that while they felt the need to inform their daughters, their daughters did not want to talk to them. The reluctance of the daughters to talk to their mothers is perhaps similar to the behaviour of these women when they were young. As I discussed earlier, many women did not talk to their mothers when they were young in part because they did not have the accumulated experiences needed to engage in real conversations. There is a need for experience and information to come together. For the daughters of these women, there is also the added factor of greater access to publicly provided information, whether from school or media. Despite that resistance, the women, as mothers, persisted. They did not want their daughters to be ignorant about reproductive experiences.

That sense of responsibility extended to observing the experiences of their daughters. Such observation aided them in preparing their daughters and helping them make sense of things. The women relied on their own experiences and knowledge in order to understand those of their daughters but at the same time they recognized that their daughters' experiences would be somewhat different because their daughters are different and the world is different. A number of women alluded to that difference, particularly in relation to access to information. Beth, for example, said girls today may not end up in situations like the women of the past because:

... now the school system has stepped in much more so than when I, I went to a school with nuns so there was also the religious aspect of it. But even though mine wasn't a model, you know, the way I was raised in that era, umm my kids have done a lot better than I had... They also get an extraordinary amount of information. They have umm sex education and health education in school and umm projects that they are doing, really detailed. I mean quite advanced I think for the grade level... And they're on the Internet. My daughter has I don't know how many magazines she reads and she's getting all kinds of information (Beth).

Beth went on to explain that in addition to information in school, her daughters are exposed to a variety of sources of information. She said, “Their world is much bigger than mine was...I’m on my second marriage so they’ve got all kinds of people. They’ve got step-moms and ex-grandmas and they’ve got all kinds of people” (Beth). Theresa also commented on the differences but focused on the improvement of menstrual products. She stated:

When I was growing up, you had these great big pads, right? And we have these elastic belts with the plastic clips on the front. And God knows they never worked properly. And you’d go to school and you’d be, I remember carrying a little brown bag and you’d carry all your supplies with you and it was cumbersome, miserable.... You’d go to church and you’d see the women with the blood on the back of their pants... the technology wasn’t there. But now technology’s there and you’ve got every assortment of pad, tampon, people on the Pill.

Theresa made similar comments about the numerous medications for reproductive problems that are available today. However, she also added that women today have a great deal more to deal with generally than they did in the past and that might explain why reproductive issues were not a primary concern to them.

Both the examples from Beth and Theresa are interesting beyond the fact that they identified differences between their experiences and those of their daughters. They indicated that those differences are based on the fact that their daughters’ experiences significantly more medical intervention than they did when younger. In other words, the medicalized view is more prominent in society today when compared to the past. Despite, or perhaps because of, those types of changes, the women in this research paid close attention to the experiences of their daughters and discussed things with them or planned to do so well in advance of an experience. Ultimately, they wanted their daughters to be informed. They

wanted them to be comfortable with their bodies and have positive experiences. Inevitably, to assist their daughters in attaining that goal, the women observed their daughters' experiences and used their own experiences to evaluate those observations.

Women Attempting to Make Sense of Daughters' Experiences

When the women in this research discussed their daughters or other young women, there was a definite process involving observation, comparison and evaluation. During these discussions, one of the things women commented on was that the world in which their daughters live is different from the one they experienced. This was a recognition that the changes in the world would make their daughters' reproductive experiences different from theirs. While the women still used their own experiences to evaluate what was happening to their daughters, that acknowledgement of social change was also factored into their evaluations. Beth recognized those differences and felt, as a result, that her daughters would also have different feelings about reproductive experiences. She observed:

They have closer, each of them have a lot of other girls in their lives, girls and boys in their lives. Their world is much bigger than mine was. They have umm, you know. I'm on my second marriage so they've got all kinds of people.... there's no problem with the exchange of information... The only thing that I can see for them that I wish was a little more umm a sense that it is going to be ok cause they have so much on their plate that umm I think sometimes they worry about shootings, the kids in the school yard, ya, they see so much of that.... So they don't have a sense yet that it'll be ok. They don't have sense of themselves yet. Once they have that – But I don't think there's an ideal situation. I think that they will learn their own rhythms and patterns and and once they get a sense of themselves I think they'll be fine, which they don't have yet, you know, because their periods haven't started.

Beth reveals in this comment that despite the differences in the world, her daughters would need to accumulate their own experiences, just as she had needed to do when she was their ages.

While all the women realized that life was different today compared to the past, they continued to rely on their own experiences as a way to understand those of their daughters. At some level they expected those experiences to be similar to their own. Perhaps this is because they were relying on folk or lay knowledge, which teaches that women's reproductive experiences are often similar to those of their mothers. Blaire, for example, had considerable pain associated with her menstrual cycle when she was young. As a result of that experience, she said, "I was prepared for my daughter [her menarche]. If she had the slightest twinge, she was going to be – I would talk to her doctor" (Group 2). Her experience had been painful and she expected something similar for her daughter. As a result, she was prepared to make use of medical interventions to make her daughters' experience better.

Carry also had pain associated with her menstrual cycle and now has a daughter going through the same kind of experience. She said, "she's 14. The poor little one. Her periods are very bad. She clots a lot. She has huge clots. And she's only 14." They had tried a number of medications and folk remedies but nothing really helped. Carry seemed to assume that her daughter would continue to have such experiences because she had until she had a child.

The reality of watching their daughters in pain, due to menstruation, was a major issue for many of the women. Carla's daughter, for example, began to menstruate at age 11

and she has had “trouble with menstrual cramps.” Carla felt badly for her daughter. She understood the kind of pain her daughter was going through each month and implied that it was worse because she was so young.

Kelly implied that even though her daughter experienced pain, as she had, her daughter was much more fortunate than she had been because she explained things to her. She felt that providing her daughter with information regarding how to deal with what she perceived to be an abnormal experience, premenstrual syndrome, would at least help her daughter to understand what was happening. Kelly had no such information to prepare her for any of the reproductive experiences she went through. She found that very difficult and, at times, somewhat traumatic. It was only recently that Kelly discovered that many aspects related to her menstrual experiences were due to premenstrual syndrome. While living through the experience she had no idea why she felt and behaved in the ways that she did. She stated, “you know, we didn’t have any information about stuff like that. We just suffered through.” Not knowing; not having an explanation for what was happening to her was what made her experiences confusing and traumatic. Because her daughter was having similar experiences Kelly informed herself by reading books and articles and talked to women at the local women’s centre. It was these women who first told her about PMS and prompted her to learn more and help her daughter. She, in turn, informed her daughter so her daughter would understand what is happening to her and be better able to deal with it.

Not all of the observations the women made of their daughters were related to menstruation or pain. Jean’s observations of her daughter’s pregnancy led her to the conclusion that the process had become much more involved and complex than when she

had given birth. She indicated that things were much simpler when she was pregnant; that there “wasn’t such a to-do.” From watching her daughter go through a pregnancy, she claimed “there seems to be a whole lot more made of having a baby. There’s all this, you know, Lamaze or something or they’re all going to this and their partners are going with them” (Jean). The implication was that pregnancy and childbirth were far more controlled by medical professionals than had been the case when Jean had her children, approximately twenty-five years ago.

Other women went beyond observation to anticipation. They imagined what their daughter’s experiences might be like, again based on their own, and tried to determine how they, as mothers, could make things better. Carla, for example, was concerned about the possible future pregnancies of her daughters. She found the lack of support she received from medical professionals negatively affected her experience and wanted to make sure that this did not happen to her daughters. Assuming that her daughters would someday become pregnant, Carla wanted to be in the delivery room with them in order to be certain that they got the support they needed. As already indicated, that concern was based on her past experiences. From her experience, “the little things that happened to me made a big difference, little things that were said or the way I was treated. So I want to be very supportive... you have to be reassured that things are okay, that you’re doing fine. And I think that makes a big difference.”

These women were genuinely concerned about the experiences their daughters were having and would have in the future. They felt a sense of responsibility to help these young women feel comfortable with reproductive experiences. They recognized that society is not

the same as it was when they had their own experiences but still assumed that their daughters' experiences would be similar. In this regard, the women wanted to make certain that their daughters had the support and positive reinforcement that was sometimes missing for their own experiences.

While it was interesting that the women so closely observed their daughters, the fact that it did not end there was more significant in terms of this research. The women did not only observe, they also talked to their daughters. That behaviour reinforces my finding that most women rely on other women for support and information. It also indicates that most women were comfortable with that arrangement. Their behaviour implies a desire to continue that arrangement into the next generation.

Preparing the Next Generation of Women for Reproductive Experiences

Several of the women commented that they wanted to discuss everything with their daughters because they wanted their daughters' experiences, particularly with menstruation, to be less traumatic than their own had been. Some like Beth, talked to their daughters and presented menstruation in a positive light, hoping that would influence the attitude of their daughters about the experience:

My daughters, I have given them lots of information which they don't want. And umm, I've got a daughter who is 13 that hasn't started [menstruation] yet and doesn't care if she ever starts and doesn't want to know anything about it. And I'm telling her what a wonderful experience it is and how powerful it is for her and the different moods and rhythms she'll get into and umm it's a very positive experience as a woman but umm she's not interested in any of that. And the eleven year old, I have a daughter who is just turning eleven, and she umm she just puts her hand up. She doesn't want to discuss any of it at all although she's very close I think to

starting her periods before the older one. So umm but the way I was raised – it was entirely different.

Despite Beth's good intentions, her daughters lacked interest in what she had to say. Beth simply thought their attitude was a consequence of their ages. She was not concerned because, despite their reactions, she knew they had the information she thought they needed. Whatever daughters' reactions were, other women implied the same sense of satisfaction and felt they had been successful in fulfilling their responsibility as mothers.

The same sense of satisfaction was seen in relation to other reproductive experiences. It was illustrated by the comment of Theresa when she said, "I have four girls and I talk to them about the night sweats and the mood swings and how awful and guilty and then I am apologizing. And I told them, 'Really, I'm not crazy even though it seems like I am'" (Group 2). She was passing on her experiences, however positive or negative they may be so that they would be knowledgeable when they had the experience. She wanted her daughters to know that menopause causes changes for women and that although these changes may appear to be "crazy" or unusual, they are *normal* changes that women adjust to with time.

As mothers, like those discussed above, more actively take responsibility for informing their daughters, the circle of reproductive experiences as social experiences closes. The women in this research wanted to be the source of information and advice for others. They became their mothers, or at least who they thought their mothers should have been. While many women were uncritical of their own mothers or felt that everything worked out despite the lack of preparation they had received, the fact that they

seemed so adamant that their daughters would be informed indicates that these women wished they had been told more when they were young.

Conclusion

What can be seen in many of the comments from the women in this study was that the ways women make sense of their experiences is a complex process. It is not simply a matter of accepting or rejecting a medicalized view of those experiences. The experiences are part of their lives and inseparable from those lives. The women acknowledged that individual experiences vary, but also recognized that women, as a group, share those experiences and women are, therefore, the best sources of information. The women were pragmatic in the way they made sense of their reproductive experiences and those of their daughters. The information that they had was considered within the context of their lives.

The women clearly illustrated that the information and advice from other women functioned in a number of ways, including: (1) supporting medical definitions of reproductive experiences and the use of medical treatments and interventions, (2) supporting interpretations of experiences that were consistent with both folk and medical knowledge, (3) supporting behaviours and attitudes that undermine biomedical approaches, (4) guidelines for assessing normalcy, (5) a way to avoid being seen as ignorant by “experts,” (6) an evaluative component, and (7) a way to avoid repeating negative experiences.

When we consider the comments of the women as well as the research that has been done by others in this area, a general social and cultural context of women’s reproductive experiences can be seen. There are issues of trust, definitions of normalcy and the

combination of physical experiences and interactions with others that are all part of women's experiences. Despite those common elements, however, there were distinctive social and cultural issues for the women in this research, living on Cape Breton Island. The local culture of the area and the influence it appeared to have on how women viewed their reproductive experiences is the focus of the following chapter.

CHAPTER 7

LOCAL CULTURE AND THE PRAGMATIC WOMAN

Introduction

In this chapter, I present the complexity of how experience and reason inform one another within the particular socio-cultural context of the Cape Breton Regional Municipality. The women had their reproductive experiences in a social environment and that environment not only affected the types of experiences they had but also influenced how they viewed these experiences. As illustrated in the previous chapters in relation to other people, this meant women were constantly synthesizing the physical experiences, information they accumulated and social interactions around these experiences into something meaningful.

For the Cape Breton women in this research, the socio-cultural context of their lives was what made them somewhat different from women in the rest of Canada. As indicated in chapter 4, the history of the area has been such that a general negative attitude and skepticism seem to pervade views about life. Given the circumstances leading to that attitude and the small size of the community, family relationships have been extremely important. These relationships influenced the actions women took regarding reproductive experiences. That influence was evident in the emphasis the women placed on interactions with their mothers, sisters and daughters, discussed in chapter 6.

This chapter presents aspects of the socio-cultural context in which the women who participated in this research had their reproductive experiences. In the first part of the chapter, I discuss the socio-cultural context within which these women lived. In the remainder of this chapter, I discuss the influence this context had on how the women thought and acted in relation to their reproductive experiences.

The Influence of the Negative Current in the Local Culture

The majority of the women in this research had lived on Cape Breton Island for their entire lives and the remainder had been there for most of their lives. More specifically, the women had lived in the Cape Breton Regional Municipality (CBRM) for many years. All the women had, therefore, lived in the area long enough that the cultural history and ideology of the area influenced the ways in which they attempted to understand their reproductive experiences. That history and ideology centered on struggles, economic hardships, environmental hazards and extremely strong ties to family and community.

The historical struggles of Cape Bretoners have been fairly well depicted over the years in novels, documentaries and movies. Examples include Hugh MacLennan's, Each Man's Son and movies such as The Bay Boy and most recently The New Waterford Girl. While the people have changed with time and are no longer necessarily like the characters in these works, there is no doubt that the struggles depicted in such popular works continue to influence the people in this area.

In addition to that history, the community faces current struggles significant enough to attract national attention. These new struggles involve continued economic hardship, serious environmental pollution, and a high rate of severe health problems combined with a shortage of medical professionals.

Given the culmination of historical and current events, many of the people in the area have come to the conclusion that the worst should be expected and good things are rare. That attitude was clearly illustrated by several of the women in this research. While discussing reproductive experiences that they identified as normal, the women qualified their statements. They used phrases like that from Carla who said, “I’ve been lucky.... I’ve never miscarried. I’ve had two healthy children.” Nina said, “I think often that I have been fortunate because I have had no problems. And it’s not always the case that women go through all the stages of the life cycle with such ease...” The implication of such statements was that these women believed that their *normal* experiences were unusual and that problems might reasonably be expected.

While this sentiment may not be unique to women living in CBRM, it is consistent with the general belief in the local culture that Cape Bretoners should expect hardship. It is a belief that has developed throughout the history of the area. In recent years, part of this perception of hardship has related to a connection between the pollution from the Tar Pond and a noticeably higher rate of miscarriages and birth defects in CBRM compared to the rest of the country. While it is not clear whether this belief is supported by the facts, it is a common belief of many living in the area.

In response to the social problems identified above, a cultural attitude of “us against them” has evolved in this area. There is a feeling among Cape Bretoners that many of their social problems are caused by others. The historical problems associated with the local steel plant are an example. The plant was never under the control of people who lived in the area. The waste produced was never properly disposed of, resulting in the pollution problem that has made national news. The feeling among Cape Bretoners is that they were left to live with the consequences. The women in this research seemed to adopt that attitude in relation to many of their reproductive experiences. As discussed in chapter 5, many women indicated a sense of “us against them” in relation to their dealings with medical professionals and also in instances in which they felt there was a need to assign blame for something that *went wrong*.

Women often experienced or expected interactions with medical professionals to be difficult, strained or even antagonistic. Whatever the specifics of the interactions, it was clear that most of the women experienced them as power struggles. Several of the women indicated an awareness, in anticipation of such interactions with physicians or nurses, that they were thought to be dismissive, rude, inconsiderate or even cruel. Some examples of this were discussed in chapter 5. One is found in comments Mary made when I interviewed her. She was discussing the problems her sister had dealt with after moving to Sydney (the only city in the CBRM) while she was pregnant. During that discussion she made reference to a specific doctor. She said, “I heard he was rude and ignorant and terrible to women. A lot of women had a hard time with him but they had no choice because he was the only one in Sydney.”

There was also the sense among a number of women, like Carry and Iris, that medicine is a business. According to these women, the result was that the interests of medical professionals – money - and those of women were often in conflict. It made these women reluctant to trust the advice of those professionals. It also made them more likely to maintain control over their bodies and seek advice and information elsewhere.

In virtually all of these encounters, the women never confronted the medical professionals. They only told friends or relatives how upsetting the experience had been for them and were eager to discuss the experiences with me. Daisy, for example, observed when talking with me about her miscarriage, “You are the only person I ever talked to about this, other than my husband.” Other women talked to their mothers, sisters, friends and daughters. And in most cases the women found that their feelings were shared by others.

In general, that view of “us against them” was reinforced by the victim blaming that Cape Bretoners, as a group, felt they had experienced. There was the perception among many of the locals that Mainlanders and others across Canada had stereotyped them as lazy, alcoholic, pogeys [welfare] abusers. The idea of victim blaming emerged a number of times in comments women made about how medical professionals made them or others feel. Carry recalled an event that she observed a few years prior to our discussion. She said she observed a young woman, who she knew to be mentally challenged, arrive in one of the hospitals:

She came in... she had the baby and they had to cut off her pantyhose to get the baby out. The baby died.... She had never gone to the doctor anytime through the pregnancy. Her mother didn't even know she was pregnant because she was obese. She, it didn't show. The doctor wanted the girl arrested. The baby died and

the parents came.... Of course everyone was weeping. It was just, just the lack of sensitivity... on the doctor's part cause it was incredible. They [hospital personnel] thought she should have been charged... and this doctor was appalled. He said, "She should be shot! Call the police! Call the police! Call the police!" It was just just awful. You wouldn't probably get that in larger cities as opposed to smaller communities.

Carry also had a personal experience with childbirth that she discussed at an earlier point in the interview. During the delivery of her first child, she was having some difficulty dealing with the pain. The doctor implied that this difficulty was her fault because she had not attended child birth classes as he had instructed her. She explained:

There was a lot of pressure too for me to take Lamaze.... I went to one prenatal class and I didn't like the crowd... So I didn't, I never went back. And I was ok with it but I got pressure from my doctor... he said some medical term and I said, "Oh, I don't know what you mean," and he said, "Well, you would know that if you had gone to prenatal class." I said, "No, I didn't go." He said, "You didn't go!" It was almost like a little lecture. I thought, "Well, the baby's coming whether I go to prenatal or not!"

In addition to the influence that "us versus them" and victim blaming had on the women in this research, there was the negative stereotype of Cape Bretoners. There was a perception among many of the locals that the rest of Canada saw Cape Bretoners as unruly and wanting something for nothing. Much of that came from the belief that the media and other public institutions emphasized the isolated, negative behaviours of some Cape Bretoners. They felt they were viewed as the problem while those with whom they were struggling were presented in the most positive light. For many, continued reinforcement of that belief made them reluctant to stand up for themselves. This filtered into women's behaviours related to reproductive experiences. They wanted to avoid the label of "problem patient." Not only was such a label viewed as negative, it also carried with it the possibility of a doctor treating them differently or refusing to treat them. Kay's

child birth experience, discussed in chapter 5, is an obvious example. When the medical professionals decided that she was simply a difficult or problem patient, they physically restrained her. Marie's experience with a doctor refusing to see her or return her calls when she was pregnant serves as evidence that women do, in fact, have reason to be concerned about such labels.

These circumstances, in conjunction with the fact that the majority of the population was Catholic and working-class or unemployed, seem to have contributed to a reluctance to challenge certain types of authority. These authority figures included priests, doctors and educators, all of whom many Cape Bretoners were taught to believe were above them. Differences in perceived wealth, power, and knowledge were often the reasons cited for such beliefs. Carry alluded to this belief when she said:

In general, you know, we always say status is very high in our society. We always meet somebody and first thing we say, "Oh, hi. What do you do?" so we sort of place a lot of emphasis on what you do. We know that cause money's so important it sort of, lots of times, dictates who you are and what you are and where you stand in society. And, so, because doctors are way up there on the pay scale, we sort of look up to them.

For many of the women in this research, this was the social reality for most of their lives. In recent years, that reluctance to challenge authority has been declining. At the same time, however, Cape Bretoners have been taught that challenge and confrontation with those in power rarely works to their advantage. They, therefore, must simply make the best of bad situations. Consequently, many Cape Bretoners, especially women, have illustrated a desire to "keep the peace," sometimes at considerable personal cost. That may be why many of the women in this research rarely told medical

professionals that they disagreed with or disapproved of what was done to them by those professionals.

Even on those rare occasions when a woman did challenge or question the advice of her physician, she was often met with a dismissive and somewhat condescending response. Carla, for example, was concerned, twenty years after the fact, that there might be negative consequences for her daughters because of a drug the doctor gave her during her pregnancies. She discovered new information that heightened her concerns and, as a result, she attempted to discuss that new information with her physician. She explained:

I remember seeing an article in the newspaper about this drug [that she was taking for morning sickness] and ah bad birth side effects on it and I cut it out and I brought it to my doctor and she kind of poo-pooed me, saying that umm, “Oh, you know, they do studies on everything.” Sort of, you know, “Don’t pay attention to that.” But I was really concerned about that and I did take it with both children. It, it – When I was having the second child this is what I had read in the newspaper. And, oh my soul, I was so nervous that I feel maybe I was getting, maybe I shouldn’t have been taking that. Although I took way less than I was supposed to and I tried to do it on my own with the nausea. (Carla).

Despite her concerns, she felt the physician was completely dismissive of her and responded to her as if she were a child. This exchange served as a reminder to Carla that her doctor, occupying a higher status than others in the community, did not feel the need to explain his decisions regarding treatment.

The desire to keep the peace seemed to be born out of necessity. Women were aware that their options regarding obstetricians and gynecologists were severely limited in the Cape Breton Regional Municipality. Mary’s comment, discussed above, that there was only one such doctor in the area illustrates this. Another woman who was very upset

by the treatment she received from the same physician explained, “I didn’t want to say anything cause he was the only gynecologist in town and I’d be left with none.”

These women kept the peace and did not say what they wanted to say because they were concerned or fearful of the consequences. Even though they knew what happened to them was wrong, they felt they had no choice. They had to remain silent. If they did not, they could end up with no obstetrician/gynecologist or they would have to make the four and a half hour drive to Halifax – something that was economically impossible for many women.

Unlike most of the women in this research who were dissatisfied with their physicians, Debra took a chance. She stopped going to her physician (GP) because of his continued insistence that she take HRT. She recognized that she was fortunate to find another doctor. However, her behaviour was simply another way of avoiding confrontation and keeping the peace. She did not want to be labeled. Although she was upset with his continued insistence that she take HRT, she never confronted him. She simply avoided the entire situation by finding a new physician. Such avoidance tactics were common among Cape Bretoners. When they felt powerless to change something, they simply avoided it and behaved as if it did not exist.

It appears from such comments that many women felt more comfortable maneuvering around problems with medical professionals than confronting them directly. As Oakley (1993: 175) found, and the women in this research illustrated, “Open and visible conflicts are rare, not because women are satisfied with medical control but because they feel themselves too powerless to oppose it.” The socio-cultural context of

Cape Breton, coupled with the shortage of physicians, forced the women who spoke with me into a position where keeping the peace was sometimes the only practical choice. They were essentially trying to make the best of a bad situation.

Despite the negative circumstances in which the women often found themselves, there was also a definite innocent optimism among the women that things would get better. That optimism was apparent in some of the comments women made about their daughters and the future in relation to reproductive experiences. As I described in the previous chapter, some women, for example, discussed the advances made in relation to menstrual products that make life easier for young women today. Others commented on the more active involvement today of male partners during pregnancy and childbirth.

While the socio-cultural circumstances in which the women lived appeared to have negative elements to them and set boundaries, we can see that the women did not allow these alone to define their reproductive experiences. Rather, these women were practical in their approach to this reality. They were able to identify some positive aspects to their lives, even if that positive perspective was couched in terms of luck or optimism for a better future. The women did not let one aspect of their reality define their experience in its entirety. The close ties with nuclear and extended family members were one reason that these women, and Cape Bretoners generally, could circumvent the negative atmosphere.

The Importance of Family in a Small Community

It is clear from chapters 5 and 6 that the women in this study were influenced by many things when attempting to make sense of their reproductive experiences. The great importance placed on significant others, especially female family members, can be interpreted as a consequence of the socio-cultural context in which they live and could be considered a defense mechanism of sorts. Family is an essential part of life for most people who live on Cape Breton Island. Until fairly recently, the families in the area were large, which reflects, in part, the strong Catholic presence in the community. Extended family members often maintained close relationships and socialized together. Part of that closeness can be explained by the historical struggles of the area. Life was and is not easy. People have been, to a great degree, at the mercy of the environment and the economy. These struggles have forced people to rely on one another, particularly family members. The old saying “blood is thicker than water” was and is a cornerstone of the dominant ideology in the area.

The connections to and dependencies on family were important issues for virtually all of the women in relation to reproductive experiences. The kinds of relationships with family members, their expectations of family members, and how those individuals responded or reacted were often considerations in women’s constructions of themselves and their reproductive experiences. Karen’s concern about telling her mother that she had “premature ovarian failure” and, therefore, would not be able to have

children illustrates the importance of family:

Umm, well, I found it really difficult to talk to my mother actually cause I felt really bad. Whenever I talked to her I felt like crying cause it almost felt like a second loss. I felt bad because I I kind of felt, umm, and this is really hard to explain in a sense because like I said, me having children was almost something I took for granted... when I found out it would never happen, I felt bad for me but worse for my parents. I am the oldest of three and I'm quite close to my mom and I felt really bad that she'd never see... grandchildren through me.... It took me about a month to be able to really talk to Mom about this.

Karen interpreted her situation not just by considering how it would affect her but also by considering the impact it would have on her mother. It was not simply her thoughts and feelings but also those of her family that made accepting her situation so difficult.

One of Carry's experiences with her family also illustrated the influence family members had over women's sense of self and their reproductive experiences. According to Carry, her sisters vigorously pressured her to breast-feed after she had her first child and they were nearly successful. The importance of family is evident in the fact that when medical professionals tried to persuade her to breast feed, she was simply annoyed with them. She felt that it was none of their business; that it was her decision. When her sisters pressured her, she felt uncomfortable. It was difficult for her to stand her ground. She sensed their disapproval and felt the need to continually justify her decision.

The comments from both Karen and Carry indicate the need for approval from female family members. Given the reliance on female family members over the years and the bonds of trust and support that existed, it was not surprising that women also sought their approval. A result of that need for approval was that mothers and sisters had considerable influence over women in terms of their views and behaviours. Therefore, it was not simply that women learned what to expect of reproductive experiences from

those women. There was also the sense among the women who spoke to me that those individuals evaluated them and their actions. It was also clear that the women wanted those individuals to positively evaluate them. Given the negative environment in which these women lived, the family was a major source of positive reinforcement. However, that need for approval was not enough to make the women think or behave in ways they believed to be contrary to their best interests.

As I became engrossed in the stories the women told me, I had no doubt that these women were involved in a complex process of understanding. They did not simply accept or reject any information, advice or experiences in relation to this process. They used everything, from personal experiences to the dominant ideology of their community, which might help them to make sense of and deal with their reproductive experiences.

**A Pragmatic Approach:
Cape Breton Women's Reasons for using Medical Treatments and Interventions**

Without consideration of all these people and circumstances that influenced women, their use of medical interventions and treatments could be interpreted as an indication that they accepted a medicalized view of their reproductive experiences. When the women were asked why and under what circumstances they used medical interventions and treatments, however, their pragmatic approach emerged. They rejected the medicalization of their experiences when it was expedient to do so, but made use of its technology and treatment when in their judgment, it was the best approach to take.

For many researchers who are critical of the medical system, that rejection has led to an eagerness to interpret women's behaviours as forms of resistance. Ellen Lewin begins her article, "Wives, Mothers, and Lesbians: Rethinking Resistance in the US," by commenting on the use of the word *resistance* in the literature. She states:

Resistance, as we have come to know it in a literature that focuses largely on women's experiences in the workplace and in health care settings, can be either conscious or unconscious, either carefully crafted or serendipitous, either direct and efficient in its impact or stymied by powerful forces beyond the control of the actors.... "Resistance" is rapidly becoming a word that covers anything, defines itself, and may be said to exist because we insist that it do so (1998: 164).

For those who define resistance as conscious and direct, the tendency has been to identify resistance in women's behaviours that are not consistent with the expectations and recommendations of medical professionals. Many of the behaviours of the women in this research could be interpreted in this manner. For example, the women talked about not doing what medical professionals recommended. They also mentioned delaying their arrival at the hospital for childbirth.

Problems have arisen, however, over such definitions of resistance. For example, many of the contributors in Lock and Kaufert's (1998) book raise the issue of whether a behaviour can be an act of resistance if it is not intended as such by the individual. Examining such behaviours in the absence of the socio-cultural context could lead one to misinterpret the behaviour as resistance. The women in this research who were involved in such activities, for example, did not describe their behaviours as resistance. They were simply doing what they thought was best given the circumstances.

I realized that applying the label of resistance to women's behaviours was overly simplistic. By listening to the women, I found, like those who contributed to Lock and

Kaufert's (1998) book, that women's meanings and behaviours cannot be explained in such limited terms. What the women in this research thought and did were products of the context of their lives and the world in which they lived. They were socialized into the Cape Breton culture. They learned that family should be trusted and relied upon. They learned that people with power do not necessarily have their best interests at heart but cannot be directly challenged. They also learned that they should trust their own experiences and do whatever seemed best in relation to their lives. Women took all of that with them when they entered into the process of trying to make sense of their experiences. Once they had meaning, the women responded or behaved in ways that reflected an approach to life that was fundamentally pragmatic.

That issue of pragmatism was most clearly apparent when I carefully considered the reasons women did or did not use medical treatments and interventions. There were many reasons women used such things. The reasons that seemed to be most important to the women in this research were: (1) social pressure and the desire to avoid blame, (2) to explore a perceived problem or to secure some benefit.

Social Pressure and Avoiding Blame

In many instances, the existence of perceived social pressure and blame hindered women's abilities to act on their thoughts and feelings. They felt their control over experiences was being challenged or taken away and identified a number of instances in which they felt that way.

The importance of social pressure in relation to reproductive experiences was not unexpected. Many researchers dealing with the topic of women's health have called our attention to it. In some instances, such pressure has been discussed in relation to societal expectations of women. For the women in this research, those expectations came from the larger Canadian society as well as the community of Cape Breton. As discussed in chapter 6, Marie alluded to social pressure as a rationale for why women seek out medical assistance for experiences like menstruation and menopause that do not, in themselves, require medical intervention. Other women discussed social pressure in relation to the idea of home births. They felt that hospital births were generally unnecessary but were certain that women who chose home birth would be blamed by others if anything went wrong during the delivery. The same logic was used to explain why women allowed medical testing that they did not want or for which they saw no need.

Another example of social pressure involved decisions about breast-feeding and HRT. Breast-feeding was a particularly pertinent example because views have gone from one extreme to another during the reproductive years of some of the women in this study. As discussed in chapter 6, when Carry was having her children in the late 1970s, she experienced such pressure from her doctor and her sisters. Debra recalled a woman she knew in the 1960s whom she assumed experienced different pressure. During that time period, bottle feeding was the more popular choice. That woman, like many others at that time, did not breast feed her children and Debra was convinced that it was because of her

husband. “I think it was to appease their husbands. And I think,... her appearance was very important to her and her husband.”

In addition to these types of societal pressure, several women made comments about the pressure that came directly from their physicians. As I explained in chapter 2, women’s reproductive experiences became a focus of the medical profession early in its development. Social pressure, in different forms, was one of the tools used to ensure that the medical professional would be accepted as the expert. With continued technological advances and new health discoveries, women continued to experience pressure to conform. Carry mentioned a personal experience in which she felt chastised by her physician. As illustrated above, Carry felt pressure to take Lamaze classes. When she did not complete the course, her doctor lectured her. Many of the women in this research directly and indirectly commented on the social pressure they had experienced in relation to reproductive experiences.

Associated with the idea of social pressure were the ideas of control and avoiding blame. Social pressure is a form of control and the issue of control was very problematic for women. While they generally desired more control over decision-making, the consequence was the possibility of women being blamed for the outcomes.

Parson’s concept of the sick role seemed to provide some understanding of why women are sometimes willing to had over control. Adopting the sick role entails certain obligations and rights. The first obligation is that the sick person must “define their sickness as undesirable.” The second obligation is that the sick person “must endeavour to seek appropriate help (usually from a physician) and co-operate with professional

recommendations and treatment.” Once these two conditions are met, the individual is entitled to “withdraw from some or all of their social obligations and responsibilities” and they are “exempt from responsibility of their sickness” (Miles 1991: 73).

In line with Parson’s sick role, if women did not hand over control to the professional, they could be held accountable and denied the right to withdraw from obligations. With that in mind, given the Cape Breton experience of victim blaming, the lack of control could be a desirable state for these women. Once the decision-making was handed over to some legitimate authority, women could avoid blame in the event of negative outcomes. The idea of avoiding blame was perhaps difficult to identify because it involved larger societal pressures, not just the perceived power and control of medical professionals.

It is obvious the women in this research considered the idea of blame in their decision making regarding reproductive experiences. They commented on the number of unnecessary tests and visits to the doctor during pregnancy, for example. Many women also mentioned that hospital deliveries were rarely necessary. But all the mothers had the tests and went to see their doctors and gave birth in the hospital, “just in case.” They did not want to deal with the guilt that they would feel if they had not done everything they could and something went wrong. They were playing it safe, particularly in cases of childbirth, because the health of another person was involved and the blame that a woman would experience would be that much greater.

Carry illustrated the idea that women do in fact take into account the issue of blame when making decisions. She was one of the women who felt that hospital deliveries were usually unnecessary. As part of that discussion, she said:

Could they really stop you, you know, say I really wanted to have a baby at home, you know, they couldn't do anything, could they? But then, I guess you're setting yourself up should anything go wrong, probably they'd charge you. Say the baby died or something, they'd say you were negligent or something. Or of it came too quickly!

Jane had planned to wait as long as possible before going into the hospital to deliver her baby but when the contractions began, she did not wait. She was concerned that something might go wrong. She was glad that she did not wait because the baby came much faster than she had expected and she would not have been comfortable having the baby at home.

The use of HRT was another example of blame avoidance. HRT was presented to the women in this research as a necessary treatment in the prevention of osteoporosis. Similar to the women in Coney's (1994) work, the women in this study felt they were being set up for blame. The implication was that women who refused HRT would be at fault for not taking the appropriate action to prevent osteoporosis.

The women were definitely aware of the social pressure and potential blame involved in their reproductive experiences. And, in some instances they behaved in ways that allowed them to avoid those things. That is, they did what others expected of them. The women had learned from the local culture and previous experiences that if they at least appeared to follow the advice of medical professionals, they would avoid blame. However, such behaviours were not indications that they agreed with the medical advice

or that they would behave in similar ways in all circumstances. They made evaluative judgements within the particular context of acting. So, while blame avoidance behaviour superficially indicated agreement with medicalization, it often disappeared upon closer examination. These women did not always agree. They were simply using the system to their own advantage. Using the medical system was, in fact, a major indication of women's pragmatism in achieving ends unrelated to medical imperatives.

Women Using the System when they Perceive a Problem or for Perceived Benefits

Most people would agree that medicine is often beneficial, especially when someone is experiencing a physical problem. Reproductive processes, however, are not problems despite medical intrusions. In a sense, that means women must live with contradiction. The contradiction lies in the fact that medical interventions in women's lives have been simultaneously detrimental and beneficial for women (Riessman 1983). The detrimental consequences for women have been discussed in great detail in chapter 5. The benefits, however, were a primary reason the women continued to turn to medical professionals.

The women who participated in this research recognized the simultaneous presence of both the detrimental and beneficial consequences of medical intervention. As Jean said, "I think medicine is a good thing overall. I think they do some good and they don't damage everybody." In general, the women in this study indicated two types of benefits that they have experienced. There were benefits in the form of correcting or

preventing physical problems and perceived benefits that fell outside the definitions of medicine.

There were a number of women who had used medical interventions and treatments because they believed they were necessary in the particular context in which they found themselves. In other words, they believed there were problems that these interventions or treatments could correct. Women adopted such a position because, through their past experiences and interactions with others, they agreed with the physicians' recommendations. When Lee was pregnant, for example, she had planned to have a completely natural childbirth. However, because she was overdue, medical interventions were used. While she was convinced that the interventions were necessary, it is clear from her description of the events that she would not have wanted such things under "normal" circumstances:

Everything was natural except at the end I hemorrhaged so I'm sure they gave me something. They give you something when that happens. So that that was at the afterbirth. So they, there was some intervention they had to do umm in order to stop the bleeding, tighten up the uterus, so. I forget the name of the thing they give you.... So other than that and I was comfortable with that... so he said, "Well we're gonna need this intervention." And I was feeling very weak at the time and had the baby in my arms and like the plan was that I would hold her and feed her and all this stuff and I got her and they wouldn't take her away and wouldn't you know they do all these things to the baby and umm they would wait to do those things. But I immediately, when I started, I gave birth to the placenta, I started to feel really weak and I had to say to my husband, "Take the baby. I just feel so weak." So whatever it is at, you know, that point umm that was necessary they did.

Beth also found herself in a pregnancy situation in which she believed there was a potential problem and saw the merits of using a medical intervention. She had already

given birth to one child and was pregnant for the second time. She said:

The second one [birth] was just a scheduled section. I went in on the specified date and they just did it, did a section.... I just couldn't deliver babies.... so I didn't have labour with the second one and the first one – it was just horrible. I couldn't believe it, what I was going through. I mean to actually feel the bones moving [laughter]. I couldn't believe the pain. Nobody told me! You know, everybody says it's going to be horrible but until you actually feel your pelvis changing, you feel the bones moving, then ah you don't know what you're in for.

Carla made a direct comment about taking advantage of the medical benefits available. When discussing her childbirth experience, she felt the need to justify her request for pain relief. This need seemed to be a consequence of the fact that Carla diligently presented herself as a woman opposed to the medicalization of reproductive processes. She said, "I had in my mind that it was going to be all natural but when I got in there and I was so, I was awake 36 hours before I delivered... I was getting so tired and my pain threshold was getting lower and lower."

Debra was induced with her third pregnancy. She explained, "I was induced with the third. I was over and they were concerned so they induced me and of course he was slightly jaundiced so it was probably the right thing to do."

Karen identified her early menopause as a health problem because she was only 34 and, therefore, believed that she needed medical treatment. She said, "I'm having to umm to ah chemically give my body what it should naturally be producing. I take estrogen and progesterone and calcium so I have to do all those things that I should be doing naturally. And umm it was kind of a big adjustment at first." Karen's physician told her that she had no choice regarding medical treatment and she agreed. She

explained:

Actually for me there was no choice and that's what he said, "Well, in your case, you have no choice. If you don't take estrogen there's gonna be some major serious medical problems, complications that you're not gonna survive in the long run if you don't take estrogen cause your body desperately needs it. It's – you should have it." And he explained a lot of things to me and he really gave me a lot of really good information about what what they're discovering now. And one really scary statistic is umm, there's now a real connection between a lack of estrogen and Alzheimers in women and that just about scared the life out of me.

Karen also discussed an experience of her mother that required medical intervention. While she suspected that the problems were at least partially the result of the physician's lack of action, there was no doubt in Karen's mind that her mother needed to have a hysterectomy. She said:

Actually, this year she just had a hysterectomy. And her doctor was really umm pretty slack umm and didn't really think to inform her of some of the, you know, complications. And she did have some complications that I'm pretty sure she could have avoided had she been taking the replacement hormones. Well, she's fine. It's no big deal cause she's, she had it taken care of and she's fine and it's over (Karen).

It is understandable that these women accepted that medical interventions or treatments were necessary or helpful under the circumstances in which they found themselves. However, the perception of a problem was only one of two reasons that women made use of such things. A number of women also indicated that they made use of medical interventions and treatments for unconventional reasons. Miles (1991) also identified this unconventional use of medicine in her work, *Women, Health and Medicine*.

While Miles' discussion of Parson's sick role was useful for explaining why women sometimes hand over control to medical professionals, it also clarifies the issue of benefits. Once the obligations of the sick role are met, the individual is entitled to

“withdraw from some or all of their social obligations and responsibilities” and they are “exempt from responsibility of their sickness” (Miles 1991: 73). As Miles (1991) indicates, women’s acceptance of the sick role in relation to their reproductive experiences is easily understood. She explained:

This motivation to escape into the sick role would certainly be understandable in the case of women... Relentless routine, feelings of being trapped with no prospect of relief, might well make an illness episode seem attractive. It is at least possible that a glimmer of such hope influences some women to go to the doctor with symptoms of tiredness, headaches, sleeplessness, backache, etc., which others in different circumstances, would regard as “part of life,” not necessitating medical intervention (1991: 75-6).

Because many women do withdraw from obligations and responsibilities, it is assumed that they view such experiences as illness and feel obliged to seek out medical expertise to “correct the problem.” It would seem, however, that there is a need to distinguish between women’s intentions and social interpretations of their behaviours.

The women I spoke to alluded to using the medical system and what it had to offer them. As already noted, in some cases, the benefits women saw were not in line with the medical purpose of the treatment or intervention. Several of the women made these comments in relation to taking medications. Many, for example, stated that they began taking birth control pills, not for the purpose of birth control, but to regulate their menstrual cycles. They in no way perceived the “irregularity” as an illness but rather as a social inconvenience that the pill could fix. As one woman explained, “That’s why I went on the pill in the first place at 16 – to manage the bleeding. I know lots of girls who are on it cause they’re irregular. I think it is a good idea so you can have some certainty about it” (Sue). Other women made similar comments, indicating that it was problematic and potentially embarrassing never knowing when to expect menstruation. Such

explanations for the use of birth control pills were conveniently compatible with the teachings of the Catholic Church that dominate in the CBRM. Taking birth control pills to regulate menstrual cycles, not to prevent pregnancy, was acceptable for young unmarried women. The result was that women received both benefits without having to acknowledge the second, socially unacceptable benefit of safer sex.

Women in one of the focus groups participated in a discussion about the length of time women stay in the hospital after giving birth. Not one of those women thought of the typical childbirth as something that required medical interventions or treatments. Several of them saw no need for deliveries to take place in the hospital. Despite such thoughts, they were unhappy with the decreased number of days women stay in the hospital after giving birth. Their concerns centered on the fact that in their experience, the only real rest women got after giving birth was while they were still in the hospital.

According to the women in that focus group, many women no longer had extended family members nearby to help them. This is a fairly recent phenomenon for women from Cape Breton. There has been an exodus of young people due to the lack of employment and many of the women were thinking of those young people living off the island without family. In addition to that situation, many mothers of new mothers were in the workforce and therefore unable to help. As a result of these circumstances, women felt that longer stays in the hospital should be an option for women. The hospital was, after all, thought to be a place to rest and avoid responsibilities.

The comment Marie made about her mother's use of HRT was another example. Marie indicated that her mother was not taking HRT in order to make the physiological

aspects of menopause less problematic, but rather to help her, as a menopausal woman, cope with social pressures.

As indicated, taking advantage of medical treatments did not necessarily mean women believed their experiences were illnesses or diseases. In fact, I found that many women resented labels like sick, ill or diseased despite their desire to take advantage of the benefits of medical treatments and interventions. They were, however, pleased to have the option of withdrawing from obligations and responsibilities during times of extreme menstrual pain, for example. Many were also pleased to accept medication made available during childbirth to manage their pain.

The idea of taking advantage of perceived benefits while rejecting a medicalized view of reproductive experiences can be understood when we consider that such experiences are “both healthy and painful [and are] confusing and deeply rooted in social attitudes” (Miles 1991: 53). The women who spoke with me, for example, had to decide what degree of pain was acceptable or tolerable. As Sue said, “I know it’s [menstruation] normal, but I don’t always feel ‘normal’ but it’s not like I can call in sick when my two year old is raring to go.”

From the experiences discussed in this section, it is clear that the women did not simply accept or reject any particular discourse or view of reproductive experiences. The women had their own agendas and guidelines for when medical interventions and treatments were necessary. They used medicine as it was intended to be used – to improve the life of the patient.

The women appeared to recognize the benefits and limitations that confronted them and created actions that reflected their understandings and beliefs in the best course of action. More often than not, how women interpreted particular situations and decided on courses of action was related to relevant interactions they had in the past.

Understanding Normal: Women's Views of Reproductive Experiences

Overall, the women in this research believed reproductive experiences were *normal* and that they did not require medical interventions or treatments. Words such as *normal* and “natural” as well as “non-event” were commonly implied by many of the women. Women talked about the natural rhythm that comes with menstruation, the unnecessary excessive testing women are exposed to during pregnancy, and their lack of interest in the use of HRT, as well as many other issues. In all cases, with the exception of problematic experiences that the women thought of as unhealthy or dangerous, the use of the medical treatments or interventions did not necessarily indicate a belief that the experience was an illness or disease.

Some of the most poignant examples of women's belief that reproductive experiences were normal arose during discussions about menopause. Becky, for example, took HRT during the beginning of menopause but has since stopped because “I came to see what was happening as normal.” She said that her physician wanted her to take it again but she refused because “there's no justification for why I should take it so I don't want to.” Jean indicated her reluctance to take any medication for menopause because it is natural. She said, “No, it's a natural thing and I'm not on any hormone replacement

medication or anything either.... So I'm reluctant to take hormone medication because I think this is something natural and it happens and I feel fine."

Other women stated that they were post-menopausal but never thought much about it. At some point they recognized what was happening but assumed it was normal and continued on with life. For example, Nina said, "I don't think about it and I don't worry about it. I just think that it's something to me it's a natural. Things like that are just the natural flow so I don't worry about it."

While several of the women actually used words like normal and natural when discussing reproductive experiences, many simply implied such views through the descriptions of their actions. Lee, for example, never used those words but described in detail the lengths to which she went to ensure a natural childbirth. Lee was the woman described in chapter 6 who had taken a medical sociology course which reinforced her anti-medicalized view of reproductive experiences. She explained:

I spent a lot of energy and time trying to find a midwife, convinced that umm well there has to be a way. I had a friend who decided to go to Halifax to have umm her birth with the assistance of a midwife. Umm, I considered that option. So I spent a lot of energy looking into that and finally just decided, "Well, it doesn't look like I'm gonna find somebody" and so umm then I talked to, I found a labour coach instead.

Claire also illustrated such a view without using the terms when she made it clear that for her the use of medical professionals only occurred in instances that she perceived a problem. She had begun to go through menopause and felt no need to see a physician. She explained, "I'm less likely to go to a doctor.... I won't go to see a doctor about night sweats. I just change the sheets and think my mother got through it without seeing anybody or needing anything. Why can't I?"

Women's reasons for using medical interventions and treatments often varied but, in general, it can be said that those reasons related to something other than the adoption of a medicalized view of reproductive experiences. Carry implied such an attitude when she indicated that the use of medicine for reproductive experiences was a choice, not something that was necessary. She said, "'Humm,' you know, that we don't have to rely on drugs. I mean if that's the way you want to go, then fine, but if you don't want to there are alternatives out there, I think."

In addition to the idea of choice, a number of women also made a point of acknowledging that every experience is in some way unique. Based on the various types of experiences that the women shared with me, I am inclined to agree. However, in terms of women's general attitudes regarding reproductive experiences, the accumulation of reproductive experiences and interactions with others appeared to determine the extent to which they viewed reproductive experiences as normal. The greater the experience, the more likely they were to adopt a perspective emphasizing normalcy.

That perspective, to a great extent, also came with age. Women of similar ages experienced the same reproductive processes, despite variations. They had also participated in similar interactions with others that were grounded in the socio-cultural context of the time period in Cape Breton. That age specificity was indicated by the fact that women of similar ages expressed similar attitudes despite variations in their experiences.

Among the women who participated in this research, the older age group, those pre- to post-menopausal, seemed to hold the strongest views in terms of reproductive

experiences being *normal*. They were also the group who, in the past, relied most heavily on medical interventions and, therefore, at that time gave the impression that they had adopted a medicalized view of reproductive experiences. That type of behaviour, however, was significantly altered as they reached menopause. That was made most obvious by their reluctance to rely on medical treatments and interventions for menopause, despite their reliance on medicine in the past. Many of the women indicated that the decision to take something like HRT would only be considered as a last resort. As Jean said, “I guess I would be sort of nervous about taking something into my system that – I, I’d have to have a really good reason. If I couldn’t function or something then I would look into it but I don’t feel the need right now.”

The change in attitude among these women can be understood in relation to changes in the local culture during their lives. These women had learned the lessons of life in Cape Breton. In their youth, they were taught to show unquestioning respect for priests and doctors. Those who were Catholic, and to some extent those who were not, learned that women’s reproductive processes were a source of embarrassment. In essence, these women learned to be silent and do as they were told. However, with time they developed an understanding that the silence and compliance were not making their lives any better. In fact, these behaviours often made things worse, as in the case of Kay. While her behaviour during labour was not interpreted by the medical professionals as compliance, that was what she was attempting to do. She associated that and her silence with the traumatic experience she remembered. With time, she came to the realization

that the medical professionals turned the normal reproductive process of child birth into something abnormal.

This kind of association also seemed to exist in the community generally. We see this particularly in relation to the pollution problem. For years people living in the area said nothing. They trusted government reports that indicated that there was no real danger. Later, when that was proven to be incorrect, they trusted that the government would do the right thing. With the consistent message that silence was not working, people began to speak out and today the Tar Ponds are known throughout the country.

The women in the middle age group tended to agree that reproductive experiences are normal and natural. However, they were also the most openly critical of medicalized views of reproductive processes. Donna, for example, illustrated that critical approach when commenting on how societal views had changed since she was younger. She implied that things like menstruation are non-events and expressed the belief that society has gone too far in terms of making it a problem. She explained, “I found it amusing because some people are very well informed. I’m old school – you know it happens. Sometimes I think we [society] go overboard, you know with PMS. Sort of like attention deficit disorder.” Carla also revealed a critical perspective toward a medicalized view of reproductive experiences. She said:

I’d be interested in exercise and dietary changes, things like that. I’d like to try before I went on the hormone replacement... Like why is estrogen dangerous when your body, it’s something that you’ve lived with all your life. My body produced it. Why is it dangerous now?! I don’t know. It’s really confusing. I don’t think they know enough about menopause, doctors. And since the majority of doctors used to be men, they weren’t interested (Carla).

In addition to the belief that we have gone too far in terms of treating reproductive experiences as illnesses, the women in the middle group were, like the older group, reluctant to use/allow medical interventions or treatments. The difference was that these women acquired this attitude toward medical interventions and treatments much earlier in their lives. They were also far more critical of the medical system than women of any other age. It was perhaps pertinent that these women were members of the Baby Boomer generation. They had grown up in a social climate that encouraged critical thinking. Because of the women's movement, society held different expectations for women than the older women had grown up with. The Catholic Church had also begun to lose its hold over the people of Cape Breton.

These women also saw themselves as very different from the women generations before them. Donna indicated that her grandmother had always looked like a grandmother and no one ever thought she was overweight or aging badly. As she pointed out, however, “[b]ut today, you know, we’re still out in the workforce.”

Despite the differences between the women in the older age group and the middle age group, all these women had life experiences upon which they could rely in order to evaluate their reproductive experiences. That was not the case for the women in the younger age group. For them, reproductive experiences were relatively new. They had accumulated a minimal amount of information and had minimal interactions with others.

Given the limited knowledge younger women had to rely on, it should not be surprising that they appeared to have no identifiable similarities that indicated a group attitude. Beth offered an explanation for that situation when commenting about her

daughters. She was discussing the differences between her attitude about reproductive experiences and those of her daughters. She said “I think they will learn their own rhythms and patterns and and once they get a sense of themselves, I think they’ll be fine.”

The young women in this research were at a point in which they had not yet gathered enough information to reach a definite view of reproductive experiences. Some appeared to be well informed and self-confident, while others had little information. Those with little information were not concerned; they simply did whatever their mothers and medical professionals told them. Those with more information had most often acquired it from their mothers and had limited interactions with medical professionals. While these young women were more likely to think of reproductive experiences as normal, they were not as critical of the medical system as the women in the middle group. These differences with the other age groups and within this group appeared to reinforce the importance of accumulated experiences and related interactions with others in assessing reproductive processes.

Conclusion

The important issue that was revealed in this chapter was that we cannot discuss women’s views about reproductive experiences as if they were static or isolated events. Women’s views constantly changed with each new experience and over time. Women interpreted their experiences from the perspective of their overall lives. Who they were, who they interacted with, the community in which they lived and the changes in their bodies were all taken into account.

In the final analysis, what women thought and how they behaved were rooted in a pragmatic approach to reproductive experiences and life more generally. The women in Cape Breton learned from the history of the area that choices often come with a price and minimizing the price should always be the goal. Therefore, decisions about the best course of action were not made lightly. The actions taken were grounded in past experiences and the advice of trusted individuals. What that meant for the women in this area was that they realized they must sometimes encourage the belief that they agree with a medicalized view of reproductive experiences to achieve non-medical ends.

CHAPTER 8

CONCLUSION

The Research Process

This dissertation reports on a case study examining the reproductive experiences of ordinary women living in the Cape Breton Regional Municipality (CBRM) of Nova Scotia. I was interested in identifying issues related to reproductive experiences that were significant and/or influential for these women. For example, given the medical emphasis in many studies of reproductive processes, I was interested in exploring whether these women agreed with medicalization models and medical “expertise” around their reproductive experiences.

My scholarly interest in carrying out this research also arose out of a broader interest in studying women’s health and reproductive processes from both feminist and symbolic interactionist viewpoints. A number of theoretical assumptions drawn from these perspectives guided my approach to this study. The lay perspective approach to the study of women’s health emphasizes the importance of considering women as active interpreters of the contexts in which they find themselves (cf. Walters, 1991, 1994; Aronson, 1990, 1998; Fisher, 1988; Shuttle & Redgrove, 1986; and Riessman, 1983). Walters (1994: 309), for example, has urged researchers to focus on the ways in which women themselves interpret their health and illness (cf. Kirby & McKenna, 1989). In

this regard, I approached my respondents as *agents of knowledge* about their own lives and reproductive experiences (cf. Harding, 1987).

The symbolic interactionist perspective also emphasizes the importance of attending to the meanings of the individuals we study. Within this perspective, all human activity, other than reflex or habitual action, is considered to be built up in the process of its execution; that is, behaviour is constructed as it goes along. Social life, therefore, is processual and emergent, not fixed or deterministic. As Stryker (1980: 93) has observed, social life is “fluid, being continuously constructed and reconstructed and premised on definitional and interpretive processes.” As a consequence, considerable attention is given to action and meaning. As Styker (1980: 87) has explained, “human beings act toward things on the basis of the meanings those things have for them, . . . meanings are a product of social interactions, and . . . meanings are modified and handled through an interpretive process used by persons in dealing with things each encounters.” In this research, therefore, I focused on understanding women’s meanings as these influenced their interpretations, actions and interactions with the medical profession in particular and other women and men in general.

Within the symbolic interactionist tradition, the self, with the “I” and “me” components, and mind, as conceptualized by Mead, allow the individual, through self-interaction, to bring about changes in herself by viewing herself in new and different ways. In other words, the self is not fixed and meanings can change over time. Further, an individual with a self can direct and control her behaviour, that is, she has agency to act. The individual is not a mere passive actor subject to all impulses and stimuli directly

playing upon her. Rather, she is able to control, check, guide and organize her actions using minded behaviour (thinking). In this research therefore, I focused on establishing the extent to which agency played a role in women's decision-making about reproductive issues, medical interventions and the influence of other women. I also examined the processual changes that took place in meanings and behaviours over time as these women negotiated their reproductive experiences.

According to symbolic interactionism, the "me" aspect of the self is based on the internalization of the attitudes of others. Therefore, it is also important to consider the social context of individuals. As Mead (1934: 155) has noted, "it is only in the form of the generalized other . . . that the community exercises social control over the conduct of its individual members; for it is in this form that the social process or community enters as a determining factor into the individual's thinking." Accordingly, any examination of the meanings women bring to their reproductive experiences also meant that I had to consider these experiences within the social contexts in which they were experienced and given meaning. In this regard, I chose to study women in the Cape Breton Regional Municipality because they live in a community that is experiencing severe economic, environmental and health care problems. I was interested in exploring whether these women's understandings of their reproductive experiences might be significantly affected by the unusual circumstances of the community in which they live.

Methodologically, I was influenced by the theoretical assumptions of the two perspectives outlined above, both of which directed me to the use of a qualitative approach to this research. Specifically, qualitative research strategies are generally

characterized as having “a phenomenological, inductive, holistic, subjective, process-oriented, and social anthropological world view” (Reichardt and Cook 1979: 9-10). As such, these strategies seemed most suited to research goals of examining subjective meanings, understandings and processes of interaction. Accordingly, I made use of two qualitative research approaches: focus group interviews and semi-structured individual interviews. My decision to proceed in this way was influenced by my interest in investigating women’s meanings in contexts of interaction and as individuals (cf. Reinharz 1992).

In addition to the rich and complex data collected by combining focus groups and semi-structured interviews, each method had particular advantages. Focus groups generated data grounded in the interactions of the focus group participants (cf. Fontana & Frey 1994; Janesick 1994). Thus, women were able to sit silently when they wanted to and to build on the experiences of others in the group when they wanted to talk. Focus groups also stimulated discussions of issues that were important to the women participating that had not necessarily been anticipated by me. This meant that the discussions more accurately reflected the thoughts and feelings of the women concerned.

In the semi-structured interviews, each woman was provided with the opportunity to speak freely without fear of judgment from others. These interviews also had a built-in flexibility that meant each woman had control over the process and direction of the interview. According to Finch (1984), one-on-one interviews with women mimic to some extent, the ways women talk to one another in everyday life. This made them particularly useful, therefore, when studying women and their everyday meanings.

While finding women to talk with me was somewhat difficult, I have no doubt that the process was easier because I was a twenty year resident of the area. Ultimately, forty-seven women from the Cape Breton Regional Municipality participated in this research. All were longtime residents of the area, were part of the local culture, and ranged in age from 20 to 64. Twenty-one women participated in focus-group interviews and sixteen of these also participated in follow-up individual interviews. An additional twenty-five women participated in the individual interviews only. All of these women generously shared their thoughts, feelings and experiences related to reproductive processes.

To conclude this dissertation, I present a summary of my findings as they relate to other research done in this area. Then I discuss the theoretical and substantive contributions of the thesis in general. I end with recommendations for further research in this area.

The Findings

Through the analysis of women's descriptions of their reproductive experiences, their interactions with medical professionals, mothers, sisters and female friends and the insights provided by their discussions of the everyday realities of Cape Breton life, the following observations were generated. First, a major theme running through the findings was that women do assess the situations in which they find themselves and make decisions to maximize their advantages. Second, I characterize this process as a form of "intensified" pragmatism engendered by the complex socio-cultural environment in

which these women live. Third, the advantages women identify are subjective determinations arising out of lived experiences. For outsiders or those operating from a biomedical position, these advantages may seem counter-productive or paradoxical.

Women's Perceptions of Medical Professionals

When the women discussed encounters with medical professionals, they inevitably commented that these professionals disregarded women's knowledge in favor of their own *expert* knowledge and attempted to control women and their bodies. These have been issues of concern in both the health and feminist literatures for a number of years. For example, Rajan's (1996) study about pain and childbirth, Williams and Calnan's (1996a) discussion of modern medicine and lay perspectives, and Kitzinger's (1992) discussion of the medicalized birthing process as violent, point to the medical profession's disregard of women's knowledge regarding reproductive processes.

The women in this research, like the Lebanese women in Kabakian-Khasholian et al. (2000), illustrate that nearly thirty years after researchers such as Zola (1972) began discussing medicalization and the element of control, very little has changed from the perspective of the lay population. As I explained in chapter 2, the process of professionalization in medicine was essentially an attempt to garner power and control over health definitions and treatments (Croucher 1994; Abbott 1988). It appears that the underlying motivation was self-interest and self-preservation. Such an interpretation is comparable to Miall's (1994: 396) statement that "medicalization... serves the interests of a medical-care system dominated by technology and a patriarchal capitalist economy."

Whether the criticism is lodged against the profession or the process of medicalization, the result is the same for the women in this research. They felt that the system and its representatives wanted to control them and their bodies.

The women illustrated their belief that medical professionals wanted to control them in two different and obviously negative ways. First, control was illustrated in their descriptions of medical professionals' practices. Second, it was illustrated through their perceptions of medical professionals' attitudes in interactions with the women.

The women's discussions of medical professionals' practices fell into three basic categories, discussed in chapter 5. They were: (1) the adoption of the role of the expert; (2) the use of professional medical terminology; and (3) a reliance on diagnostic tests and technology. These categories support the findings of researchers such as Blaxter (1990) and Kitzinger (1992) who indicate that medical professionals view their own knowledge as superior to that of women. Blaxter (1990: 13), for example, found that "medical knowledge is seen as based on universal, generalizable science." Kitzinger (1992: 64) explained: "Research on women's attitudes to birth often also discusses them merely as patients whose lives have no context or meaning other than as patients.... Women's own accounts of birth are ignored, trivialized or pathologized when they do not match 'objective' facts."

The women in this research also based their perceptions about control on the attitudes of medical professionals during interactions. There were five attitudes and one behaviour that women perceived during their interactions with physicians: (1) viewing women as a homogeneous group; (2) objectifying women and their bodies; (3) giving

women a false sense of control; (4) demonstrating a lack of empathy; (5) having an almost complete reliance on tests and technology; and (6) doing to women.

These women felt that medical professionals often treated them as members of a homogeneous age category rather than as individuals. One woman, for example talked about the doctor pressuring her to have an abortion because she was in her early forties. Other women talked about being treated badly by medical professionals because they were “too” young for the particular experience. Researchers investigating women’s health have alluded to medical professionals’ assumption of the homogeneity of women. Like Debra, one of the participants in this research, who felt her doctor was treating her like a statistic rather than an individual, Graham and Oakley (1981) comment in their study of pregnancy that physicians proceed from the assumption that *all* women will experience abnormality. The individual’s situation is given little, if any attention. Similarly, in her discussion of menopause, Coney (1994) states that women are placed into homogeneous categories based on specific reproductive functions.

The idea of objectification that emerged from the stories of the women is also present in existing feminist literature but often not explicitly discussed in the health literature. In much of this literature, these instances are typically not identified as objectification but rather as byproducts of medicalization within a patriarchal society (Boddy 1998; Hays 1996; Riessman 1983). For the women in this research, objectification was much more explicit. They felt that medical professionals looked at them as body parts, did not allow or expect expressions of modesty and talked about them rather than to them.

The false sense of control that medical professionals often gave women is an issue that has gone unmentioned in the literature but was an important point according to the women in this research. Researchers such as Oakley (1993) and Crook (1995) discuss the lack of control women have over experiences once they enter a medical environment but do not address the idea that medical professionals give women the impression that they will have control over their experiences. For the women in this research, being given such false hope of control was more problematic than if they had known from the beginning that they would not have control. Given the importance of interactions between women and medical professionals in determining the way women evaluate their reproductive experiences (Jackson et al. 2001; Britten 1996; Williams and Calnan 1996a; Graham and Oakley 1981), women's sense that they have been misled seems particularly important in attempts to understand reproductive experiences.

Also tied to the importance of interactions between women and medical professionals was the issue of empathy. Numerous women in this study commented that they often felt medical professionals failed to express empathy for them. They felt medical professionals were often unnecessarily rude and short-tempered. They also indicated that these professionals responded to their pain in a dismissive or condescending manner. In most cases, these experiences were related to childbirth but some women also made such comments in relation to menopause. These experiences are consistent with findings such as those of Williams and Calnan (1996a) indicating that women felt that physicians were rude and treated them as if they were wasting the doctors' time. A significant number of the women in this study responded to such

situations in the same way as the women in Britten's (1996) study – they minimized their interactions with the professionals as much as possible.

The final attitude of medical professionals that women identified related to medical control was the professions' reliance on tests and technology. This reliance is no doubt tied to the medicalization of women's reproductive processes. As Hays (1996) and Boddy (1998) indicate, while medical professionals initially dealt only with abnormal functioning that required interventions, with time *all* experiences became viewed as potential problems. An interventionist approach was then adopted by medical professionals in all circumstances. Also, because of the way in which the medical profession developed, the knowledge of folk healers and midwives was not part of their training (Crook 1995; Ehrenreich and English 1979). These professionals, therefore, turned to science and technology and they became dependent upon them. Whatever the reason medical professionals may point to for their reliance on tests and technology, the women in this research, such as Carla and Carry, clearly indicated it was a control issue. They explained that they had no control over the type or number of tests or technologies used. In addition to being subjected to these things, the women often felt anxious or fearful.

While the women's perceptions of medical professionals' attitudes can obviously be tied to control, the behaviour of "doing to" women was by far the most obvious example of control. Like the women in Kabakian-Khasholian et al.'s (2000) study, the women talked to me about medical professionals doing things to them without any consultation or conversation prior to the act. This "doing to" women behaviour was a

relatively common experience among the women who spoke with me. From the examples they provided, I was able to identify four different categories of “doing to,” and, therefore, expanding on the insights of Kabakian-Khasholian et al. (2000) regarding control. The four categories were: (1) interventions and treatments, (2) physical restraints, (3) controlling medications, and (4) not allowing women to control the presence or absence of others during reproductive experiences and/or examinations.

Despite the experiences the women in this research discussed and the literature indicating medical professionals’ attempts to control women, those professionals did not control the women in this study. One major reason for this was that other women played a much more significant role in influencing and sometimes controlling women.

The Importance of Other Women

Similar to the findings of Crook (1995), the importance of other women was repeatedly stressed by the women in this research. Walters (1994) states that such lay networks have been documented at least since Freidson (1970). She explains:

We turn to them for advice and information.... Kaufert (1988) notes that tales of childbirth, menopause, and assorted aches and pains are shared with other women. Robert’s (1985) account of her research on women and their doctors also emphasizes the sharing of information among women. In Pirie’s (1988) study... few had learned of pre-menstrual syndrome from their doctor, most had heard it from a magazine, other media, or friends and family members (Walters 1994: 312).

For the women in this research, mothers were particularly important because most women had not only discussed reproductive issues with their mothers but also observed their experiences. That reliance on mothers was extended to sisters and female friends as

the women grew older and expanded their social networks. The women typically used the experiences of these individuals to evaluate their own experiences. It was often that type of evaluation that determined whether the women would even see a medical professional.

It was clear from the stories women told me that these other women were particularly important in helping them deal with, assess and incorporate reproductive experiences into their lives. The depth of the information the women provided allowed me to expand on the issue of reliance on other women that earlier researchers, such as Walters (1994) and others discussed. This expansion involved specific identification of the ways in which these women used and were influenced by other women.

According to the women in this research, other women provided information and advice that both confirmed and rejected medical knowledge. They: (1) offered women guidelines, based on their own experiences, for assessing normalcy of experiences; (2) were observed by the women who then evaluated their own experiences based on those observations; (3) supported medical definitions of abnormality, indicated by a belief in the need for medical treatment or intervention; (4) supported interpretations that were consistent with both medical and folk knowledge; (5) supported undermining biomedical approaches; (6) assisted women in avoiding the appearance of ignorance in the presence of others identified as experts; and (7) helped women avoid repeating negative past experiences. The women relied on these other women because they were considered trustworthy and had personal knowledge based on experience with reproductive processes. Unlike interactions with medical professionals, the interactions with other women were ongoing and part of everyday life.

Observations and discussions assisted the women in this study in terms of identifying what constitutes *normal* reproductive functioning, in a general sense. The women would look to the experiences of other women and use them to create guidelines or definitions that they would then have available for themselves when needed. To create these guidelines, the women considered all the experiences of other women of which they were aware. They learned, as Miles (1991) explains, that pain was often normal but excessive pain was abnormal and the distinction should be based on whether the pain was intolerable or interfered with the experience and everyday life.

The women in this research also indicated that they used specific discussions with and experiences of other women as an evaluative tool in relation to their own experiences. That is, they would use these things as a basis of comparison or preparation for their own experiences. The women had learned from the guidelines or definitions that there is a degree of commonality among women's reproductive experiences. In many cases, when women saw commonality in their experiences and those of others, they felt a sense of normalcy and security.

While a superficial glance may lead one to believe that medical professionals had a great deal of control over what women did regarding reproductive experiences, women's decisions to accept medical interpretations were the result of other women in their lives reinforcing such interpretations. In fact, it was typically because of interpretations of abnormality on the part of other women that these individuals sought out medical professionals. This reliance on other women was particularly evident in the comments of women like Ellen who directly stated that she preferred discussing

experiences with other women who had experiential knowledge before seeking out medical assistance.

In many instances, the support other women gave to medical definitions of abnormality were also consistent with folk or lay interpretations. Childbirth experiences in which the health of the child became an issue or experiencing symptoms during menstruation that dramatically interfered with regular activities were the kinds of experiences that appeared to fall into both medical and lay definitions of abnormal. This is not surprising given Blaxter's (1990) comment that in the Western world we see various mixes of lay and medical perspectives.

Despite the occasional support for a medicalized approach to reproductive experiences from other women, there were also instances in which other women made it clear that they supported undermining biomedical approaches. Some of the women in this research recalled other women encouraging them to delay arrival at the hospital during labour in order to avoid being strapped down and losing control over the experience. Others said they learned to undermine or manipulate the medical system through observations of women like their mothers and grandmothers. A grandmother refusing to allow the doctor to do a pap test or a mother who never told her doctor that she was menopausal and had no interest in taking HRT were examples of such observations.

Through both discussion and observation other women also assisted women by preparing them for interactions with health care professionals. The women felt this preparation helped them avoid appearing ignorant in these interactions. They exchanged information with other women, discussed medical articles and relevant news reports. This

gave many women a sense of the terminology used by medical professionals as well as the kind of attitude the women should expect to encounter during interactions with these professionals. Karen's experience with premature ovarian failure serves as an example. In her initial interactions with her doctor she felt ignorant. She and her friends then talked, read and shared information that help prepare her for the next interaction with the doctor.

Finally, all these influences and uses of other women came together to assist the women in avoiding repeating what they identified as negative experiences. Following negative experiences, the women would discuss their experience with others. They would ask for advice or explanations for the experiences and compare details that may account for their negative experiences. Becoming aware of differing perspectives and new information often helped these women change circumstances in order to make the next experience more positive. Some examples the women mentioned included going to a new doctor, trying alternative (herbal) remedies rather than HRT or prescriptions for PMS or opting for natural childbirth with a second child.

In addition to the fact that the women in this research looked to other women as a way to evaluate their own experiences, the general importance of other women was illustrated by two factors. The first was the virtual absence of men as sources of support or information that influenced women's experiences. In those rare instances in which men were mentioned, the women were quite critical of them. The general impression was that men were not helpful in relation to reproductive experiences. The second factor was that all of the women in this research indicated that they had taken on or would take on the role that other women had taken in relation to their experiences. In other words, they

were or would be passing on their knowledge and experiences to other, younger women, particularly their own daughters.

There is not doubt that other women had a great deal of influence over the women in this research. In most instances, the role of other women can be seen as positive assistance. In other instances, their influence can be seen as a type of control. While this may be perceived as an inappropriate comment according to other feminists, it is a fair assessment. Other women, particularly mothers, were primary agents of socialization. They, therefore, had varying degrees of control over how these women learned to think about their reproductive experiences and related interactions. They also, on occasion, pressured the women to do what they thought was best, as in the case of Carry's sisters pressuring her to breastfeed.

It is important to recognize that the exchanges between the women in this research and other women, just like those with medical professionals, did not take place in a vacuum. They occurred within the local cultural context and the uniqueness of this community served as a backdrop for everything else.

Cape Breton Life and Its Influence on Reproductive Experiences

The local culture in which the women lived can be seen as a significant part of the reason the women relied so much on other women and were critical of medical professionals. As I discussed in chapter 7, within this community, ties with family and friends were essential. The historical hardships of the community have forced Cape Bretoners to rely on one another. They have faced and continue to face high rates of

unemployment, shortages and delays regarding health care services and severe environmental pollution. Despite the fact that these circumstances have been issues for many years, nothing significant has been done to rectify the problems. Cape Bretoners, therefore, have learned that outsiders, especially those in positions of authority, should not be trusted; that they do not have the Cape Bretoners' best interests at heart.. There was a cultural attitude of "us versus them." This attitude filtered into women's interactions with other women and medical professionals. It fostered the belief that medical professionals, as authority figures, should be viewed with suspicion. This attitude was implied through women's behaviours, nonaction and sabotage (Martin 1987) in interactions with medical professionals. They recognized the power differential in many of the interactions with medical professionals and felt subversive behaviour was necessary. While such attitudes and actions were common among women in other studies, such as Graham and Oakley (1981) and Doyal (2000), the history of the Cape Breton area appeared to intensify them.

Resisting medicalization or its professionals, however, was not the motivating factor for these women in most instances. The women were simply attempting to do what was best for them. They had learned that when their views were incompatible with those of medical professionals, there was no point attempting to discuss the situation with the physician. The women felt that if they tried, the physician would not listen to them. The objective for these women, therefore, was to get what they thought was best. Resisting was simply an unintended consequence of women's attempts to get what they thought was best in relation to the particular circumstance.

The local culture encouraged women to trust and rely on female family and close female friends while at the same time encouraged distrust of everyone else. The women also learned through their interactions with trusted individuals and life experiences that reproductive experiences are normal despite the fact that they are forced into a medicalized model by medical professionals.

Pragmatism: Why Women Use and Reject Medical Interventions

Just like the women in Lebanon (Kabakian-Khasholian et al. 2000), those in Britain (Graham and Oakley 1981), those in Puerto Rico (Lopez 1998), and those in Mexico (Castro 1995), the knowledge base of the women in this study differed from that of medical professionals. Women's pragmatism emerged in response to what they had learned through their lived experiences and interactions with significant others. Similar to Lopez's (1998) findings, they did not comply with or resist a medicalized approach to reproductive experiences. They reacted to specific circumstances according to their lives and desires, just as the women in Lock and Kaufert's (1998: 16) *Pragmatic Women and Body Politics*. It was that pragmatism that sometimes led women to use medical professionals and the services they provided and other times to reject them.

Researchers, such as Lewando-Hundt et al. (2000), Walters and Denton (1997) and others have also found that women have their own reasons, separate from medical explanations, for why they use medical interventions and treatments. Part of the explanation for the differences is the fact that medicalization has been beneficial and harmful to women. Walters (1991, 1994), Oakley (1984), Lock and Kaufert (1998) are all

examples of researchers who acknowledge the presence of both. They argue that women's experiences are complex and we need to understand their conceptions of benefits and harm in order to fully understand the decisions they make around medical interventions. Specifically, the women in this research claimed that they used medical interventions and treatments for four basic reasons: (1) social pressure; (2) in order to avoid blame; (3) to deal with a problem; and (4) to secure some benefit that fell outside medical intentions. I will now discuss the theoretical and substantive contributions of this thesis.

Research Contributions

This research was a case study exploring the thoughts, feelings and behaviours of women from the Cape Breton Regional Municipality related to reproductive experiences. The results of this work contribute to the discipline of sociology and the study of women and health in numerous ways. These contributions illustrate, replicate and extend current work in sociology and in the area of women and health.

The specific contributions of this dissertation fall under two categories: theoretical and substantive implications. The theoretical contributions relate to understandings of the role of medicalization and the need for a sociological approach that deals effectively with women's lives. Substantively this work contributes to our understanding of women's pragmatism and the importance of the context in which it plays out.

Theoretical Contributions

Theoretically, this dissertation makes two specific contributions to the fields of women's health and sociology. First, it reaffirms the need to pull together the two strands of literature focusing on structural constraints and lay perspectives. Second, this research illustrates that control is an important issue in interactions between women; in some ways more of an issue than in interactions between women and medical professionals.

In chapters 2 and 3, I presented the literature focusing on both the structural constraints of the medical system and the lay perspectives on health and health care. Literature focusing on structural constraints, specifically medicalization, has provided us with crucial information on the ways women, as a group, have been viewed and treated by the medical system. Literature focusing on lay perspectives has clarified women's thoughts and feelings regarding reproductive issues and experiences.

In this research, I adopted an approach influenced by feminism and symbolic interactionism similar to that found in the lay perspectives literature that focuses on the construction of meanings and resulting behaviours in light of structural constraints and the socio-cultural context, more generally. The consequence of considering agency and structure together in this research is a contribution to the literature on medicalization. It illustrates that women's views of and relationship to medicalization are very complex and a complete understanding requires attention to both agency and structure (Lock and Kaufert 1998; Lopez 1998; Walters and Denton 1997).

While the women in this research recognized the multiple ways in which medical professionals attempted to control them, they did not simply comply with or resist

medicalization. This research reveals that their thoughts, feelings and actions were consequences of the entirety of their lives, their culture and the history of their community. Four emergent issues revealed this complex reality. First, there were the seven quite different ways in which other women influenced the thoughts, feelings and actions of the women in this research. Second, there were women's critical perceptions of the medical system and its professionals. Third, there was the hardship, cynicism and importance of family embedded in the local culture. Fourth, there were the reasons women turned to medicine. Sometimes their reasons were to receive the benefits indicated by medical professionals, while other times they wanted benefits that were outside the biomedical domain and based in subjective meanings embedded in the social context.

In addition to contributing to the lay perspectives literature on medicalization, this dissertation also presents a new, and possibly controversial, issue. As stated above, a great deal of attention has been given to the ways in which the medical system controls women in relation to medicalization. However, from the stories of the women in this research, it became evident that the medical system had far less control over them than did other women. Mothers, sisters and female friends were the individuals who informed, guided, and sometimes pressured or judged these women more successfully than any other group, including medical professionals. This process may be explained by considering the local culture. These other women were the individuals that Cape Breton women had been taught to trust and rely upon. As a result, a great deal of power was bestowed on these other women. By accepting the role of these other women, it appears

that the women in this research often felt more pressure to conform to their expectations than those of others, including medical professionals.

More specifically, the influence other women had over these women was that this influence often functioned as a form of control. On occasion, these other women exerted what was perceived to be pressure and guilt in order to force the women in this research to do what they thought was best. Because these women were trusted and part of the women's everyday lives, they were far more effective at influencing, changing and controlling what the women thought and how they behaved.

What I learned from these women reaffirms Smith's (1987a: 88) claim that if we are to understand the experiences of women, we need

a sociology whose knowers are members of the society and have positions in it outside that abstracted ruling apparatus... and who know society from within their experience of it as an everyday world. Their experiences locate for us the beginning of inquiry. This is to constitute the everyday world as problematic, where the everyday world is taken to be various and differentiated matrices of experience – the place from within which the consciousness of the knower begins, the location of her null point (Smith 1987a: 88).

It seems that only when we, as researchers, begin inquiry with the assumption of the everyday world as problematic that the rich and complex experiences presented in this dissertation and similar research are possible. It is also only when we devote attention to the ways in which individuals make sense of their lives, as symbolic interactionism instructs and Smith (1987a) and the contributors in Lock and Kaufert's (1998) book suggest, that the full extent of women's pragmatism can be understood.

Substantive Contributions

The issues raised by the women in this research contribute to the substantive areas of women and health in three ways. First, the women revealed that they do not comply with or resist medical views or the views of other people. Similar to the conclusions identified in the lay perspectives literature, they respond to their experiences in a pragmatic way. However, the pragmatism of the women in this research was intensified by the context of the socio-cultural environment. Second, this research adds to our understanding of women's reproductive experiences as influenced by other women's thoughts, experiences and information. Finally, and related to the other contributions, this research offers insights into women's understandings of *normal* reproductive processes.

For many years, compliance versus resistance was the dominant theme in the literature on women and health. However, the work of Lopez (1998), Walters (1994) and others illustrates the idea that women's experiences and their responses to those experiences are complex and not simply a matter of compliance versus resistance. As a result of such discussions, the idea of women's pragmatism in decision-making has become the dominant theme in the literature. In this research, that idea was supported but also extended to include the relevance of the socio-cultural context.

Specifically, the unique circumstances of Cape Breton, in which the women in this research lived their everyday lives, offer us an insight into an intensified pragmatism. It appears that the disadvantages of this context resulted in a strengthening of women's agency. These women had no choice but to improvise and be pragmatic given the

constraints on access to health care and the problems of pollution and high unemployment.

The area has long since been identified as a Celtic community with a strong Catholic foundation. It also has been experiencing problems related to environmental pollution, unemployment and lack of health care services for many years. These historical circumstances have affected the local culture. The culture has definite negative undercurrents, with expectations that the worst case scenario is likely, and an “us versus them” attitude toward outsiders and people in authority. These circumstances in large part tied to the social and environmental problems of the area have created the intensified pragmatism discussed above and the very strong ties among family members and friends.

The result of the problems and circumstances associated with these realities was that women learned to assess each situation and make decisions that they felt would maximize advantages. They did not simply accept or reject a medicalized view of reproductive experiences. They sometimes made use of medical treatments and interventions while at other times rejected them depending on what they thought would be best for that particular situation. This research, therefore, not only supports the literature establishing women’s pragmatism but also helps us understand why women’s behaviours may have been misinterpreted as simple compliance and/or resistance for so many years.

Behaviours alone can be classified according to such categories only when the behaviours are examined in the absence of women’s meanings and interactions. It was only through discussions with the women that went beyond what they did to why they did

it and how they felt, that the simplicity of “compliance versus resistance” became apparent. As I indicated above, the women in this research wanted to maximize advantages. These advantages included attempting to reduce social pressure, avoid blame, and acquire non-medical benefits such as escaping regular social roles for brief periods of time. These advantages, however, could appear paradoxical to outsiders because they were not restricted to advantages of medicine. To the outsider, the behaviours associated with these advantages could appear to be compliance with medicalization. The concept of resistance was not really an issue for the women in this research. Even in those cases in which the women behaved in a way that might be viewed as resistance, they were not. The women were not resisting medicalization. They were simply doing what they thought was the best thing to do given the circumstances.

For these women, compliance and resistance were essentially non-issues. Pragmatism was such an integral part of their everyday lives that they often did not stop to think what their behaviours indicated in relation to the process of medicalization or medical professionals’ expectations. They were thinking and acting from within a broader context; the entirety of their lives and their social location.

Associated with the influence of the local culture is the role of religion in the lives of the women. Women’s knowledge of religious dogma was obvious, especially among the older women in the study. They talked about the secrecy and embarrassment associated with menstruation. They said it was not something women were supposed to talk about. Other women indicated their anger over being exposed to tests during pregnancies that could identify fetal abnormalities even when abortion was not an option

in their minds. The gradual deterioration of religious influence in this community was evident by the fact that older women had been more influenced by it than the younger women in the study. While there were occasional remnants of such influence, the women who were not among the oldest seemed to be far less concerned about the negative images of reproductive processes historically presented by Catholicism.

A contribution of this research then is to extend the analysis of women's pragmatism to more fully address the importance of the socio-cultural context. By using a case study approach, this research reveals an intensified pragmatism on the part of women that emerged from the specific socio-cultural context of Cape Breton.

The second substantive contribution of this research is also, in large part, a consequence of the local Cape Breton culture. Other women, particularly mothers, sisters and female friends were key figures in women's lives and influenced the ways they interpreted their reproductive experiences. These were the individuals that the women had been taught to trust for guidance and information.

The importance of these other women was a consistent theme in the stories of the women in this research. The women had learned from the local culture that these were individuals who could be trusted. They collected information from these women through observations and verbal communications. As stated above, these women provided information and advice that covered a wide spectrum, and may have exerted an exaggerated influence on women's decision-making, given the local context.

The third and final substantive contribution related to the socio-cultural context and the importance of other women is the insight into the ways in which women

determine *normal* reproductive experiences. From the stories the women told me, it seems clear that there is no single definition of normal, not even for the individual woman. In essence, the women in this study created a definition of the situation for every experience. While the process women used to arrive at definitions of *normal* and *abnormal* in relation to particular experiences was similar to the complex process involving interactions with other women and past personal experiences identified in the lay perspectives literature, these definitions were also affected by the socio-cultural context of Cape Breton.

The influence other women had over those who participated in this research was a factor in women's definitions of normalcy. However, there were typically many other women providing information and advice. As I stated above, this information and advice took many different and sometimes conflicting forms. In addition, in certain instances there was one particular other woman who appeared to have more influence than others. This was often the case in relation to women's first menstrual experiences. The information, advice and attitudes a woman learned from her mother generally determined how she defined normal and whether she thought her experience was normal. With pregnancy, the women often turned to sisters and female friends, particularly those with personal experiences.

Other women were not the only sources of information that guided women's definitions of normal. With time, these women also had their own personal experiences to rely upon. This was apparent when the women indicated that they knew a particular experience was abnormal because it was different or more problematic than previous

experiences. Women who compared first and second pregnancies, for example, illustrated this process of comparing past to present.

While there is no doubt that other women and past experiences influenced the reasons women had for viewing an experience as normal or abnormal, the unique socio-cultural environment of Cape Breton was an ever-present backdrop. As stated earlier, the local culture encouraged individuals to expect the worst. This expectation was reinforced in relation to reproductive experiences by the common perception that *abnormalities* and complications frequently occurred in this area. Further, many believed that these circumstances were tied to the health care *crisis* (shortage of services) and Tar Pond pollution. The women illustrated these perceptions with statements such as, “I think of that I have been fortunate because I have had no problems” (Nina). It was as if medically defined abnormalities were believed to be the norm.

While we can see how the social and environmental problems of the area could constrain women’s behaviours and limit the meanings they constructed regarding their reproductive experiences, it appears that quite the opposite occurred. These circumstances have created such restrictions that they have forced women to think and act beyond them. In essence, they have freed women to define their experiences according to standards that were outside the medical domain and more beneficial to them in their everyday lives.

Considering these theoretical and substantive issues, it is apparent that we cannot examine reproductive experiences as if they were static or isolated events. Women approach their experiences in pragmatic ways that emerge out of their everyday lived

experiences. They are influenced by the local culture in which they live and the interactions with others they have learned to trust and rely upon. These findings are consistent with the research found in Lock and Kaufert's (1998) *Pragmatic Women and Body Politics*. Women make sense of their reproductive experiences within a complex context of interpersonal relations and unique social and physical contexts.

Potential for Future Research

This was an exploratory case study in which I attempted to identify reproductive experiences from the perspectives of women living in the Cape Breton Regional Municipality. The research opens the door for more thorough examinations of reproductive experiences. The underlying goal of this research was to understand reproductive experiences as social processes. The findings indicate that women's pragmatism is in large part associated with the importance of other women, the local culture and the social problems of the specific community. Due to the unique socio-cultural environment in which the participants of this study live, I refer to their pragmatism as intensified.

Future research should test these findings by more systematically examining the importance of other people and contexts for different groups of women. Such studies would be beneficial to women, the health care system, sociology and society. They could answer such questions as: If there is intensified pragmatism, under what circumstances might women's pragmatism be muted? Are women who live in less problematic environments less likely to adopt a pragmatic approach to understanding their

reproductive experiences? Further research could also begin with specific questions about family history, detailed descriptions of interactions with other women and health care providers as well as direct questions about the process of decision making. The transferability of the findings of this research could then be established.

The primary limitation of this research is the composition of the sample of women who participated. They were all long time residents of the area and white. While I believe the length of residency was important in this study as an indication of women's sense of belonging to the local culture, further exploration would be beneficial. Additional studies could address questions such as does the process of understanding reproductive experiences vary among women based on their integration into the local culture? Also, further research should include a sample of participants that more accurately reflects the ethnic/racial composition of the community from which they are selected. Given the differing relationships people have with society due to their ethnic/racial categories, it seems logical to assume that these categories may also alter the process women use to make sense of their reproductive experiences.

While I believe such considerations will provide new insights, I also believe the basic foundations of the social process related to reproductive experiences will be the same as that indicated in this research because of the similarities in this research and numerous other studies. Women in most of the world are exposed to a cultural context that gives preference to medicalization despite the uniquenesses of their everyday lives. Women, therefore, find themselves having to make decisions about how to interpret and respond to medicalization. Their decisions, as can be seen in this research as well as other

studies described in the literature, are rooted in their everyday interactions and the ways they have learned to make sense of their lives. In light of these similarities, I believe that investigations of the unique synthesis of the influences of other women, the socio-cultural context and geographically specific social problems in any community will reveal commonalities among women and further our understanding of women's meaning construction process in relation to reproductive experiences.

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Appendix A: Request for Participants

WOMEN'S HEALTH EXPERIENCES

RESEARCH PARTICIPANTS REQUIRED

A research project is currently under way investigating women's experiences of menstruation, childbirth and pregnancy, and menopause.

One meeting (interview), approximately one hour in length is requested.

Any woman who is a resident of the industrial area and over the age of 18 is welcome to be a part of this study. All participants are given a guarantee of confidentiality. Respect for the person is always the most important consideration.

If you are interested or have questions about the study, please contact: Elizabeth Graham at 563-1255

Appendix B: Focus Group Confidentiality & Release of Information

GUARANTEE OF CONFIDENTIALITY FOR FOCUS GROUP MEMBERS

AND

RELEASE OF INFORMATION AGREEMENT

Prior to participating in the study of Elizabeth Graham, on Women's Reproductive Health, this form must be signed by those participating in focus group discussions.

By signing this form, I agree to be a participant in Elizabeth Graham's study on Women's Reproductive Health. As a member of a group discussing the topic, I understand that I am not to discuss any information that others in the group present during our meeting with Elizabeth Graham. Nor am I to reveal the names of those in the group to anyone.

By signing this form, I give Elizabeth Graham permission to use all information that I voluntarily offer her, with the understanding that she will not use information which would reveal my identity to others.

I understand that the contact number will be used by Elizabeth Graham only if she requires clarification of information that I have provided or if I have indicated interest in participating in a follow-up individual interview.

I am interested in participating in a follow-up interview. **Yes** **No**

Participant Name: _____

Participant Signature: _____

Contact Phone Number: _____

Date: _____

Appendix C: Comparison Tables

Table 3.1
Age Group Comparison

Age Group	Sample	Cape Breton	Nova Scotia	Canada
20-24	9%	9%	8.9%	8.7
25-54	70%	55.5%	59.4%	60.8%
55-64	21%	13%	11.6%	11.7%
Other Ages	0	22.5%	20.1%	18.8%

(Information other than that for the sample came from Statistics Canada, 2001. The numbers refer to the percentage of women in each category.)

*Age categories were chosen to reflect the types of reproductive experiences participants reported at the time of data collection.)

Table 3.2
Marital Status Comparison

Marital Status	Sample	Nova Scotia	Canada
Single	12.8%	38%	39%
Married/Common Law	59.6%	48%	47.2%
Divorced	23.4%	5%	5%
Widowed	0	9%	8%

(Information other than that for the sample came from Statistics Canada, 2001. The numbers refer to the percentage of women in each category.)

Table 3.3

Level of Education

Level of Education	Sample	Cape Breton*	Nova Scotia	Canada
High School	21%	21%	17.4%	20.1%
Some Post Secondary Or College	36%	56.5%	58.3%	36.7%
University Degree	43%	22.5%	24.2%	13.8%

Appendix D: Focus Group Interview Guide

Introduction:

Tell them who I am. Tell them that for this research I am interested in women's thoughts and feelings about things like periods, pregnancy and menopause – What were those experiences like? Who did you they talk to about them at the time? Where did they get information or did they get any? These are the kinds of things I would like them to talk about with me.

Explain that they can terminate the interview at any time and they do not have to answer any questions they do not want to answer.

Ask if they have any questions. Then discuss the Confidentiality and Release of Information Form. Ask if they have any questions and have them sign the form.

Questions:

1. What comes to you mind when you think about things like periods, pregnancy/childbirth and menopause?
2. (Pick up on something they mention, like periods.) What sort of experiences did you have with (periods)?
3. (Continue with the same example.) Were you prepared for it? Was the situation dealt with in some way? (ie., did they have to do something about it?)
4. Did you talk to friends or family about the situation/experience? What did you say to them? What did they say to you? Were you satisfied with what they said to you?
5. Did you talk to a physician about the situation/experience? What did you say to her/him? What did s/he say to you? Were you satisfied with the discussion? Were there any medical interventions involved as a consequence of your discussion with the physician? How did you feel about the intervention or lack of it?
6. Who did/do you rely on more for advice and information, your physician, a family member, a friend? Why do you rely on that person? Did you find that person(s) helpful with the situation/experience that you have been telling me about? In what ways?
7. You have shared some of your experiences and talked about those people who were involved. At this point, I wonder if you could tell me how your idea of the ideal situation would be different from what actually happened. In other words, if you could relive the experience, exactly the way you would like, what would it be like?
8. Do you have any questions or comments? Is there anything that you would like to discuss that was not covered? Is there anything that was discussed that you would like to go back to? Is there anything that you have said that you would like to have excluded from the transcript?

Appendix E: Individual Interview Guide (Sample)

Introduction:

If they did not participate in a focus group interview - Tell them who I am. Tell them that for this research I am interested in women's thoughts and feelings about things like periods, pregnancy and menopause – What were those experiences like? Who did you they talk to about them at the time? Where did they get information or did they get any? These are the kinds of things I would like them to talk about with me.

Explain that they can terminate the interview at any time and they do not have to answer any questions they do not want to answer.

Ask if they have any questions. Then discuss the Confidentiality and Release of Information Form. Ask if they have any questions and have them sign the form.

If they did participate in a focus group interview – Remind them about who I am and the purpose of the study. Explain that this interview is meant to get more details and clarification relating to things that were discussed in the focus group.

Explain that they can terminate the interview at any time and they do not have to answer any questions they do not want to answer.

Ask if they have any questions. Then discuss the Confidentiality and Release of Information Form. Ask if they have any questions and have them sign the form.

Questions asked during an interview with a woman who had participated in a focus group. These questions were designed as follow-up to the things that were discussed in that focus group:

1. What thoughts did you go away from our first meeting with?
2. Did/do you think that the issues of importance to you were shared by the other women?
3. What are the important issues for you?
4. When we met before with the other women, there seemed to be a lot of attention given to things that are not normally considered when talking about reproductive issues. Things like the bleeding after childbirth; being tired or lack of sleep; child bonding; breastfeeding. Why do you think those things were different from the standard sorts of things like morning sickness, PMS, etc.?
5. There was also considerable variation among all the women as far as the experiences they have had. Do you think that is typical? Why?
6. Women seem to have a considerable amount of information about reproductive issues. How do you think most of us get the information that we have? (It seems, from what everyone was saying, like a lot of it is not given directly to women but we still seem to know.)
7. Do you see any connections between what kind of information women have and from whom they seem to get the information? (ie., different kind of information from mothers versus doctors.)

8. From whom did you get the information that you found the best? What was that information?
9. Did you get any bad information from people? If yes, what was it?
10. What types of things do you think future women should be informed about in order for them to be better prepared for things than the women in the focus groups who have experienced them?
11. Who should give them this information?
12. Aside from information, what kinds of things would you like to see happen in society in order to make experiences like menstruation, pregnancy and menopause better for women?

Appendix F: Guarantee of Confidentiality

RESEARCHER'S GUARANTEE OF CONFIDENTIALITY

For study on

WOMEN'S REPRODUCTIVE HEALTH

This form guarantees that Elizabeth Graham (the research) will not reveal my identity to anyone.

I, Elizabeth Graham, will not use the name of any participant in written documentation; nor will I use any information that would reveal a participant's identity to others. I will not discuss information given by participants with anyone in a way that would reveal their identities to others. I have also arranged for the same assurance from all research participants (for those participating in focus groups). I also guarantee that all names will be changed during transcription.

Researcher Name: _____

Researcher Signature: _____

Date: _____

Appendix G: Release of Information

RELEASE OF INFORMATION AGREEMENT

Prior to participating in the study of Elizabeth Graham, on Women's Reproductive Health, this form must be signed by those participating in an interview.

By signing this form, I agree to be a participant in Elizabeth Graham's study on Women's Reproductive Health. I also give Elizabeth Graham permission to use all information that I voluntarily offer her, with the understanding that she will not use information which would reveal my identity to others.

Participant Name: _____

Participant Signature: _____

Date: _____