‘I’ll worry about that when it comes along’: osteoporosis, a meaningful issue for women at mid-life?

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Abstract
This paper reports findings from a qualitative study of the health concerns and perceptions of health risks and osteoporosis of women in the age group 40–55 years. Osteoporosis has been increasingly put forward in the popular and scientific press as an important issue for women in mid-life. A variety of preventive measures, including use of hormone replacement therapy (HRT), are suggested. The medicalization of women’s experiences and associated use of HRT at this point in the life course is the subject of considerable debate in the medical, social scientific and feminist literatures, although, to date, this issue has received less attention in health promotion. Much of this debate is informed by quantitative and survey data, and there is a lack of in-depth qualitative information on women’s own views. This study casts doubt on the salience of osteoporosis for women at mid-life. Our qualitative research suggests that, unless they had experiential knowledge which had rendered osteoporosis particularly salient, most women in this study evidenced a surprising degree of disinterest in this health issue. To make sense of this disinterest we examined women’s wider accounts of their lives, health and the lifecourse, and the menopause. These findings would appear to present a challenge for those in health promotion who might wish to emphasize early preventive strategies for osteoporosis.

Introduction
In this paper we report findings from a qualitative study of the health concerns and perceptions of health risks and osteoporosis amongst women in the age group 40–55 years. Much of the existing knowledge about ‘women’s views of osteoporosis’ has been drawn from epidemiological evidence and quantitative surveys (see below). These data are valuable for mapping women’s views in response to a range of predefined questions. However, it can be argued that the simple act of asking about osteoporosis in this way may imbue the condition with a greater salience for respondents than, ordinarily, it may hold. Furthermore, whilst acknowledging that there is an interplay between lay and scientific knowledge (Popay and Williams, 1994), in health promotion there is now increased interest in accessing lay views about health-relevant issues, and in understanding how these relate to the social and cultural contexts in which they are enacted and given meaning (Milburn, 1996). In the present study, therefore, we wished to explore in greater depth how women at mid-life themselves made sense of osteoporosis, how they expressed this in terms of their wider perceptions of health and health risks, and how they related such concerns to their own lives and everyday experience.

In recent years osteoporosis has been increasingly put forward in the scientific and popular press as an important issue for women in mid-life (Green and Wadsworth, 1998). Primary preventive
measures, e.g. those associated with diet, exercise, smoking and alcohol consumption, are suggested for women and men at all stages of the lifecourse (SNAP, 1997). However, women going through the menopause are also encouraged to consider hormone replacement therapy (HRT) as preventive medicine to replenish the declining oestrogen levels associated with bone thinning and possible development of osteoporosis (Macpherson, 1993). In the UK prescribing rates for HRT have vacillated over the years in line with changing evidence about its risks and benefits (Hunt, 1994). However, prescribing rates for HRT are low in the UK (10% of women in their 50s) in comparison with North America (30%) (Leather and Studd, 1993).

Issues around osteoporosis prevention are the subject of ongoing debate in the scientific press (Gonyea, 1996; Rueda, 1997). Such debate takes place largely within a biomedical discourse informed by data derived predominantly by quantitative surveys and epidemiological methods; and is characterized by discussion of risk factors or predictors for osteoporosis and the relative merits of primary preventive measures (Draper and Roland, 1990; Ali and Twibell, 1995; Liao et al., 1995; Smith, 1995; Taggart and Connor, 1995; Steele et al., 1997). Such data form the background to health promotion policy and planning for women at the menopause (SNAP, 1997). Although there is longitudinal survey work providing psychosocial data about the menopause (McKinlay et al., 1992; Kuh et al., 1997), qualitative studies exploring women’s own perspectives are rarely reported (Jones, 1997).

The medicalization of the menopause, of which HRT for osteoporosis may be seen as one element, has been debated and critiqued in the social scientific and feminist literatures (Klein and Dumble, 1994; Daly, 1995; Lupton, 1996; Komesaroff et al., 1997). These literatures have focused on: challenging gendered notions that women are at the mercy of their hormones (Harding, 1996; Martin, 1997); questioning whether hormonal imbalance at mid-life is potentially damaging for women (Green and Wadsworth, 1998); and highlighting that menopause and osteoporosis have now been socially constructed as ‘a syndrome’ (Macpherson, 1985). However, as has also been the case until recently in the social sciences (Greer, 1992; Gullette, 1997; Cunningham-Burley and Backett-Milburn, 1998), health promotion has paid less attention to the health needs and issues of women in mid-life generally compared with other age groups in the population (SNAP, 1997). In Scotland, for example, only four Health Boards have even considered in detail the recommendations of the Barlow Report on osteoporosis let alone made any plans with regard to its implementation (Barlow, 1994; SNAP, 1997).

In this paper we discuss whether and how women constructed osteoporosis as a meaningful health issue for themselves. We then explore these findings by locating them in the context of women’s accounts of their everyday lives, general health experiences, lifecourse positioning and the menopause.

**Study rationale and methods**

This paper draws on a collaborative study carried out during 1997 and 1998, when we were working as colleagues at the Research Unit in Health and Behavioural Change, University of Edinburgh. The project was unusual because it was developed with an explicitly methodological focus. It involved us, as three experienced qualitative researchers, each carrying out equal parts of a small piece of research for the methodological purpose of reflecting on how, faced with the same topic and conditions, we each actually did our qualitative research (Backett-Milburn et al., 2000).

Given this methodological rationale, our shared interest in women’s health guided the subsequent choice of a substantive topic area. After considerable debate, we decided to focus on osteoporosis partly because, relative to other women’s health issues, we felt that it would be relatively unproblematic for respondents and indeed ourselves. Osteoporosis is diagnosed primarily in older age groups and it was, therefore, less likely that women would actually have the condition at the time of study. However, in view of the current associations...
being put forward in the biomedical and popular press between HRT and its protective effects regarding osteoporosis, we decided to locate the topic of osteoporosis within the wider context of the health experiences and risk perceptions of women in their middle years.

Following background reading and discussion of the substantive area we agreed that we would each cover the following topics but work with them in whatever ways, and in whatever order, felt comfortable and appropriate to our usual style of interviewing. In keeping with our own practises of conducting semi-structured interviews, we also agreed to explore the topics with women in the order in which they themselves raised them in the interview. If women themselves did not speak about osteoporosis, the topic was to be raised, and their perceptions and understandings of the condition probed, only at a later point in the interview.

The topic guide was:

- Women’s general health concerns in this age group.
- Interviewee’s own health concerns at her present age.
- Perceptions of own health risks in future years.
- Personal preventive health behaviours/ways of looking after own health.
- Views of own health location in terms of protective or damaging factors.
- Health risk perception—where do these come from? Nature versus nurture, etc., risk in general and specific terms.
- Menopause—attitudes, feelings, experiences.
- Perceptions and understandings of osteoporosis if not already mentioned.
- Personal lives and contexts (partnership status, children, educational background and work history).

We decided to interview a sample of 36 women, aged 40–55, to enable each of us to carry out 12 interviews. We recruited employees equally from three different grades at a Scottish University: service, administration and professional. The Personnel Department sent out an initial recruitment letter on our behalf to a representative sample of 100 women, drawn at random from their staff list, none of whose names we knew until they sent back a pre-prepared acceptance slip to us at the Unit. The response rate was approximately 60%. We then randomly selected a sample of 36, followed by some further snowballing to make up the numbers of women in the service grades. The final sample contained 14 women aged 40–44, 11 aged 45–49 and 11 who were 50 and over. The fieldwork was completed in the first 3 months of 1998.

We each analysed the complete data set of 36 interviews in the ways to which we were accustomed. Thus, we all read and re-read the verbatim transcripts, and studied them in different cuts (e.g. by interviewer set, by respondent occupation, by age) in order to identify emergent themes. However, we carried out our analyses either manually and with hard copies of transcripts or by using a qualitative data package and reading from the screen. We had several meetings where we shared and brainstormed our individual analytical work, and checked out and agreed on emergent analytical themes from the whole data set. As a result of this we are confident that the findings presented in this paper were apparent in all three of our data sets, albeit sometimes rather differently expressed, and this, we feel, strengthens rather than detracts from our analysis.

Findings

Osteoporosis—not a meaningful issue for women?

As explained above, the purpose of the interview was presented to respondents in very general terms as being about the health experiences and concerns of women in the age group 40–55. However, given the open remit, we were all surprised to find that it was only a minority of women who spontaneously mentioned osteoporosis. Moreover, when the topic was raised, little interest tended to be shown by many of the respondents. Although most women, when prompted, were able to say something about
osteoporosis or its protective factors, many of the women (across all of the occupational groups) seemed to feel insecure about their knowledge and claimed that they knew little about the condition. As one woman explained:

I mean I think up until a few years ago I mean no-one had really heard of osteoporosis. I mean, you heard someone’s mother fell and she broke her wrist or something like that, but you never thought it, you just said she was frail or she was older, it always happens. (KM3)

Although we made it very clear that the interview was about their own ideas and experiences, several women expressed embarrassment or alarm at their lack of knowledge of the topic. For example, in reply to the prompt, ‘people talk about issues to do with HRT, osteoporosis, these kind of things when they’re thinking about the menopause, do you have any views on these kind of things?’, an otherwise health-aware and interested respondent said:

I’m really ill-read on that kind of, you know, my life’s so busy, I hear all these things swanning round the office and I think ‘what’s all this about’ and it hasn’t, you know I’m not into it yet so I’m not really taking time to find out about it. (KM4)

Several women said that they had just not thought about osteoporosis. Occasionally, women asked the interviewer if they should know more or implied by their answers that our questions had raised the salience of the topic for them.

The following comments were typical:

Now let me get this right, osteoporosis which one is that? That’s the one, is that the one you can get and your fingers end up gnarled. What’s that one? [And she later reflected:] I mean you’re receptive to what the information is that you want to know and if I’m not into osteoporosis then... (OP3)

Now my mother-in-law is from the States and she’s very into all of this. You know with her calcium pills before um menopause and going for her measurements and so on. Um, so very much a different culture. Um, but, but I haven’t, on the other hand I do wonder, well maybe, maybe I haven’t protected myself and once I start falling and breaking things, oh God, I could have protected myself and I didn’t. (NM13)

Perhaps understandably, it was mostly those women who defined themselves as not yet menopausal (50% of sample) who professed a lack of knowledge of or concern about osteoporosis. However, even the minority of women in our sample who were already taking HRT were often somewhat vague, ill-informed or disinterested about its links with osteoporosis. For instance, when osteoporosis was raised with one such woman, she simply inquired, ‘Is HRT supposed to help with that?’ Another said, ‘just basically if you’re on, if you’re on certain tablets for something it helps you—helps your bones or something, I cannae remember’ (KM7). Another who said she did worry about osteoporosis and hoped that her HRT would help, then said that it was impossible to know if you were likely to get it until symptoms showed, unless you could afford a private check-up, and that she had heard that cod liver oil supplements might help but she really did not know. She concluded her thoughts by saying ‘to be honest I don’t worry about anything healthwise much’ (KM8). Thus, for those taking HRT, concern about osteoporosis was tangential at best. For instance, one woman, who said she had seen people the interviewer if they should know more or with osteoporosis and would hate to end up like that, went on to explain that:

I’m not a worrier as I’ve told you but I do, well they’ve said the HRT helps that, doesn’t it? It also helps your heart, HRT and everything. Not that that was the reason I went on it, I didn’t know that at the time I went on it. (OP10)

Making sense of disinterest

These general findings perplexed us as we ourselves had observed considerable media attention being paid to osteoporosis, usually in the context of advocating the future benefits for the condition
of taking HRT at the menopause. Indeed this, and our reading about the medicalization of the menopause, had been one of the reasons behind our choice of osteoporosis as a topic for study.

In the rest of this paper we try to make sense of these expressions of relative disinterest in three main ways. Firstly, we look further at the minority of women within the sample who did display a higher level of both knowledge of and interest in the condition. Secondly, we examine women’s statements in the context of what they told us of their lives and how they positioned themselves in the lifecourse. Thirdly, the disinterest which was expressed about osteoporosis is examined by locating it in the wider context of how women conceptualised the menopause. At the end of the paper we consider these findings in the light of reflexivity about our methods and how we constructed the data.

How does osteoporosis become more salient?

One way of making sense of the disinterest is to look at examples within the data of the minority of women who did display more knowledge of and interest in the condition. From these women’s accounts it seemed that osteoporosis had become more salient when it had in some way touched their lives or health experiences.

For example, perhaps the most well-informed group were those women in our sample (about one-fifth) who had undergone medical treatments, such as chemotherapy, which debarred them from being able to take HRT. However, even some of those women said that they probably would never have thought about osteoporosis had they not been ill. Moreover, others highlighted that the very fact of their cancers meant that this knowledge of a disease of relatively old age might now be somewhat slightly irrelevant for them. Thus, one respondent who was being treated for cancer said that previously she had not been concerned about osteoporosis because she had high bone density. Although the cancer and its treatment now rendered her at risk for osteoporosis, it did not assume a personal priority and the potential impact upon her life was perceived as relative:

But anyway it’s in my best interests not to be convinced now because if anyone’s going to get osteoporosis it should be me because I’ve had all my oestrogen shut off, ...but I don’t...I’m not frightened of that at all. But I mean the chances are I wouldn’t you know, because I once jokingly said to one of the oncologists [at the cancer clinic] ‘so what about osteoporosis I suppose you think we won’t live to get it.’ (OP1)

However, other women who had had health experiences which rendered osteoporosis more salient still said that they knew little about it. For instance, when asked if osteoporosis was something that she had thought about, a woman replied:

Is that brittle bones? Yes I have thought about it because I had a hysterectomy and they told us, I was told that I would go through an early change and that and to be quite sure, I don’t know whether I’ve actually gone through it or not [laughter]. And I have thought of that because I am at the age now where—but that’s another thing again. I only think about it if I actually see it or hear it. (NM4)

Another group of women, about a third of the sample, said, usually after probing and prompting, that osteoporosis was something they had thought about. When they talked further it was evident that this was generally because it had assumed a particular salience through their own personal contacts. Some of these women spoke about a friend or relative who had either had the disease or who, through their own concerns, had heightened the respondent’s own awareness. For instance, one woman said:

Em, my girlfriend is 71. I worked beside her, I’m very close to her. She told me years ago to put myself on calcium tablets with vitamin D, about 20 years ago... [but she went on to assess her own risk of the illness by saying] There’s no osteoporosis in my family, again I think it can be hereditary. But I don’t fancy osteoporosis so that’s why I hedged my bets I take the calcium tablet. (OP5)
Another woman, who was taking HRT following an early menopause and had spontaneously mentioned osteoporosis, explained:

Em, I don’t know if, if I have a lot to say because I don’t really know that much about it. Em, actually we’ve got a friend, em who, I think he was 39 or 40 and em, a very talented guitar player and er, we found out that he’d been diagnosed as having osteoporosis... [and she later explained] ...it brought it to out attention a bit that he had had quite a close call. (KM9)

However, by definition, this latter was an unusual experience and, for most women who said they had thought about osteoporosis, any experiential knowledge was about older friends or relatives. For instance:

That’s one I’ve seriously thought about. My husband’s mother got it quite quickly, its quite bad osteoporosis and it came on quite suddenly... [but she then went on as follows to distinguish between general awareness and salience for herself personally] So that’s made me very aware of it all. Now as far as I know its not on my side of the family very markedly but its also true that my mother was on HRT really from about the time of the menopause and still is so that I’ve been aware of that as an issue too. (NM5)

Another woman, who said she did tend to compare her own health with that of her mother, said osteoporosis did worry her slightly, in part because:

I mean my mother has had a couple of quite bad break, fractures since she was older. And she reckons she’s got brittle bones. She’s never had it diagnosed by the doctor and em whether she’s right or not I don’t know. (NM8)

Interestingly, though, women were just as likely to draw on personal experience to explain that they did not feel at particular risk of the condition. For example, one woman explained that she deliberately chose to have cereal and milk for breakfast, partly because of the benefits of calcium for osteoporosis. However, she went on to say that this was simply because of her reading about it in the context of general health education advice because, from her observation of her mother’s health, she did not think she came from ‘particularly fragile stock’ (NM11).

In similar terms, some respondents said that osteoporosis was not an issue for them simply because they had little or no personal experience of it:

No, no I know that it’s an issue, I mean a lot, there’s a lot of my friends feel very anxious about it. I think, I mean again because it’s, I don’t know anybody in my family who’s got problems, as I say they’re all, many of them are in their 80s now. I just kind of assumed I wouldn’t have it, maybe [I’m] naive. (OP4)

*Health, everyday life and the lifecourse*

Our analysis of these women’s accounts showed that, as with other health issues, we could make better sense of this disinterest in osteoporosis by locating it in the wider context of women’s lives. The qualitative interviews revealed that there were many more pressing issues than osteoporosis in their lives, be they health or otherwise, and it is to these that we now turn.

Our sample comprised women who were in full-or part-time paid employment. In addition to their family and domestic labour, many of the women in the service grades had one or more additional part time jobs and several women employed full-time in the other grades reported out of work-related commitments, courses or study. Unsurprisingly, many of our sample looked tired, and spoke of tiredness and other forms of stress.

For our respondents a functional attitude to health predominated. As in other studies these women stressed the importance of ‘keeping going’, ‘coping’, ‘keeping young’ and not letting things ‘get you down’. Thus, it seemed that thinking about future health concerns or risks was, for many, a diversion from getting on with their present lives and managing any current health issues. For instance, in reply to the prompt, ‘is your health
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something you think about very much?, the following respondent’s reply was typical, she laughed and said:

Not really, no. I don’t have a lot of time to worry about myself [laughter]. I don’t think a lot of women do. I think if you’ve got a family and a job and everything else going on its only just if something happens, you know, if say you, say I had a lump somewhere or something I mean that’s to worry about. (NM8)

Women’s accounts of their health concerns and lives therefore indicated that they were predominantly interested in knowing and thinking about what was necessary for their present daily circumstances and age. Thus, although all respondents made varying amounts of reference to current health education concerns, such as a good diet and taking exercise, it appeared that dwelling on future health risks, concerns or illnesses tended to be regarded by most as a somewhat indulgent diversion from getting on with the present. Such sentiments were also sometimes applied to thinking about future experience of the menopause, as was summed up by the following respondent:

I suppose I think quite a lot about kind of being menopausal because things are starting to change there. Em, so I think about the sort of effects that will have on me and em, you know, how its kind of important to kind of keep ahead of it as it were, but, you know, I’m sounding awfully pompous. (OP4)

Connected to this is how, in these accounts, women positioned themselves, their health, their bodies and their bodily experiences within a lifecourse trajectory. In order again to try to access views about osteoporosis, we each asked women how they saw themselves and their health concerns in the future, and many also spoke about their health earlier in their lives. The majority of women were remarkably positive about themselves in the future. Whilst acknowledging that illness and physical debility may eventually come upon them, most women spoke about these as an inevitable feature of ageing, but one which, for them at present, was a distant concern. Furthermore, several respondents claimed that, in many respects, they now led healthier lives than when they were younger. In all these ways, therefore, women did not portray their healthiness over the lifecourse as a downward trajectory.

It is against such wider perceptions of health, ageing and the lifecourse that women’s disinterest in osteoporosis can also be understood. Moreover, although a few women did have first-hand experience of osteoporosis, for most there was little personal encounter with the frailties of extreme old age. Indeed, for most of the population this is a relatively new phenomenon. Understandably, therefore, for the majority of our respondents osteoporosis may have had little salience as, for these women it seemed to be an issue only in the abstract and at a distance. As one woman explained:

You know, you don’t imagine you’re going to be crippled in any way. I don’t think so. Also, looking back on my family, my mother had a lot of sisters, and they were all very able, you know, they were physically well until they died. That’s very Irish isn’t it! (KM3)

Locating osteoporosis in the menopause?

Looking reflexively at our data it is evident that, in our efforts to engage women with the topic of osteoporosis, we ourselves tended to frame it in terms of the menopause and HRT. Thus, although we were and remain critical of medicalizing women’s health in mid-life, our modes of questioning, and indeed much of our prior reading and discussion, tended also to be within that frame of reference. Interestingly, because we did not sample for menopausal status, 50% of respondents self-identified as pre-menopausal and 50% as menopausal. Of the latter half of the sample, nine women were currently on HRT.

We would like to suggest that, whatever their menopausal status, women’s very disinterest in osteoporosis may be one mechanism whereby they are resisting the medicalized discourse around the menopause and that this applied also to our interviews. Indeed, women often did not raise the
menopause in response to our earlier questions about ‘health’ concerns and issues. Moreover, when anticipating the menopause, many women spoke of it as a process of physical change which they hoped would be relatively unproblematic. Several spoke of managing, or hoping to manage, any menopausal symptoms in ‘a natural way’. For instance, when asked how she thought and felt about the menopause one woman said:

I’m not quite sure because I haven’t done it, so I think I see it as a normal process that will happen and will have certain benefits. (OP6)

Another said:

I get some flushes now and again but I find if I keep on my herbal tea I don’t get them so much. (OP7)

Another who confessed that she knew ‘sod all about the menopause’ said:

I’m not a great believer in sort of mucking around with the hormones and things like that. (OP4)

However, although women might express optimism that they themselves would have a relatively unproblematic menopause or that their symptoms would be manageable, their accounts also tapped into a prevailing wider discourse which was predominantly negative. Many women told us about the menopause by using often somewhat stark statements describing a constellation of potentially upsetting or disruptive physical or emotional symptoms, or by telling distressing stories about their observations of relatives, friends or colleagues. For instance, one woman, who at other points told us that she hoped she would be like her mother when older because ‘she looks fit enough’, nevertheless spoke as follows of her mother’s experience of the menopause:

I mean one minute she’d be alright and the next minute she’d be roaring and greeting [crying] for nothing and then she’d be moody and then she’s alright and oh, she just really, she was—oh! It was terrible. (KM7)

Interestingly, those who had or were experiencing the menopause usually described their signs and symptoms in terms of how they had managed them and regained some control over their bodies. It was only the occasional woman who made remarks such as ‘I’ll never forget it’ (NM6). Women who chose to take HRT explained this largely by it being a remedy for very immediately experienced physical or emotional symptoms such as hot flushes, mood swings and tiredness. For instance:

Because I was waking up in the night feeling really peculiar as if I was fainting lying down [KM: ‘Oh right’] em, and there would be this hotness—just feeling tired. You know, it was incredible you know; it was OK in the morning but by the time I was going home at night I was sort of dragging myself home. (KM8)

Such accounts indicated much less interest in potential longer-term effects of HRT such as protection against osteoporosis or heart disease and, indeed, those women who felt it might have some physically enhancing side effects usually mentioned these somewhat apologetically as ‘a piece of vanity’ (KM9). Thus women appeared to be distinguishing between what they felt were appropriate and inappropriate reasons for taking HRT.

In these ways, women’s discourses around the menopause tended to focus more on visible and sensate bodily and emotional experience. Overall, they had less knowledge or interest in what was happening inside the body, which tended to be viewed as mysterious and often unpredictable. Statements were made such as, ‘you don’t know what’s going on inside the body’ (KM8) and, when thinking about bones and joints, ‘I don’t know how to tell, you know, whether there’s anything wrong or right or anything’ (KM9).

Therefore, from these accounts, it appears that women’s disinterest in osteoporosis may be further illuminated by appreciating that they tended to legitimate the use of HRT essentially for short-term symptom relief of menopausal symptoms. Furthermore, women’s main ways of understanding physical changes at menopause seemed to be in
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terms of outer body or sensate experiences. For the majority then, osteoporosis, as a longer-term potential degenerative illness of the inner body had little salience, even in the context of menopausal experiences.

**Discussion and conclusions**

This qualitative study casts doubt on the salience of osteoporosis for women at mid-life. This would appear to be a very real challenge for those in health promotion who might wish to emphasize early preventive strategies for this illness. Much previous research about ‘women’s views on osteoporosis’ has used quantitative survey methods. Our qualitative research suggests that, unless they had experiential knowledge which had rendered osteoporosis particularly salient, most women in this study evidenced a surprising degree of disinterest in this health issue. To make sense of this disinterest we examined women’s wider accounts of their lives, health and the lifecourse, and the menopause.

However, in keeping with the reflexive imperative of qualitative research it is also important to consider the part which we ourselves may have played in the construction of these findings. Here, it is relevant to note that, from the very first pilot interviews, we commented to each other and in our fieldnotes that the women did not seem to be interested in osteoporosis; and that we felt that the interviews were shorter and more superficial than those we had carried out in our respective previous projects. In response to this we reflected on the relatively broad and unspecific way in which we had been presenting the interview to the women, our pre-fieldwork decision not to flag up the topic of osteoporosis until later on in the interview, and on the degree of flexibility being allowed for respondents to diverge from the stated topic of ‘health issues and concerns for women aged 40–55’.

Consequently, in the hope that we and the women could address and explore the topics, including osteoporosis, more meaningfully, we agreed that we should each give the respondents greater opportunity to place their accounts and views in the context of areas of their lives which they themselves defined as salient. For instance, if women mentioned work-related, domestic or personal issues we agreed now to be freer to explore these, instead of feeling, as we had earlier, that these were diversions from our remit of finding out about perceptions of health, health risks and osteoporosis. We also decided that we could be more upfront with women from the outset about our interest in osteoporosis. However, although this might have made us feel more relaxed about the fieldwork, and resulted in somewhat longer and more detailed interviews, overall these changes did not result in subsequent respondents expressing any greater interest in osteoporosis. It appeared that the subject of osteoporosis simply did not resonate with the more pressing concerns of most of these women’s lives.

These qualitative findings seem to provide an important reminder for health researchers and health promoters that issues which are potentially biomedically salient for later life may not have everyday resonance for those at earlier points in the lifecourse (Backett and Davison, 1995). Here we have found that, unless other events or experiences drew women’s attention to osteoporosis, it did not have a salience for them as a concern in mid-life. Moreover, when asked to reflect on their current and even future health concerns, women seldom spoke about long-term bodily degeneration, especially of the inner and unseen parts of the body. Finally, we suggest that lay theorizing and practises (in this case disinterest in osteoporosis) may in themselves represent sites of resistance to the further medicalization of aspects of women’s lives.

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