CHRONIC ILLNESS AND CONCEPTIONS OF SELF IN LATER LIFE

CHRONIC ILLNESS AND CONCEPTIONS OF SELF IN LATER LIFE:
CONTINUITY OR CHANGE?

By

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ABSTRACT

This thesis examines the processes by which the self-concept is shaped by chronic illness in later life. This study contributes to our understanding of the development of the self in later life by examining patterns of continuity and change. Twenty-four women diagnosed with osteoarthritis (0A) were interviewed. The participants were community-dwelling females, aged between 67 to 85 years. They were selected to reflect a range of OA, from mild to severe forms of the disease. A qualitative approach, more specifically, the grounded theory method was adopted for this study.

The findings illustrate that OA in later life presents a source of change for the self-concept. However, the influence of these processes of change vary considerably. In particular, the significance of change for the self-concept is shaped by the individual's perception of the impact of chronic illness for the self. These are shaped by several factors. The impact of OA on the self is influenced by the ways in which the person's *multiple* identities are affected. And, the person's perception of continuity and change for her "overall" or global sense of self must be considered. Finally, the type of process mechanisms that are drawn upon shape the person's perception of continuity and change. Such processes include: shifting and non-shifting prominence hierarchies, the ability to adjust and accommodate to one's limitations and the extent to which interactions and valued identities are modified, social comparison, reflected appraisal, and the dialogue between the past, the present, and the future self.

The data show that older people do reflect some of the same issues that have previously been revealed by studies of chronic illness which do not focus on later life. However, experiences of chronic illness in later life also present unique variations.

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CHAPTER 1
INTRODUCTION AND LITERATURE REVIEW

INTRODUCTION

In recent years, there have been numerous debates over the impact of population aging. Often presented within "alarmist" or "crisis" oriented frameworks, researchers and policy makers from a wide spectrum of academic disciplines and professional fields have collaborated to assess the implications of the North American aging population. In particular, the issue of aging and health has been central to these debates. While advances in medicine and technology have been pivotal in the successful treatment of acute diseases, increases in the morbidity rates for arthritis, heart conditions and other **chronic illnesses** have been documented. Chronic illnesses are defined as, "organically based, severe chronic conditions that lead to significant loss of function or disability and generally have a slowly but progressively debilitating course" (Barnard 1990, 535). Statistics reveal that 25 to 50% of older adults who live in communities and 45 to 80% of the nursing home residents are diagnosed with chronic illness (Roberto 1994a, 111-112). Moreover, the longer life expectancy of women has also meant that older women are particularly vulnerable to chronic health problems (Roberto 1994b, 1-2). Chronic illness in later life, then, may be viewed as a gendered issue. Interestingly, the research literature provides very little insight into the impact of chronic illnesses on the lives of older women.

While many of the discussions have focused on health care expenditures and care giving issues, it is unfortunate that the voices of chronically ill persons have not been heard. Various in-depth investigations of self and chronic illness have been conducted, (most notably by Charmaz 1994, 1987, 1983, 1980; and Corbin and Strauss 1988, 1987). However, these studies do not highlight the experiences of thsoe who suffer from chronic illness in later life. Indeed, there is very little research that examines the relationship between chronic illness and conceptions of self in later life. Those studies that do address issues relating to chronic illness in old age generally reflect medical health care orientations (Ory, Gift, and Abels 1994; Ory, Abeles, and Lipman 1992; Chilman, Nunnally, and Cox 1988), and social work policy frameworks (Alpert 1994; Roy 1994; Kramer 1991). A number are self help books. There are also psychological assessments of stress and coping mechanisms that measure traits and relate these to levels of well-being in later life (Hymovich and Hogopian 1992; Gregg et al. 1989; Burish and Bradley 1983). Research projects that deal with personal experiences of chronic illness, with the social construction of illness and with the meaning of chronic illness in the lives of the aged are few in number (for exceptions, see: Roberto and McGraw 1991; Belgrave 1990; Corbin and Strauss 1988).

It is the contention of this study that a sociological perspective offers the unique opportunity to investigate the experiences and perspectives of such individuals. In this particular study, the processes whereby the 'lived' experience of chronic illness shape conceptions of self in later life will be explored. This topic is significant for several reasons. Chronic illnesses may profoundly influence the quality of daily life. The impact of disability, impairment, uncertainty, and fear of dependency often have significant ramifications for a person's self-concept in later life. Restricted mobility may limit participation in activities that are central for the maintenance of the self. Social activity, personal interactions, hobbies and other interests may be implicated. In addition, the ability to carry out daily tasks that are necessary for independent lifestyles may be hampered, and these may influence conceptions of the self as well. The ways in which these challenges influence the self-concept have not been documented widely.

As the literature review will reveal, the research problems addressed by this study reveal both the gaps and contradictions within the current research literature. While sociological accounts of chronic illness and self-concept are well developed, most of the research has focused on middle-aged persons. It seems fair to say that the experience of older individuals warrants more attention, and that illness in later life may raise different issues. An examination of these issues provides the opportunity to both assess the relevance of the current literature, and to broaden the theoretical and conceptual scope of the existing sociological studies of chronic illness.

In general, the over-arching questions that will guide the formulation of the research problem are: How is the self concept influenced by chronic illness in later life? Which aspects of living with chronic illness, if any, challenge the self concept? Is the self-concept changed by chronic illness? In what ways? What adaptive mechanisms or strategies are utilized in order to preserve or to enhance the self-concept? What conditions impede such processes? In turn, how does self-concept influence the subjective and personal "lived" experience of chronic illness? (These questions will be elaborated on at a later stage in the thesis).

For the purposes of this investigation, the experiences of those diagnosed with osteoarthritis (OA) will be examined. The high incidence of cases of OA among the elderly makes this chronic illness an especially interesting one to study. OA is the most commonly diagnosed musculoskeletal problem in older women. Moreover, it is the most common chronic condition among older women. It has been estimated that 57.1% of American women, 70 years and older, suffer from arthritis. More significantly, 90.6% of these women have OA (Verbrugge 1992). In Ontario, statistics reveal that 2.5% of the population are disabled by arthritis. When other musculoskeletal disorders are included, it is estimated that about 20% of persons who are 85 years and older are disabled (Badley 1992).[1]

The disabling effects of OA will be better understood when one considers the etiology of the disease. OA affects weight-bearing joints, typically those in the spine, the knees, and the small joints of the hands and feet. OA produces degenerative changes in these joints, and pain is often accompanied due to the growth of osteophytic spurs which exert pressure on nerve roots (Gold 1994, 46). The effects of OA are potentially severe. Disability arising from musculoskeletal disorders may limit locomotor activities. Badley (1992) found that individuals were limited to varying degrees in their ability to make trips away from home. Travel by public transit, buses, trains and airplanes presented some obstacles. People's levels of participation in leisure activities and other social pursuits were also curtailed. In addition, the ability to perform tasks necessary for daily living was also limited to varying degrees depending on the severity of the condition. These findings indicate the challenges presented by OA. Interestingly, the significance of OA in the everyday lives of older women remains underexplored. The ways in which OA influences conceptions of self is an interesting area for investigation.

Having presented a very **brief summary** of the research questions and a short description of the relevance of osteoarthritis as a chronic illness, an examination of the relevant literature will be provided. First, the research pertaining specifically to aging and self-concept will be considered. Next, studies deakubg wutg chronic illness and identity will be discussed. The limited number of studies that have examined how chronic illness affects conceptions of self in **later life** will also be considered. Finally, a

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[1] Osteoarthritis is not to be confused with rheumatoid arthritis. Rheumatoid arthritis is not as prevalent as osteoarthritis in the later years. The etiology of rheumatoid arthritis also differs from osteoarthritis and the peak age of onset for rheumatoid arthritis is usually between the ages of 25 and 55 years (Gold 1994).

more precise formulation of the research questions will be presented in light of this review.

LITERATURE REVIEW

Self-Concept:

In order to better formulate the research problem, and also the theoretical framework that will guide this investigation, an overview of the issues that relate to self-concept development and formation must be provided. Self-concept has been defined and measured by researchers in various ways. While some investigators provide clear and concise definitions, others do not. Self-esteem, self-image, self-concept, and identity are often used interchangeably, and at times, it may be difficult to find a clear definition. Nevertheless, it is possible to identify those concepts and issues that are commonly addressed by researchers of the developing self-concept. First, the self-concept is often viewed as an object, not as subject. The differentiation between the self as subject, (the "I"), and the self as object, (the "me"), illustrates the interplay of the dialectic relationship between the self as knower and the self as known (Charon 1992; Bengtson, Reedy and Gordon 1985; Breytspraak 1984). Self-concept, then, has been defined as "the totality of the individual's thoughts and feelings that have reference to himself as an object" (Rosenberg 1979, 7). Hence, self-concept has been viewed as a set of attitudes.

Further investigation reveals that researchers divide the overall self-concept into different components, and in turn, sub-components. Moreover, the components of the self are organized, thus providing structure to one's overall sense of "self". Because the self is capable of viewing itself as an object, the self evaluates itself, in and of itself, and in interaction with others. Hence, it has generally been the consensus that the self is driven by two basic motives. These are first, the desire to think well of oneself, (self-esteem motive), and second, the desire to protect the self-concept against change or to preserve a consistent image of the self (self-consistency motive) (Rosenberg 1979, 53).

Continuity and Change:

These concepts provide the foundation for the study of the self-concept. More important, it is possible to link these ideas with the issues that have been generated by those who have conducted research on the developing self in later life. The conceptual significance of continuity and change over the life span is one example. "Do the general traits and personal characteristics of the individual change with aging?" (Ryff 1986, 51). Do adults perceive themselves as changing as they age? How are changes mediated into the self concept by older persons? Certainly, chronic illness presents one source of change in later life. Several researchers have investigated the dynamics of continuity and change in the self-concept in later life. However, not all researchers have focused exclusively on issues relating to health as potential sources of change. **Nevertheless, their studies are worth examining because they point to the processes that are involved in the negotiation of the self in old age.** The following section will demonstrate that conceptions of self in later life present patterns of both continuity and change. The research presents "mixed" results.

Several researchers report patterns of continuity. Kaufman (1986) examined the conception of self in later life, and describes the continuity of an ageless self. In essence, the author discovered that the individuals she interviewed drew upon themes created earlier in life in order to explain their lives and to provide meaning to present conceptions of who they were. Kaufman reports that the older individuals she studied were able to maintain coherent and consistent identities, despite physical and social changes (1986, 7). Moreover, these individuals were also able to draw upon their sense of continuity (made possible by these life themes) in order to adapt and adjust to change

(14). Kaufman's work is interesting because she points out that older individuals do not simply react passively to the various changes that are brought about by aging processes. Rather, this study highlights the active and dynamic nature of individuals in their interactions with the self and with the environment. Hence, chronological age and the various changes associated with the aging processes are not pivotal in themselves. Rather, individuals actively respond to, interpret, and impute meaning to their experiences in light of the significance they they attribute to the past.

Tobin (1988) also reports remarkably high levels of stability over time. Tobin was especially interested in examining the impact of psycho-social changes, for example, various losses, decreased locus of control, and ambiguous roles for the aged. The changes associated with moving to a seniors' residence were assessed in relation to people's self-concepts. In light of stressful changes, for example, the loss of "life space", and the loss of people and familiar surroundings, new expectations for adaptation, and in some cases, impending death, the author was particularly impressed with the findings. Despite conditions that could potentially threaten consistent self-concepts, the individuals under study showed high levels of stability in their self-concepts in the face of such abrupt changes. The author found that while the content of the self-descriptions showed patterns of continuity, the sources drawn upon to validate the self shifted. Various losses in later life meant that sources of self-validation were difficult to locate. Significantly, Tobin reports that individuals alternated between their past and present experiences in order to maintain their identities as a strategy for dealing with the scarcity of sources for self-affirmation (Tobin, 1988, 551).

The research conducted by Mac Rae (1990) reveals the significance of older women's involvement in social networks for the maintenance of identity. Interestingly, the study highlights those roles and relationships that are retained in later life (in contrast to role loss), and their importance in enabling people to cultivate positive identities. Hence, the significance of continuity in network relationships for preserving stable identities is demonstrated (Mac Rae 1990, 248). Mac Rae's analysis of identity focuses on three categories of factors: there are those that relate to statuses and roles, those that relate to personal attributes, and those that relate to the older woman's understanding of her relationship to others (1990, 255).

While most traditional studies of identity crisis tend to highlight problematic aspects of "role loss", this study reveals that most of the women did not experience such losses. The women identified various roles associated with their membership in clubs, churches and other community organizations. Informal roles were very important in the structuring of self-identities (Mac Rae 1990, 255-256). The roles of wife mother, and homemaker continued to be the most important to these individuals. Moreover, the role of housewife continued to serve as an important component of identity even after husbands passed on. For many women, maintaining the home and "getting the work done" were given top priority. Most significantly, changes and losses in roles did not alter self-identities, since former roles were often retained as components of the self:

> While "wife" is a role that the majority of these women have had to give up when their husbands died, the knowledge that they have performed the role well, and their reputation as "good" housewives is consoling and continues to form a meaningful component of their current configuration of self-perceptions. Unless and until the older woman's health fails and she becomes incapacitated, homemaker is a role-identity that appears to be available to the elderly woman for a lifetime (Mac Rae 1990, 258).

Similarly, the role of mother continued to be a meaningful component of the self:

> The mother role is subjectively interpreted by many of these women as a role that is never lost. Mothering, like homemaking, lends continuity to the older woman's identity and it can be an available source of self-meaning for almost a lifetime (Mac Rae 1990, 259).

Significantly, many of the older women studied by Mac Rae continued to perceive themselves in terms of their family relations. While self-assessments often focused on abilities, these abilities were associated with the capacity to relate to others. Hence, "interpersonal relationships constituted the primary basis of self-identity for most of these women" (Mac Rae 1990, 262).

Mac Rae's study provides evidence of the conceptual significance of continuity in the maintenance of identity in later life amidst personal life changes. The study also suggests opportunities for further areas of investigation. For example, the role of homemaker continued to remain a significant component of the self-identity for many of the women. Mac Rae states that unless changes in health impede the activities associated with the role, it may continue to serve as a meaningful marker for self-identification (Mac Rae 1990, 259). Hence, the impact of chronic illness and how it potentially threatens such an identity is an important area of research. Moreover, the ways in which illness may undermine the abilities associated with relating to others may also be examined.

Coleman and his colleagues (1993) examined sources of stability and change in self-esteem among older adults. The individuals were re-interviewed ten and thirteen years after the initial study and the findings revealed consistent patterns of self-esteem. However, some changes were evident. There was a decline in the tendency to attribute positive ascriptions only, and there were alterations in people's sources of self-esteem. Individuals used leisure activities and interests as sources of self-esteem rather than those associated with the realm of work and family. Moreover, the number of hobbies and interests, the frequency of social activity outside the home, and perceiving oneself as an active individual all contributed to the maintenance of self-esteem (Coleman, Ivanichalian, and Robinson 1993, 187-188). This study illustrates that physical health is implicated as individuals evaluate their self-concepts. What happens then, when an older, disabled person is unable to engage in leisure activities, social interactions, and an active lifestyle? This question points to the importance of assessing the impact of chronic illness on conceptions of the self.

Finally, Matthews (1979) discusses the ambiguity and the uncertainty that surrounds people's efforts to negotiate identities in old age. The author contends that efforts to maintain the self presents a "precarious" exercise. Matthews examines the negotiation of the self in interaction with friends, family, and other social actors. Often, older women are confronted by divergent identities. There is one assigned to them by society, with its definitions of old age, and then there are the "felt" identities of the women themselves. While many of the women did not view themselves as old, they utilized various strategies to manage this self-concept when confronted by social conceptions of old age. For example, they suppressed evidence (ie, avoided revealing their ages), cultivated alternative definitions of what is means to be old, avoided threatening situations, attached new meaning to old activities, and created alternate interpretations when confronted with the signs of aging (Matthews 1979, 73-83). Moreover, the negotiation of the mother identity in later life also involved various strategies. Matthews describes the way in which the identities of older women are precarious because of changes in the balance of power between mother and adult children, and because of their lack of resources in later life (111-137). While Matthews does not address issues of continuity and change explicitly, her work does address the issue of how people's identities are challenged in later life, and she describes the various the strategies that older women draw upon in order to maintain their preferred identities, and their perceptions of themselves in light of potentially threatening changes.

Taken together, these studies illustrate the variety of processes that are involved in the negotiation of continuity in conceptions of self in later life. Even as older persons confront significant challenges to their identities, changes may be experienced as an extension of one's personal biography, as evidenced by the significance of "themes" in the work of Kaufman (1986). Or they may engage in "unique psychological" processes in order to affirm themselves when other validating sources are absent (Tobin, 1988). They may find continuity in roles that have been central to their sense of personhood even in later life (as suggested by Mac Rae, 1990). Or they may engage in a variety of strategies when confronted by threatening situations and interactions (as suggested by Matthews, 1979).

While these findings provide insightful information, they are not conclusive. A review of the literature shows that patterns of stability and change in the self-concept are very complex and difficult to define and measure. Indeed, Bengtson, Reedy, and Gordon (1985) conducted a comprehensive overview of the personality and aging literature. These researchers report mixed findings in addressing their question as to whether self conceptions change with aging. Three components of identity are identified: the cognitive, affective and conative components. The cognitive component refers to the content of the self, the "factual attributes" of the self that the individual believes is most descriptive of him/herself. The affective component involves the evaluations, feelings, preferences, likes, and dislikes one imputes to the self. Finally, the conative component refers to the motivations as the basis for action. These evolve with reference to the individual's reflection of self, that is, his/her conceptions of self. Hence, "the issue here is how the individual acts on the basis of motivation deriving from particular self-conceptions" (Bengtson, Reedy, and Gordon 1985, 547). Of particular significance are the attempts made by the individual to change aspects of the self that do not fit images of what the individual would like to be. This aspect is important when one is studying change or stability of the self over time. Researchers interested in analyzing conative components may examine the extent to which striving and behavioural orientations for self-enhancement or self-maintenance are stable over the life span (Bengtson, Reedy, and Gordon 1985, 547-548).

Bengtson and his colleagues analyzed 62 studies. These studies were categorized in accordance with the three components of the self as presented above.

Cognitive Component: An overview of the research reveals that the findings vary according to the type of research design that was employed. Mean levels of measured self-concept variables reveal significant patterns of continuity in longitudinal studies in terms of amiability, insecurity, assertion, self-control, hostility, dysphoria, adjustment/anxiety, extroversion-introversion, and neuroticism (Bengtson, Reedy, and Gordon 1985, 586). Correlational studies also reveal significant levels of stability over the years. However, other self-conception variables, such as autonomy, self-competence, self-confidence, excitability, and generative concerns, increase in terms of mean-level change from young adulthood into middle age (Bengtson, Reedy, and Gordon 1985, 586). Next, the studies reveal a reversal in sex related attitudes. Men tend to internalize traditionally female traits, such as expressiveness into self-conceptions, while women incorporate instrumental attitudes (Bengtson, Reedy, and Gordon 1985, 587). Overall, "there is substantial structural stability of those self-conception dimensions that are most closely related to temperament (especially personal well-being, security/adjustment, sociability/amiability, and competence/assertion/achievement)" (Bengtson, Reedy, and Gordon 1985, 586).

Affective Component: Significantly, an overview of the literature reveals either a positive relationship between age and self-esteem, or no relationship at all. Interestingly, only one study reported lower self-esteem among older cohorts than among their younger counterparts. However, while general levels of self-esteem may be higher among elderly individuals, those aspects that relate to competence may decrease (Bengtson, Reedy, and Gordon 1985, 587).

Conative Component: The studies report that levels of stability in self-attitudes over time vary according to the focus of the study, with gender, and with personality type. Mean level analyses also reveal lower levels of consistency than do correlational analyses. Moreover, some self-attitude variables that are indicative of action and striving exhibit more stability than others. For example, personality dimensions, such as cognitive style, adjustment-anxiety, and energy-outgoingness, reveal greater stability than do the other behavioural dimensions (Bengtson, Reedy, and Gordon 1985, 583).

> Process-oriented dimensions of the self (ie dimensions reflecting temperamental or constitutional differences, influence of heredity or genes, or early learning experiences) are more stable. Content-oriented dimensions of the self (such as interests, role-related behaviours and attitudes) are less stable (Bengtson, Reedy, and Gordon 1985, 583-584).

Given the variety of research designs that have been employed, these results are not surprising. It is probably safe to assume that patterns of continuity, as well as change, are both important features of the development of self in later life.

Continuity and Change: Inconsistencies in the Research:

A few comments will be made in order to highlight the significance of the lack of consistency revealed by these studies: First of all, the review of the literature reveals that it is difficult to distinguish the exact nature of the change that is being examined. Is the researcher reporting continuity and/or change in terms of the "overall"/global self-concept? Or is the researcher isolating certain components of the self?

Secondly, the review of the literature reveals that it is equally difficult to determine the influence of the factors which have been identified as the sources of change, if indeed they are identified at all.

Thirdly, in assessing patterns of continuity or change, researchers highlight different components of the self-concept. While some researchers highlight personality traits, dispositions, and values, others emphasize change in terms of social identity components, that is, in terms of social status, membership groups, labels, and derived statuses. The variability in results is, therefore, not surprising.

Finally, operative definitions of continuity and change are rarely conceptualized. However, it appears that, for some researchers, continuity and change reflect a state of remaining the same (continuity), or the process of becoming different (change). Bengtson, Reedy, and Gordon (1985) utilize this framework. Others conceptualize the ways in which changes are negotiated in order to preserve continuity, as evidenced by the work of Kaufman (1986) and Tobin (1988). These differences are significant. However, the authors fail to establish their operative definitions of continuity and change more explicitly in their work.

These points were considered in the construction of this particular study. More specifically, a clear definition of self-concept was adopted, and efforts were made to identify which components of the self-concept were influenced by OA.

Chronic Illness and Conceptions of Self in Later Life:

Up to this point in this review of the literature, studies pertaining to aging and to the psychology of the developing self in later life have been presented. While there is strong evidence to indicate that perceptions of continuity are maintained in later life, despite various challenges associated with old age, there is also evidence of change. These studies were also presented to explore the ways in which patterns of continuity are maintained in later life. But what about those studies that examine, in particular, the influence of chronic illness in shaping people's conceptions of the self in later life? Is the self-concept changed by chronic illness? Or is continuity maintained? Once again, it is difficult to present any conclusive statements, partly because of the limited number of studies that have been conducted. Moreover, those studies that do exist present "mixed" findings. Some authors contend that conceptions of the self are changed by chronic illnesses (Eisenhandler 1992; Roberto and McGraw 1991; and Blackwell and Levy 1987). In contrast, Brandtstadter, Wentura, and Greve (1993) report patterns of stability. Belgrave (1990) reports both continuity and change. Belgrave reports that, while changes in the self-concept are evident, these changes are not experienced uniformly. In addition, the review of the literature also reveals that many studies lack adequate conceptual and theoretical frameworks and thus cannot do justice to the issue of self and identity. Finally, the studies conducted so far do not elucidate the processes that are involved in determining the ways in which physical limitations actually translate into preserved or altered self-concepts. These issues will be considered next.

The following studies demonstrate that conceptions of the self are changed by chronic illnesses. Roberto and McGraw (1991) investigated the self-perceptions of older women with osteoporosis. Self-perception was defined and measured in terms of two related "perceptual" variables- self concept and self-esteem. Self concept was defined in terms of how the women perceived and described themselves with respect to their physical selves and abilities. Self-esteem was defined in terms of the women's self-worth, that is, the feelings associated with the self. Three research questions were investigated. These were, first, what is the relationship between the physical consequences of having osteoporosis and the self concept of the older women? Second, how is the women's self esteem affected by the physical problems associated with having osteoporosis? Third, do the physical effects of osteoporosis and the associated changes in women's self-perceptions contribute to the likelihood of depression? (Roberto and McGraw 1991, 62).

Roberto and McGraw report that osteoporosis did indeed influence the sense of self. Lower self-concept scores were reported by the women (1991, 64). These lower scores provide evidence of the changes in the subjects' perceptions of themselves. Moreover, having fewer illnesses, greater mobility, and being dependent upon fewer supportive devices contributed to higher self-esteem scores (Roberto and McGraw 1991, 66). Drawing upon these findings, the authors suggest that physical impairment contributes to feelings of dependency and loss of control, thereby altering the self-image. They also suggest that the gradual and progressive nature of the disease contributes to negative views of aging and to lowered self-perceptions (1991, 68).

The study by Roberto and McGraw provides evidence that chronic illnesses do contribute to changes in the self-concept. However, the study is limited for various reasons. First, it must be noted that self-concept and self-esteem were narrowly operationalized to reflect the subjects' views of their physical capacities alone. This is a rather limited definition of the self. Nevertheless, the authors claim that their findings show that having osteoporosis altered the women's "overall sense of self" (1991, 67). Other components of the self, aspects from which the women may derive gratifying support for their self-image, are ignored by the instrument used in the questionnaire. Moreover, no attempts were made to assess the influence of age. The authors imply that living with osteoporosis contributed to the women's negative attitudes towards aging, and hence, to their self-perceptions. However, no measures were included in the design of the test instruments to make this association.

In another study, Eisenhandler (1992) investigated the significance of urinary incontinence and explored its potential to threaten conceptions of the self. Eisenhandler highlights the social constructions, or the meanings, that are associated with physical changes. The author discovered that the subjects commonly associated incontinence with "old people in nursing homes". As such, "incontinence symbolized a lack of control that was strongly connected to the aging of the body and to a diminished adult status" (Eisenhandler 1992, 53). This author reports that the uncertainty surrounding one's ability to maintain control over one's physical functioning presents a threatening source of change to the person's self-concept. Incontinence serves to remind the person that "old age must be reckoned into identity" (Eisenhandler 1992, 55).

Eisenhandler demonstrates that incontinence does present a source of change. Some of the women felt ashamed. They felt discredited by their experiences. However, the study also illustrates that when some individuals make adjustments and are able to manage their conditions, they do not perceive themselves as having a problem. For instance, some of the women noted the challenges of their physical condition, but they did not incorporate their symptoms into their identities. Unfortunately, the author fails to explore the processes that enabled the women to disassociate their identities from their experiences of incontinence. This suggests another area for further investigation.

Blackwell and Levy (1987) also investigated the relationship between functional impairment in old age and self-concept. The authors worked under the assumption that the self-concept is preserved and/or reinforced through processes of social interaction. Hence, Blackwell and Levy explored the impact of hearing loss on self-concept, making the assumption that interactive processes are potentially threatened by such impairments. Significantly, perceiving oneself as having a hearing impairment greatly undermined self-concept. This in turn contributed to negative attitudes towards aging (Blackwell and Levy 1987, 25). In this particular study, self-concept was defined in terms of how the individual "felt" about him/herself. The test instrument assessed changes in personality traits. It also assessed the individual's feelings and evaluations of him/herself. Unfortunately, the operationalization of self-concept was unclear. These authors utilized measures that were more appropriate for measuring self-esteem. Nevertheless, they operationalized these measures as indicators of the self-concept.

Belgrave (1990) provides an account of the significance of chronic illness in the everyday lives of older women. Unlike Roberto and McGraw, Belgrave addresses age-specific considerations that may serve to distinguish the experience of chronic illness in later life. The social context of aging is also taken into account. Hence, Belgrave recognizes that the "usualness" of health problems in old age may shape experiences and meanings of illness in old age. Indeed, physical impediments may be both expected and accepted as part of the aging process. Therefore, the issue of stigma may not be a significant component of chronic illness in later life. As such, discrediting may not be as inevitable. The findings confirmed this proposition and stigma played a very limited role in shaping the everyday experiences of older women. Most significantly, there were great variations in the extent to which illness altered the women's self-concepts. In essence, the perceived magnitude, or intrusiveness, of the physical impediments and their management in daily life determined the relevance of illness for self-concept. When chronic illness was viewed as a mere inconvenience to be dealt with (more peripheral than other matters), then the self-concept was not altered. Illness was not incorporated into the self-concepts of these persons. In contrast, those who viewed themselves as ill tended to adopt the illness identity. Managing the illness consumed the lives of these persons (Belgrave 1990, 494-495).

Although Belgrave provides a valuable descriptive account, many areas are under-explored. For instance, the author reports that disruptions in carrying out daily tasks were of the utmost concern to the subjects. Unfortunately, Belgrave does not the uncover the processes whereby disrupted, everyday performances shapes conceptions of self. The author contends that the extent to which one defined the self as ill was pivotal for the self concept. The extent to which the woman was able to continue valued activities and to manage daily life determined the extent to which she defined herself as ill. However, the author does not examine the various strategies, or processes of adjustment, that are involved in enabling women to maintain their valued pursuits. Finally, Belgrave fails to provide a working definition of self-concept. The reader is, therefore, never sure how the self is conceived, or how patterns of continuity or change are to be observed and explained.

Significantly, many studies highlight the impact of the decline in mental and physical health in shaping one's propensity to define or label the self as "old" (Connidis 1989; Furstenberg 1989; Ward, La Gory, and Sherman 1988; Bultena and Powers 1978; Ward 1977). However, this is not always an inevitable process and other studies do report the **stability** of self-conceptions despite decrements in health.

Brandtstadter, Wentura, and Greve (1993) report that the elderly people in their sample were aware of their developmental losses. However, the researchers discovered that the individuals viewed themselves positively. Twenty-two categories of diseases were examined. Aged-related chronic illnesses, such as arthritis, cancer, diabetes, high blood pressure and emphysema were highlighted. While this study did not examine self-concept, (it examined sources of stability in self-esteem), this study is useful because it elucidates the processes that are involved as individuals negotiate changes to preserve personal continuity. In particular, the authors confirmed that "accommodative processes" are the means through which self-perceptions are successfully preserved. Accommodative processes refer to the "processes by which personal goals and frames of self-evaluation are adjusted to changes in action resources and functional capacities" (Brandtstadter, Wentura, and Greve 1993, 323). The authors discovered that goals and preferences were adjusted in order to accommodate constraints so that limitations were not experienced as severe threats. Hence, this study contributes to our understanding of the ways in which patterns of continuity are preserved.

This body of literature demonstrates that studies report mixed findings with regard to issues of stability and change in the aging self. It was also shown that the existing studies suffer from conceptual ambiguity. Operational definitions and measurement of "self" have not been fully developed and it is clear that these researchers have only begun to "dig beneath the surface". In addition, these studies do not uncover the processes involved in determining the ways in which physical limitations translate into a preserved or altered self-concept. Indeed, the paucity of studies dealing with issues relating to old age, health and self-concept suggest underexplored areas of research.

Chronic Illness and Conceptions of Self: Does Age Matter?

Perhaps the most developed conceptual frameworks have been provided by sociologists who have assessed issues of chronic illness and identity. However, these researchers have not focused on the significance of age and life stage factors. The age factor is rarely highlighted as a potentially significant factor to consider. This is particularly important considering the studies that have documented significant age differences in self-reported, subjective assessments of health (controlling for objective measures of health), and differential responses to physical pain as a function of age. Nevertheless, the chronic illness and identity literature is worth examining. First, these studies present conceptual frameworks, themes and issues that address the "lived" experience of chronic illness. It may be worthwhile to examine whether these issues apply to older individuals as well, or whether chronic illness in later life presents unique issues. Next, the studies address the processes of adjustment that are involved in the negotiation of the self- an area that was not addressed by most of the studies presented above. Finally, a presentation of these studies will reveal the areas that remain uninvestigated. These unexplored issues will also contribute to the formulation of the research problems for this particularly study.

Interestingly, the most notable studies report that chronic illnesses produce significant changes in the self-concept. Charmaz (1983) conceptualizes "the loss of self" as a fundamental form of suffering among the chronically ill. She provides an analysis of the processes involved in transformations of the self as individuals progress through their illnesses. Hence, the issues that are involved in the "lived" experience of chronic illness are presented. The author not only identifies four factors that characterize the illness experience, but she also presents them in relation to changes in self-concept. These include the leading of restricted lives, the experiences of social isolation, the experience of being discredited, and burdening others. Utilizing a symbolic interactionist perspective, Charmaz conceives the self as "fundamentally social in nature" (1983, 170). Self-concept is defined as "the organization of attributes that have become consistent over time...though the self is organized into a structure, ordinarily that structure ultimately depends on processes to sustain it. In other words, maintaining the organization of the self means empirical validation in daily life" (Charmaz 1983, 170).

Charmaz argues that chronically ill persons may have fewer opportunities for maintaining valued selves. Managing one's illness may consume the person's time and the loss of control in exercising choice and freedom of action may lead to losses of the self (Charmaz 1983, 172-173). The uncertainty of chronic illnesses, that is, the unpredictable course of some illnesses, led many individuals to restrict their lives. Social engagements and certain activities were curtailed. In some cases, restricted lives caused individuals to retreat into themselves. Interests and concerns were narrowly directed towards the illness.

Chronic illness also resulted in social isolation. The individual's contact with others through work, social organizations, and shared activities became limited. This also resulted in losses of the self since opportunities to affirm and engage in valued identities were limited (Charmaz 1983, 176). Moreover, the inability of the ill individual to meet the expectations of others led to the self being discredited (Charmaz 1983, 182). Charmaz argues that discrediting definitions of the self contribute to a sense of the loss of self. Charmaz also discovered that becoming more dependent and perceiving oneself as a burden on others often translated into the loss of self. Feelings of uselessness reminded the individual that the illness has overtaken the identity (Charmaz 1983, 188-189).

These factors, that is, restricted lives, social isolation, discrediting definitions of the self, and issues of dependency, are the major themes found in the literature on chronic illness. Such themes include the concepts of stigma, illness trajectories, uncertainty, social isolation, managing regimens, information sharing, and family relationships (Conrad 1987). It is important to note that very few authors focus on the consequences of experiencing illness for the tranformation of self and identity as Charmaz does. However, Charmaz does not focus on older people. Hence, one may ask whether these same issues also apply to experiences of chronic illness in later life. Belgrave (1990) reports that stigma did not play a significant role because of the "usualness" of health problems in old age. However, experiences of social isolation, uncertainty, and dependency may apply to older individuals.

Two other important studies address the processes by which identities are challenged, and fundamentally altered by chronic illnesses. These studies examine the ways in which individuals adjust or negotiate re-constructed conceptions of the self. However, experiences which may be unique to the roles occupied by older women are not dealt with in these studies. This suggests yet another area of research. These two studies will be presented next.

First, Charmaz presents a hierarchical model of identity. Utilizing this model, she provides a conceptual map that allows one to chart the various phases in identity transformation. Two key concepts are introduced. These are the role of preferred identities and the development of identity hierarchies. Preferred identities represent "the hopes, desires, and plans for a future now unrealized" (Charmaz 1987, 284). Identity hierarchies illustrate the processes through which ill individuals select different kinds of preferred identities according to the difficulties they experience in attaining particular aspirations and goals. Four levels are identified within this hierarchy. These are, first, the supernormal social identity- an identity in which the individual strives to participate more successfully than those in a non-impaired world despite illness. Second, there is the restored self- the reconstruction of a past identity. Third, there is the contingent personal identity- tentative and uncertain identities not guaranteed because of the possibility of further illness. And fourth, there is the salvaged self. This is the level at which the person attempts to maintain self-worth and value, while at the same time acknowledging his/her present impaired state (Charmaz 1987, 287).

Four conditions are identified in determining the selection of a preferred identity. These are the type and stage of the illness, meanings of experiences of illness, the timing and sequencing of the illness, and expectations of and for self (Charmaz 1987, 288). In illustrating the dynamic, fluid and ever-changing nature of identity formation, Charmaz contends that individuals may *move* within the identity hierarchy. Interestingly, changes in physical status are pivotal in contributing to shifts in identity levels. Typically, individuals "spiral down" from the top of the hierarchy.

These four types of identity are very useful, because they conceptualize the developmental phases through which transformations in identity occur. However, a more detailed analysis of the ways in which identities, (characteristic of older women) are influenced by chronic illness would be interesting. For example, Mac Rae (1990) notes that the preservation of valued identities from the past (such as homemaker, wife, and mother) provide perceptions of continuity for older women in the present. While Mac Rae does not address the ways in which disabilities and health problems may hinder the maintenance of these identities, it would be useful to investigate the ways in which older women construct, for example, salvaged or restored selves in terms of their valued role identities.

The second study is the one conducted by Corbin and Strauss (1987). They provide a detailed account of the significance of chronic illness with respect to changes in body, self, biography, and biographical time. Corbin and Strauss introduce the term "biographical accommodation". Rather than merely describing aspects of illness management, the authors define accommodation as "action aimed at achieving a sense of control and balance over that life, as well as giving it continuity and meaning despite the illness and the changes it brings" (Corbin and Strauss 1987, 251). Hence, "biographical accommodation" refers to the processes in which attempts are made to maintain a sense of mastery over biographies disrupted by illnesses. Four topics are presented to illustrate the processes of biographical accommodation. They are, first, dimensions of biography-body, conceptions of self, and biographical time. Second, action performance. Third, the impact of disrupted action performance. And fourth, the biographical work necessary for successful accommodation to body failure.

Body failure sometimes impinges on desired performance levels. The authors describe this process as "the shattered BBC chain". When individuals are unable to perform tasks that are closely related to, and invested in concepts of the self, these persons may experience the loss of self (Corbin and Strauss 1987, 264). It becomes important then to repair the BBC chain. Engaging in such processes is referred to as biographical work. Four such strategies are considered. The first strategy, contextualizing, entails the incorporation of the illness into one's biography. It may be completely integrated into the biography, or it may be kept totally separate from the person's self-concept. Most people strike a balance between the two. Hence, it is common to hear comments such as, "I have a chronic illness, it is part of me, there is an ill aspect of self to be added to the others but there is more of me than it" (Corbin and Strauss 1987, 265). Moreover, trajectories are contextualized into the biography through "ideational processes". Here, the issue of time is significant. As Mead states:

> Now it is by these ideational processes that we get hold of the conditions of future conduct as these are formed in the organized responses which we have formed, and so construct our own past in anticipation of that future. The individual who can thus get hold of them can further organize them through the selection of the stimulations which call them out and thus build his plan of action (Mead 1920 in Corbin and Strauss 1987, 268).

Through ideational processes, persons engage in backward and forward reviews. An individual may recall the past, assess the present, and gaze into the future. He or she may also interpret events in the context of the present. Reviews are often shaped by the type of the illness trajectory. Changes in trajectory and biography, failed performances, and interaction with others may all serve to stimulate ideational processes. Often, ill persons may engage in backward reviews in order to find some meaning to their current symptoms. People may also look into the future, in light of present uncertainties in order to ascertain the possibilities of unrealized identities (Corbin and Strauss 1987, 268-269).

The second type of biographical work is called "coming to terms". It may be described as the process whereby the individual comes to comprehend and to accept the implications of living with chronic illness. He or she must come to accept performance limitations and biographical consequences (ie dependence, social disengagement etc.). However, some individuals never accept the consequences of chronic illness. (Corbin and Strauss 1987, 270).

Identity reconstitution is the third type of biographical work identified by the authors. This term describes the processes through which the ill person, who has suffered the loss of self, attempts to re-establish a sense of who he/she is. People may define and redefine the self in two ways. The first process involves re-learning the capabilities of the altered body. Limits are tested, and activities that can and cannot be performed are reassessed. Second, priorities, values, goals, and objectives are modified. The loss of one's previous capacity to carry out past levels of performances is mediated by the replacement of old goals by modified ones. In this way, the nature of performances is mediated by the replacement of modified ones. Corbin and Strauss call this the refocusing of direction. Hence, modified performances may be utilized to cultivate valued aspects of self (Corbin and Strauss 1987, 273).

Finally, the fourth type of biographical work is called biographical recasting. Here, the individual formulates a biographical "map" that will provide direction to his/her future (Corbin and Strauss 1987, 276-277). Two conditions are necessary for the facilitation of biographical recasting. First, crystallization and second, control over the trajectory. Crystallization is the process whereby one comes to recognize those performances that are no longer possible. After these limitations have been recognized, an alternate biography is recast. This new biography takes these limitations into account. Finally, the individual must be able to exercise control over the trajectory. This may include the development of a strategy for managing the trajectory. Without such conditions, it may be impossible for the individual to project into the future in terms of his/her biography (Corbin and Strauss 1987, 277-278).

This study is valuable because it uncovers the processes by which individuals negotiate the changes brought about by their chronic illnesses. Once again, however, it appears that an examination of chronic illness in later life presents the opportunity to uncover additional information. For instance, Corbin and Strauss note that biographical work entails the acceptance of one's altered physical capabilities. If the person is to maintain a sense of mastery over a life, disrupted by chronic illness, he/she must re-learn the limitations and abilities of his/her changed body. Priorities, values, goals, and objectives must be modified as well. But what are the experiences of older women as they attempt to adjust to their changed bodies? As mentioned earlier, Roberto and McGraw (1991) and Belgrave (1990) report that changes in the self-perceptions of older women are evident. However, they do not uncover the processes by which these changes are enacted. Nor do they explore the ways in which individuals adjust to their disabilities. Are roles modified? Are values, priorities, and personal aspirations modified? If so, in what ways?

Taken together, the work of Charmaz, and Corbin and Strauss do provide valuable information concerning the processes by which identities are transformed and adjusted. However, many areas remain unaddressed. The ways in which identities, more specific to older women, are influenced by chronic illnesses present a possible avenue of further research. Indeed, the importance of recognizing the implications of the situated biography of the individual in the later stages of the life cycle has not been recognized. The gains and losses that are commonly associated with old age may produce different responses to illness experiences, responses that are different from those of younger cohorts. Experiences within the life cycle may produce changed perceptions of time and later life may present a period in life in which emphasis on the future is less important. (For example, shortened future perspectives may influence what Corbin and Strauss call backward and forward reviews). Old age may be viewed as a distinct period as it is the only time in which a sense of the entire life cycle has already been experienced (Botwinick 1984). It is quite possible then, that older individuals may utilize modified strategies and mechanisms in order to preserve a sense of self and that these may be unique, quite different from those of other age groups. An examination of these processes is therefore a worthwhile exercise.

In summary, this review of the literature reveals several issues. First, the studies report mixed results with regard to patterns of continuity **and** change in the self-concept. These results vary depending on which operative definition of self-concept has been used/. Often, adequate and clear definitions of the self-concept are not provided. Next, some researchers have identified the processes that are involved as individuals preserve their sense of self-continuity in later life. However, these authors have not focused on chronic illnesses in particular as the agents of change. Other researchers have examined the role of chronic illnesses in bringing about changes in older persons. However, these authors have not uncovered the processes that are involved in determining the ways in which physical limitations translate into preserved or altered conceptions of the self. Finally, research in the area of chronic illness and identity reveals the themes and concepts that are involved as individuals adjust to their challenged identities. They conceptualize the phases through which transformations in identity occur, and the processes by which individuals adjust to changes in light of their "disrupted biographies". However, age factors are not specified and other questions remain. How are roles which are specific to older women influenced by chronic illness? What are the experiences of older women as they engage in "biographical work"? Are roles modified? Are values, priorities, and goals modified? If so, in what ways? It is clear that many areas remain uninvestigated. These issues will be considered in the formulation of the problems for this particular study.

THE STATEMENT OF THE RESEARCH PROBLEMS

The Research Problems:

What follows is a refinement of the research problems in light of the issues raised earlier. In its most general form, the main question guiding this investigation may be stated as follows:

> **How is the self-concept influenced by chronic illness in later life? Is the self-concept influenced in any significant ways by the experiences of living with chronic illness in old age? In particular, are there patterns of continuity and change in the self-concept?**

This study will also attempt to provide a clear and concise formulation of the ways in which the self-concept is influenced. In order to clarify which components of the self-concept are shaped by chronic illness, this study will focus on social identities. Hence, the general research problem may be further refined:

> **How are social identities influenced by chronic illnesses? In what ways?**
>
> **Which processes reveal the ways in which the self-concept is negotiated, that is, changed, or unchanged?**

The next questions will attempt to uncover the significance of chronic illness in old age and the conditions that are influential in mediating stability and/or change:

> **Which aspects of living with chronic illness are influential in challenging the self? Do older people reflect the same issues, (that is, uncertainty, stigma, biographical work, dependency, social isolation, family relationships) that have previously been revealed by studies of chronic illness which do not highlight the significance of old age? Do**

> **life stage factors shape the ways in which chronic illness influences the self-concept in later life?**
>
> **The intrusiveness of chronic illnesses in later life may or may not be associated with the aging process. How does chronic illness influence age identity?**

THEORETICAL CONSIDERATIONS

An examination of the self-concept in later life presents many challenges. It is important to be aware of the significance of socially constructed age and life periods, and also of age-related norms and transitions. At the same time, there is the danger of adopting deterministic and normative assumptions when studying older persons.. Symbolic interactionism provides a useful framework for acknowledging the social structures to which individuals are related, while at the same time acknowledging the variability within individual experiences. Breytspraak contends that symbolic interactionism is quite suitable for this purpose. Symbolic interactionism is:

> vitally interested in the construction of human behaviour, particularly with regard to the self. The self is projected onto the world and is the basis from which the meaning of the self is further negotiated with others. Thus, this negotiation of selfhood is first and foremost a collective enterprise...This perspective is potentially quite useful in the study of aging in that it assumes persons to be always developing, acting, constructing and negotiating selfhood, no matter what their age (Breytspraak 1984, 46).

In recognizing that humans act, construct, develop, and negotiate selfhood throughout the life span, the processes whereby both minor and more significant changes are negotiated into the self may be explored. In particular, it is possible to examine the processes by which the self is shaped by changes and interruptions instigated by chronic illness. What follows is a working definition of self-concept. Some guiding principles, derived from the symbolic interactionist tradition will also be presented, and their relevance for this particular study will also be considered.

Self-Concept Defined:

Some of the basic principles espoused by the symbolic interactionist conception of the self are worth noting. The "self as object" was described earlier. This refers to the interplay between the "I" and the "me". Hence, identities are said to be reflexive. Burke (1980) also notes that identities are relational, and that identities are the "meanings" individuals impute to themselves. The meanings attributed to identities are derived through interactions in the course of which other actors are responding to the person who occupies a certain role. Finally, Burke notes that the symbolic interactionist conception of the self posits that identities are structured in a hierarchical arrangement (1980, 18-20). These principles will be explored in more detail. First, a more concrete definition of self-concept will be provided, keeping in mind these basic principles.

Rosenberg's (1979) definition of the self-concept will be adopted for the purposes of this investigation. Rosenberg's framework will be useful because it incorporates symbolic interactionist, and social psychological theories of the self. In essence, Rosenberg synthesizes all the major conceptual components of the self-concept commonly utilized by both symbolic interactionists and social psychologists alike. His conception of social comparisons and reflected appraisal (reminiscent of the works of Goffman, Mead and Cooley) and his principles of psychological centrality and self-attribution theory (utilized by identity theorists) support this contention. Significantly, Rosenberg himself argues that his principles represent "most of the theoretical reasoning employed in the literature to understand the bearing of interpersonal and social structural processes on the self-concept" (1979, 62). Moreover, he provides a clear and concise formulation of the self-concept. Bengtson and his associates (1985) conducted a comprehensive review of the literature on aging and personality. In their analysis, three components of the self-concept were identified in order to reflect the published studies. These were as follows:

the cognitive aspect (the content of the self), the affective component (evaluations of the self), and the conative component (the behavioural orientations that reflect the self) (Bengtson, Reedy and Gordon 1985, 547). Rosenberg's conception of the self resembles that of Bengtson and his colleagues. This is illustrative of the breadth of his theoretical framework.

More significantly, Rosenberg's framework will be of most use in elucidating the conceptual and theoretical categories relevant to my study. **In short, his framework will be helpful in determining how the self-concept in influenced by chronic illness, that is, which components of the self are influenced, in what ways, and through which processes. This will be discussed next.**

Rosenberg identifies three broad areas of the self-concept. These are, the extant self, (how the person views him/herself), the desired self (how the person would like to see him/herself), and the presenting self (how the person presents him/herself in front of others). A brief description of these components will be provided. Their significance for this particular study will also be considered.

Extant Self-Concept: Rosenberg (1979, 9-11) provides a clear definition of the self-concept by identifying the **content** of the self-concept. This is composed of social identity elements, dispositions, and body image. For the purposes of this study, the social identity component will be described. Social identity is defined as the groups, statuses, or categories to which the individual is recognized as belonging. Social identity is further sub-divided into six categories. Thee are social statuses, membership groups, labels, derived statuses, types, and personal identity.

While **social statuses** refer to universal categories such as sex, age, occupation, and social position, **membership groups** refer to groupings based on voluntary association, shared beliefs or interests, and cultural or regional identification. Identities may also be conceived as the names given to the self by the self and by others. This process entails a **labeling** process, whereby the verbs used to describe the actions of a person are converted into nouns. Hence, "the individual is no longer someone who drinks heavily but an alcoholic; who takes drugs, but a drug addict; who behaves peculiarly, but a mental case; who has shoplifted, but a criminal" (Rosenberg 1979, 10). Next, a person's identity is often **derived** from other statuses, membership groups, or labels. This is usually based upon the person's personal history or biography. "Whether the individual likes it or not, as far as society is concerned part of what he is is what he was" (Rosenberg 1979, 11). Next, **social types** refers to those interests, attitudes, characteristics, or habits which are categorized or "boxed" in together. For example, an individual may be identified as a jock, a nerd, an intellectual, or a womanizer... Finally, **personal identity** refers to the identification of the individual into a specific category "with one case" (Rosenberg 1979, 11). Hence, individuals are assigned a personal label, for example, a name. Personal identities are therefore rooted in characteristics that are unique to the individual.

Taken together, identity may be viewed as a "typified or socially expressed dimension of self...identity is a system based on one's reflective view of self, perceptions of the expectations or response of others (reflected images), and subsequent reactions to shared reality or validation" (Weigert, Teitge, and Teitge 1986, 40-41).

Rosenberg also highlights another significant feature of the self. He points out that the self is organized in a **structure**. This refers to the relationship among the components of the self. Of particular interest, he notes that "the self-concept components are of unequal centrality to the individual's concerns and are hierarchically organized in a system of self-values" (1979, 18). Termed psychological centrality, this principle holds that components of the self vary in the extent to which they are central or peripheral to the self. Some components are favoured more than others. And the more significant ones may contribute to a greater sense of integration and consistency. One's assessment of the self is based on those components of the self that are more valued, that is, those qualities "that count" (1979, 18). Hence, Rosenberg argues processes of continuity and change are shaped by the extent to which the identity component is central or peripheral to the individual (1979, 76). In short, the significance of a specific component depends upon the importance that is attributed to it.

The author also contends that the principle of psychological centrality reflects much of the theoretical reasoning used by researchers who have examined the development and the formation of the self-concept (1979, 62). This principle is relevant because it highlights the importance of determining which parts of the self the individual perceives to be most influenced by his/her chronic illness. Indeed, it seems fair to propose that identities which are more important to the individual will bring about more change if they are limited by OA than the less central ones. For this reason, it is important to consider the principle of psychological centrality when examining processes of continuity and change.

Taken together, the content and the structure of the self-concept, as described by Rosenberg, provide some of the organizing principles for investigating which components of the self-concept are challenged, and the processes through which such changes manifest in lost, preserved, or re-constructed identities. How are the elements of one's social identity shaped by chronic illness? Has the "content" of the self changed because of the chronic illness? How has this affected the person's overall sense of self? Do age identities influence the processes by which chronic illness is negotiated into the developing self? That is, are there, in later life, variations in identity constructions that may shape the way in which the meaning of chronic illness is constructed? Are there any roles, group associations, labels, stereotypes, or social expectations, that are specific to older persons and that may shape the experience of chronic illness and the processes through which these are negotiated in conceptions of the self? When central components of the self are threatened by chronic illness, what are the processes that are utilized in order to preserve the self? What are the juggling or adjusting mechanisms that are involved? These questions may also be explored in conjunction with other areas of the self. To this we next turn.

Desired Self-Concept: In addition to the extant self, Rosenberg (1979) also identifies the desired self as another major component of the self-concept. The desired self refers to the idealized self image, the committed self image, and the moral self image. Idealized images of the self refer to an imagined picture of oneself as being other than who that person really is. Idealized images are unrealistic and it is unlikely the person will ever fulfill his/her idealized image. At the same time, the desired self also contains the committed image. "This self-picture is one that we take seriously, not simply one that is pleasurable to contemplate" (Rosenberg, 1979, 40). Committed images may well be attainable. Both the idealized and the committed image represent how the individual would prefer to see him/herself. Finally, the moral self image refers to what one feels (s)he ought, or should be. The moral self image is related to the rules or personal standards the person feels compelled to abide by (Rosenberg, 1979, 40-42).

These considerations are particularly pertinent to the study of self and chronic illness. As ill individuals confront the limitations of impaired bodies, and perhaps, severe disability, it may be impossible for them to perform those activities that were once central to the extant self-concept. Several questions emerge. What happens to the person's self-concept when components of the extant self are limited? Or when they are no longer possible to enact? Do they become idealized or desired? Is there an interactive relationship between the desired self and the extant self? These questions are worth exploring since the desired self may be implicated as individuals experience changes and perhaps losses in their valued identities.

The Presenting Self: Finally, the third component of the self, the presenting self, refers to the process in which the self is intentionally presented to others. Often termed as impression management, this concept addresses the ways in which the individual performs and controls his/her personal behaviour in the attempt to present an image of the self that the actor wishes to convey. Such performances vary in the extent to which the presented self converges with or diverges from the actual self-picture that the person holds (Rosenberg 1979, 45-46). Individuals engage in performances in the attempt to preserve their self-pictures. Rosenberg notes:

> Although the immediate aim may be to convince others that we are a certain type of person, this objective serves the deeper purpose of convincing ourselves. However much an individual may like to think of himself as intelligent, attractive or skilled in some way, in the long run he will actually believe he is so only if this view is substantiated by external evidence. One of the major sources of evidence is the responses of others toward us (1979, 48).

It is important to address the presenting self, considering the potentially disabling effects of OA and the increased likelihood of impaired performances. The individual's ability to perform preferred presentations of the self may become limited. As a result, it may become more difficult to foster the kinds of appraisals that will affirm valued components of the self-concept. Corbin and Strauss (1987) address this issue and they state that body actions or performances are important, because individuals perform not only for themselves, but for others, with them, and through them (257). Hence, the interactive and evaluative component of "performance as action" are evident. These points underscore a key point: the changes in the disabled person's self-concept are often mediated by the perceptions and attitudes of others. Hence, chronic illness presents an interesting scenario because *reflected appraisals* may take on new meanings.

The presenting self is also intricately related to reflected appraisals. This is a basic principle advanced by the symbolic interactionist conception of the self. Basically, reflected appraisals means that an individual's picture of him/herself is shaped by the attitudes of others toward that person. Rosenberg notes that a reasonable agreement between other people's views of the person and the person's own view of him/herself is "indispensable for adjustment to society" (1979, 63). Indeed, one's sense of personhood emerges through the process of assuming the views of others toward the self (Rosenberg, 1979, 64). Mead states this clearly:

> The individual experiences himself as such not directly, but only indirectly, from the particular standpoints of other individual members of the same social group, or from the generalized stand-point of the social group as a whole to which he belongs (1934, 138 in Rosenberg 1979, 64).

Hence, the person's self-concept develops as he/she, "takes the role of the other" and reacts according to the standpoints of others. This also involves "the imagination of our appearance to the other person and the imagination of his judgment of that appearance" (Cooley1912, 152 in Rosenberg 1979, 65). Cooley's formulation of the "looking-glass self" is in keeping with the symbolic interactionist conception of the self because it emphasizes the significance of the person's *perception* of the attitudes of others for the development of the self-concept. In short, reflected appraisal is an additional principle that is certainly important in this particular study. Perceptions of continuity and change may be influenced by one's imagined appraisals of others. Indeed, the meanings that one attributes to one's own identities will be shaped in the context of interaction with others, as one adopts the appraisals of others.

Up to this point, three components of the self-concept were introduced. These were the extant self, the desired self, and the presenting self. In addition, two principles were introduced: psychological centrality, and reflected appraisal. Rosenberg presents a third principle that is often reflected in studies of self-concept formation: that of social comparison. In essence, social psychologists have established that individuals often compare themselves with others. Through these comparisons, individuals learn more about themselves. Moreover, they evaluate and judge themselves with reference to "the standards set by the individuals employed for comparison" (Rosenberg 1979, 68). Social comparisons are influential in the development of the self-concept. It is in relation to others, in interaction with them, that individuals are able to assess themselves.

This principle points to some pertinent questions. Do individuals draw upon social comparisons as they assess their own situations? Does the "usualness" of health problems in later life facilitate positive social comparisons and hence favourable assessments of one's own disabilities in later life? Indeed, positive or negative social comparisons may shape a person's assessment of his/her own situation. This will affect the extent to which chronic illness is perceived to be intrusive. Significantly this may affect people's experiences of continuity and change and the principle of social comparison presents an important mechanism for negotiating such experiences. Interestingly, this idea was not incorporated in the planning of the study. Social comparisons were not anticipated in the early stages of the research. However, it soon became evident in the interviews that social comparisons were indeed influential for shaping the person's assessment of her own situation.

An additional aspect of the self-concept is worth noting. One must consider the symbolic interactionist conception of the "biographical self" (Hewitt 1991). The biographical self is significant because it points to the importance of recognizing the role of time in shaping people's perceptions of continuity and change in the self-concept. Not only are roles enacted from situation to situation, but a person also derives his/her sense of continuity because of experiences that are remembered. Continuity is essential to the person's sense of self. This is because connections are made between events and interactions so that the individual can attribute structure, order, and meaning to them (Hewitt 1991, 123).

The issue of time is relevant for this study, because the biographical self may be implicated in the *processes* by which the self-concept is negotiated. An examination of the self in the past, in the present, and in the future makes it possible to addresses several questions which may serve to uncover important process mechanisms. Are the contents of the extant self, established over the years, preserved, even though present conditions are not affirming these qualities? How is this achieved? Is one's perception of time implicated in this process? Are desired images modified when the individual is confronted with the finitude of life? How does this influence the relationship between the extant self and the desired self and how does this affect consequent stability or change in the overall self-concept?

In their study of those suffering from a chronic illness, Corbin and Strauss noted that themes such as "the eternal present", "the lost past", "the person left behind", and "the overbearing present" were significant (1987, 201). These researchers also contend that time, in relation to conceptions of self, may be implicated in process of adjustment. These processes are referred to as biographical work. Part of biographical work may entail examining the past, assessing the present and making projections into the future **in terms of the present**. This is what Mead called, "ideational processes" (see page 25 of this chapter). The past may be re-captured in a person's attempts to come to terms with the illness. For example, the past may be symbolically reconstructed in order to provide meaning to the present condition. The future may be assessed in light of present circumstances and old plans may have to be altered because of the illness. Furthermore, activities that were once central to the person's self-concept may no longer be possible and the acknowledgment of this inability may alter conceptions of the self. In order to preserve the self, biographical continuity may be particularly important. Individuals have to re-define the activities and the aspects of the self that are valued (shifting identity hierarchies). The individual may also attempt to re-establish him/herself by incorporating certain changes into his/her self-concept. This may involve changes in the way the future and the past are viewed in terms of the recasting of biographies. As the limits of the ailing physical body are recognized, the self may be re-directed towards alternative courses of action, courses of action that may serve to affirm other aspects of the self (Corbin and Strauss 1987). Clearly, these processes may be implicated in the negotiation of continuity and change and it is important to address the role of time.

This may also be important in identifying conditions and issues that are specific to the experiences of older people. Particular questions emerge. Having experienced the entire life cycle, do chronically ill, older people engage in unique processes to maintain their self-concepts? How is time perceived and experienced by them? Do older people transcend the linear progression of time in order to overcome the challenges presented by natural aging processes? How does the perception of time positively or negatively shape people's abilities to preserve the self? Older persons are brought face to face with mortality and with the finitude of life. How does this shape their experiences of chronic illness and the developing self? Indeed, as individuals confront changes in life circumstances while progressing through the life cycle, the past is interpreted and the future is structured through present circumstances. Even more so, older persons may be located in a time-continuum such that future-oriented perspectives may be less emphasized. Hence, as older people confront chronic illness, their illness experience may be unique. (As the review of the literature suggests, researchers have often failed to consider the differential impact of age). These questions point to the importance of considering the role of the past, the present, and the future in shaping conceptions of self in chronic illness.

In summary, these theoretical considerations provide structure for the examination of the questions for this particular study. Rosenberg's definition of the self-concept, that is, the extant self, the desired self, and the presenting self provides a concrete working definition. Thus, it is possible to identify clearly **which** components of the self-concept will be assessed, and more specifically, how social identities are influenced by OA. The principles of psychological centrality, reflected appraisal, and social comparison are also useful for uncovering the **processes** that are involved in the negotiation of continuity and change. These principles reflect the basic tenets of the symbolic interactionist conception of the self. Hence, the proposition that identities are hierarchically structured is addressed by psychological centrality. The proposition that identities are relational and that identities are the meanings imputed to the self are both addressed by reflected appraisal and social comparison. This is because these principles are based on relational associations and on shared interactions (Burke 1980). Finally, the biographical self is also relevant because it will serve to uncover those aspects of chronic illness that may be unique to older persons. It is the contention of this thesis that these theoretical constructions provide the means to address the questions raised earlier in the review of the literature.

OVERVIEW OF THE THESIS

In the next chapter, the methodology employed for this study will be presented. A description of the sample, as well as an explanation of the procedures that were used in the collection and the analysis of the data will be provided. In Chapter 3, the ways in which social identities are shaped by OA will be examined. Patterns of continuity and change will also be assessed. This chapter demonstrates the relational dynamics of social identities. Chapter 4 explores the relationship between the components of identities. Prominence hierarchies are examined. The principle of psychological centrality is useful when one is uncovering the ways in which identities interact within the hierarchy to bring about both continuity and change in the self. Chapter 5 deals with the experience of living in a disabled body, and the processes by which individuals adapt and accomodate to limitations in order to preserve self-continuity. Hence, this chapter extends the examination of those process mechanisms that are involved in the development of the self. In Chapter 6, the principles of social comparison and reflected appraisal are introduced. This chapter demonstrates how these principles significantly shape the woman's definition of her own situation, and in relation, her perception of the intrusiveness of her disabilities. Chapter 7 explores the role of time. This chapter also highlights the significance of the past, the present, and the future self for negotiating changes in the self. The unique experiences of older persons are considered. Finally, Chapter 8 presents a discussion of all the findings, and their contribution to research. See the next page for a schematic overview of the study.

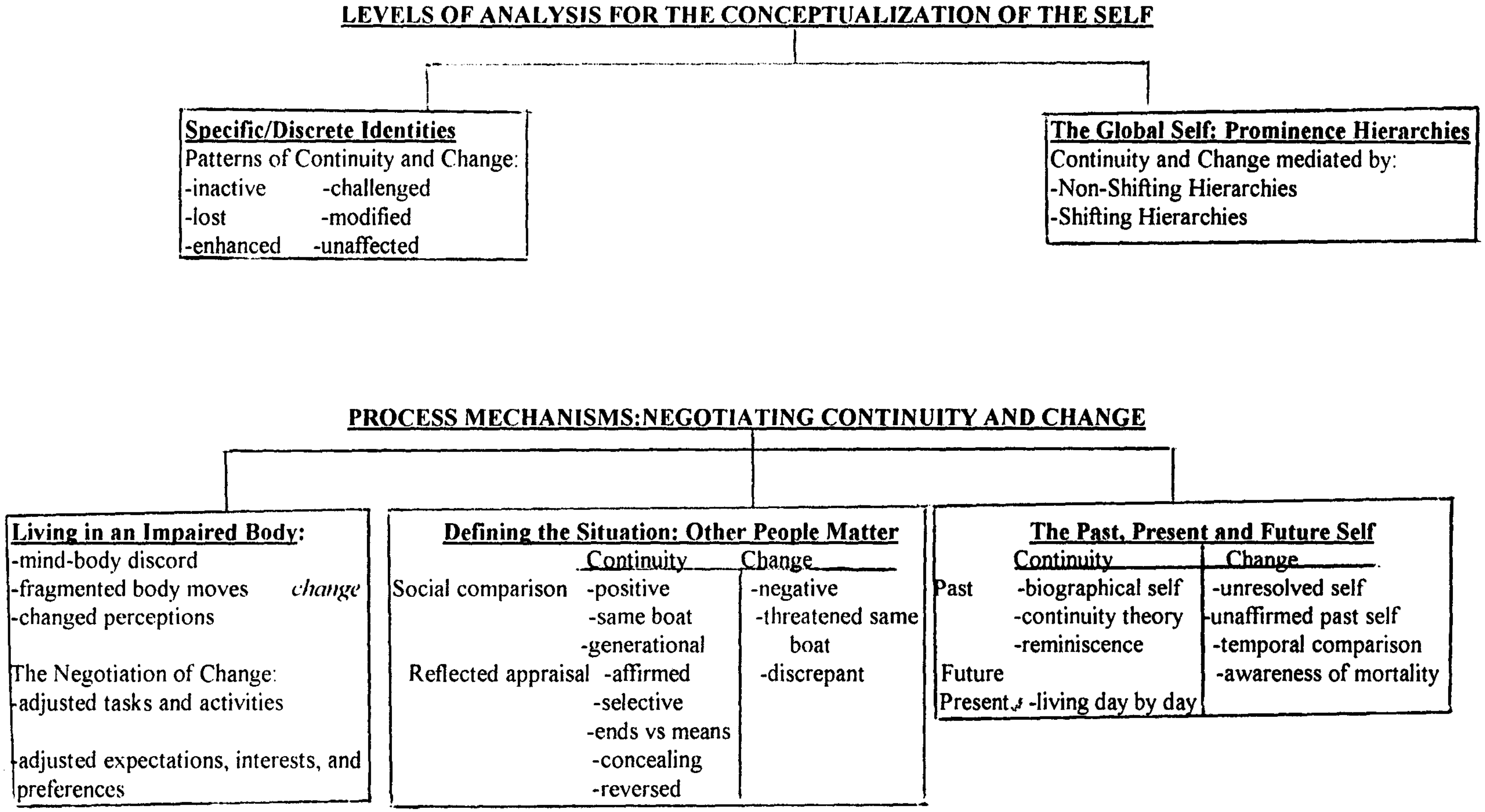

Fig. 1. Summary Diagram and Overview of Process Mechanisms

CHAPTER 2
METHODOLOGY

SAMPLE

Twenty-four women, all of whom had been diagnosed as having OA, participated in this study. The participants were female, between the ages of 67 to 85 years, non-institutionalized, and able to conduct conversations in English. These criteria were selected for the following reasons. Gold (1994) reports that osteoarthritis, along with osteoporosis, characterize the majority of the chronic musculoskeletal disorders among older women. Similarly, Verbrugge's study (1992) documents the high rates of osteoarthritis among American, older women, aged 70 and older. Given the "gendered" and age-related nature of the disease, older females were targeted. Next, non-institutionalized participants were selected in order to uncover the significance of disability and impairment in managing everyday life in independent living arrangements. It was possible to examine issues of dependency, uncertainty, and the conceptual significance of "performance as action" under these conditions. Since the data were obtained through in-depth interviews, individuals had to be able to conduct conversations in English. Six of the participants were married, seventeen of the participants were widowed, and one woman had never married. Given that widowhood is quite common among women in later life, the high proportion of widows was not surprising.

The sample was selected to reflect a range of OA in order to avoid documenting only the most serious experiences of OA, as is often the case in studies of chronic illness and identity. Efforts were made to obtain a sample with an even distribution of severity of OA.

After obtaining approval from the McMaster Ethics Committee, participants were found through three different sources. These were the Arthritis Society of Hamilton, the Arthritis Society of Toronto, and Aging in Place- a community resource centre for seniors, located in central Hamilton. The Arthritis Society of Hamilton informed their clients about the nature of this study. Those who consented to have their addresses and phone numbers released were then sent letters, requesting their participation in the study. A few days later, the individuals were contacted by telephone in order to confirm their willingness to participate and to arrange dates for interviews.

The Arthritis Society of Toronto provided referrals to several aquatic exercise programs. The co-ordinators of these aquatic classes were contacted and their assistance in locating prospective participants was obtained. These co-ordinators spoke with the members of the aquatic programs, who then consented to have their addresses released as well.

Finally, the director of Aging in Place knew of several women who met the criteria of this study. The director spoke with her clients and those who had expressed interest and who had given their addresses and phone numbers were contacted as well.

Although the sample may appear to be biased, (since it reflects those involved in community organizations and consultation services), many of the clients obtained through the Arthritis Society of Hamilton reported that they had not been involved with this organization on a regular basis. Some of the respondents had not been involved in any type of program for people suffering from arthritis for several years. Hence, the sample does, in fact, include a range of people in terms of the extent of their association with groups and community organizations.

One additional comment must be made with reference with the size of the sample. Because of the limited time available for this research project, it was only possible to interview thirty women. Of these, six of the interviews were not included in the study. These respondents were unable to complete the interviews because of poor health. Unfortunately, they did not consent to a subsequent interview. It is also important to note that, because the sample size is small, it is not possible to make broad generalizations. However, the findings do show that there are several process mechanisms that are involved in negotiating the preservation of the self in old age. This contributes to our understanding of the various ways in which conceptions of the self are negotiated as people age. Indeed, they are of great interest.

DATA COLLECTION

In order to assess the severity of OA, the participants were asked to complete the Health Assessment Questionnaire. This questionnaire was developed by James Fries of Stanford University (Ramey, Raynauld, and Fries 1992). The questionnaire assessed the extent of the respondent's limitations in performing tasks necessary for daily living. (see Appendix 2 for the questionnaire). Of the twenty-four women who completed the interviews, one did not complete the Health Assessment Questionnaire. This participant reported that she preferred to complete the form and mail it to the researcher at a later time. Unfortunately, her form never arrived.

In-depth interviews were conducted in the homes of the participants. Interviews ranged in length from one to three hours. All of the interviews were tape-recorded with the permission of the interviewee. It was not uncommon for respondents to cancel the interviews on the day of the scheduled meeting on account of pain. Interestingly, both the weather conditions and the unpredictable nature of the illness meant that respondents were never sure whether they would be able to participate in the interviews. The duration of the interviews also varied, since some women provided more detailed accounts of their experiences than others.

The interview questions were explicitly constructed in order to address all the issues raised in the review of the literature. They were designed to explore the ways in which OA affected the woman's ability to manage her day to day affairs, and whether valued activities, interests, hobbies, social interactions, and family relationships had been influenced. Hence, the ways in which the respondent's various identities were affected by the disease were addressed in order to uncover patterns of continuity and change. The importance of these identities to the individual was also established by the questions. Hence, discrete components of the self-concept as well as the centrality and the position of these identities within the organization of the person's self-concept were assessed. Several questions dealt with the processes or strategies that were used by the women to adjust to the limitations caused by OA. Patterns of continuity and change were assessed in relation to the ways in which perceptions of continuity were either preserved or disrupted. The processes that were involved in shaping the person's perception of her chronic condition were also addressed. As such, patterns of continuity and change were examined. Finally, the ways in which OA influenced the person's experience of aging and also her perception of time were also addressed. (See Appendix 1 for a list of the guiding questions, **as well as an explanation of the significance and relevance of each question**).

Although these questions served to structure the interview (the interviewer made sure all of the questions had been presented), there was also a great deal of room for flexibility. When a woman made comments that appeared to be significant, or if she made references to issues that might prove to be interesting, these issues were explored.

DATA MANAGEMENT AND ANALYSIS

All the interviews were transcribed, word for word, using a word-processor. However, a qualitative, computer software package (such as Nudist) was not utilized for the coding and the analysis the data. The names of all of the respondents were changed in order to preserve confidentiality. (The names used in this paper are all pseudonyms).[1]

The grounded theory method was utilized in the gathering, transcribing, coding, and analysis of the data. This method complements the symbolic interactionist approach to the conception of the self, where the self is viewed as an active object of change and a process of "becoming". An important element of grounded theory "is to build change, through process, into the method" (Corbin and Strauss 1990, 5). The grounded theory approach enables the researcher to understand the various ways in which actors interact with changing conditions and the implications of such actions. It is the responsibility of the researcher to capture this dialogue. A brief overview of the grounded theory approach and its relevance for examining conceptions of self and chronic illness shows this.

Grounded theory may be defined as the:

> *detailed* grounding by systematically and intensively analyzing data, often sentence by sentence, or phrase by phrase of the field note, interview, or other document; by constant comparison, data are extensively collected and coded...producing a well constructed theory. The focus is *not* merely on collecting or ordering a mass of data, but on *organizing many ideas* which have emerged from analysis of the data (Strauss 1987, 22-23).

Rather than verifying hypotheses, grounded theory encourages the generation of ideas.

Following in the tradition of grounded theory, data collection and systematic analyses were conducted collaboratively and simultaneously, thus ensuring that key topics and

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A list of the respondents' true names, in addition to their code names were recorded on a list. This list was stored in a filing cabinet in the researcher's home. The tape recorded interviews, the transcribed interviews, as well the completed Health Assessment Questionnaires were also locked in this filing cabinet, in order to maintain confidentiality.

themes were captured. Corbin and Strauss contend that this process guides the researcher towards the relevant issues and serves to re-direct the interview as new themes are discovered (Corbin and Strauss 1990, 6-7). That grounded theory "builds" change, through process, into the method is illustrated by the interactive relationship between the researcher and the data whereby categories are created. "The discovery process consists of the researcher creating discoveries about the data and constructing the analysis" (Charmaz 1990, 1165).

In the tradition of grounded theory, concepts became the "building blocks" during the analysis of the data. Those who work in this field contend that theories are not merely extracted from the raw data. Rather, incidents and events are viewed as "potential indicators" of phenomena. Conceptual labels are created in order to identify these indicators. (Corbin and Strauss 1990, 7). This principle was drawn upon during the stages of analysis.

Next, categories were constructed from these concepts. According to Corbin and Strauss, categories refer to the groupings of those concepts. Categories are in fact, the foundations for generating theory, for they are the mediums through which theory may be synthesized (Corbin and Strauss 1990, 7).

Proponents of grounded theory method also contend that *patterns and variations must be accounted for* in the structuring, the ordering, and the integration of the data (Corbin and Strauss 1990, 10). In addition, grounded theory requires that *analysis makes use of constant comparisons* when conceptual labels are created. Comparisons must be made when catagories are constructed in order to ensure precision and consistency (Corbin and Strauss 1990, 9).

Next, proponents of grounded theory approach contend that *hypotheses about relationships among categories should be developed and verified as much as possible* *during the research process.* Hypotheses must be continually checked and revised throughout the various phases of the research "until they hold true for all of the evidence concerning the phenomena under study"(Corbin and Strauss 1990, 11).

Finally, *theoretical memo-writing* was adopted as part of the methodology to facilitate the analysis of the data. Theoretical memos have been described as:

> writing in which the researcher puts down theoretical questions, hypotheses, summary of codes, etc.- a method of keeping track of coding results and stimulating further coding, and also a major means for integrating the theory (Strauss 1987, 22).

In order to put these principles into practice, the data were "coded". Coding was the principal means by which the data were analyzed. According to grounded theorists, codes are used to represent developing ideas, not mere description. Furthermore, codes are utilized to build analytic questions, and to construct analyses of the data (Charmaz 1990, 1167). Three types of coding procedures were utilized. These were open coding, axial coding, and selective coding.

Open coding is "the interpretive process by which data are broken down analytically. Its purpose is to give the analyst new insights by breaking through standard ways of thinking about or interpreting phenomena reflected in the data" (Corbin and Strauss 1990, 12). Through processes of open coding, incidents, actions and interactions were assessed. Conceptual labels were applied to them. Such concepts were clustered together and categories were created. In addition to identifying the properties and characteristics of categories, open coding serves to facilitate the development of analytical questions. It also allows the researcher to make use of 'constant comparisons' (Corbin and Strauss 1990, 12-13).

In axial coding, "categories are related to their sub-categories, and the relationships tested against data" (Corbin and Strauss 1990, 13). This allowed the categories to be further developed.

Finally, selective coding refers to the process by which all the categories are integrated in relation to a "core" category. The categories are analyzed with reference to the central issues of the investigation. This procedure facilitates the commitment to a focus of analysis, it encourages conceptual density, and it aids in the integration of the various concepts and categories that are generated in the course of the research processes (Corbin and Strauss 1990, 14). These core categories were used when organizing the findings. In essence, they provided structure to this study.

Taken together, these coding procedures were utilized to analyze the data. The coding procedures, in combination with the principles espoused by grounded theorists were used for this particular study in the following ways. First, the collection, and the analysis of the data occurred simultaneously. The coding of the data occurred during the interview phase of the research. In the early stages of the research, open coding was utilized. Events and interactions were labeled according to an identifying concept. For instance, the ways in which a person's ability to engage in valued activities had changed were noted. Or, the ways in which certain interactions had been shaped by the chronic illness were coded. Hence, physical limitations, the challenges of meeting day to day needs, disrupted activities, significant interactions, the ways in which the individual dealt with these issues, and the individual's perception of these events, were all given labels. These labels were listed on a separate sheet of paper. The labels were then grouped together into categories if they had similar features or patterns or if they pointed to similar themes. These categories were named. For example, the loss of an activity and its replacement with an alternative one was, at first, coded as "impeded activities and performances".

Next, axial coding was utilized, and the categories were then compared. For example, those categories which appeared to overlap were combined. Often, categories were further refined as the research continued. These refined categories were divided into sub-categories for the purposes of achieving organizational and analytical clarity. Hence, the category of "impeded activities" was further refined, and was subsequently called the "shuffling task/activity model".

Other examples include the analysis of social identities. For example, in the early stages of open coding, the data were grouped in terms of general topic headings. For example, when a woman spoke about the ways in which her mother identity had been influenced by OA, the sections were simply coded as "mother identity". Gradually, in the course of inverviewing, variations in these mother experiences were noted. Hence, the categories were further refined in terms of role requirements, role performances, and role interactions.

In the last stages of the research, all the categories and their related sub-categories were assessed. At this point, these categories had been listed on separate sheets of paper. The page numbers, and the specific interview from which these categories had been derived were also noted. These categories were then grouped together in broader categories so that they reflected the topics that were central to the study. This helped to organize the presentation of the findings. Hence, the ways in which various social identities were influenced by OA formed one core category. Subsequently, this was organized as one chapter of the study. Various categories had also been constructed with regard to hierarchies of identity. These categories reflected the principle of psychological centrality. They were also grouped together to form another chapter. The categories that related to impaired body performances and to the processes of adjusting to physical disabilities formed another chapter.

The coding procedures greatly facilitated the analysis. Data collection and analysis occurred simultaneously and concepts served as the basic building blocks for the ideas that were generated by the data. Categories were then constructed from these concepts, and the categories were later compared to form sub-categories. In making comparisons between the categories, the relationships between the categories were analyzed. For example, several age identities were constructed after the distinguishing features of each category had been compared. Other relationships, which had been hypothesized throughout the phases of the research were also collapsed, if further evidence failed to provide support.

There is another issues that must be considered. Charmaz (1990) has noted that the theoretical background of the researcher is extremely important and shapes the analysis of the data. This often serves to guide the direction of the research. The researcher may also draw upon his or her theoretical background in order to expand the analytical scope of the developing grounded theory (Charmaz 1990, 1169). Hence, the symbolic interactionist conception of self as object and process, the nature of action as performance, and the relevance of temporal order and time, guided the types of questions that were asked and also the way in which the data were coded. It is important to note that this broader theoretical framework shaped the development of the codes. Of course, the major focus of the research questions continued to be grounded in the theory. Throughout the coding phases, the researcher asked the following kinds of questions: How did this action influence the actor's conception of self? How did this interaction, (and the subsequent reflected appraisal, or social comparison) shape the actor's perception of her disabled body? How did a particular strategy maintain self-consistency? Hence, it was possible to uncover new concepts, categories, and themes within the symbolic interactionist framework in relation to chronic illness, and self-concept in later life.

Taken together, these were the principles and the procedures that were utilized in the gathering, the coding, and the analysis of the data. The findings are presented in the chapters that follow.

CHAPTER 3

CHRONIC ILLNESS AND THE NEGOTIATION OF CONTINUITY AND CHANGE: AN EXAMINATION OF DISCRETE IDENTITY COMPONENTS

INTRODUCTION

The review of the literature reveals that the onset of a chronic illness has the potential to alter the person's self-concept. But more important for the purposes of this chapter, it was also noted that much of the research presents abstract or general definitions of self-concept. As a result, it is often difficult to identify which component of the self-concept is being examined in relation to issues of continuity and change. This chapter will contribute to our understanding of chronic illness in later life by examining the ways in which specific identities are shaped by OA. Several questions will be addressed. How are identities influenced? How do individuals experience changes in their valued identities? When are perceptions of continuity preserved? Drawing upon Rosenberg's definition of the self-concept, this chapter will explore the ways in which the extant self, that is, the content of the self-concept is shaped by OA.[1] Hence, elements of social

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[1] The self-concept also consists of a number of dispositions. Dispositions include attitudes, abilities, values, traits, and likes or preferences. Because of the limited time available for this study, dispositions were not included in the analysis. However, the findings of this study do highlight the importance of considering the individual's reactions and interpretation of her illness experience, the perceived strain of chronic illness and the varying levels of awareness of the impact of OA for the self. Dispositions also shape the way in which the individual defines her situation. Moreover, emotions, traits and coping styles are often objectified, that is, the person may in turn define herself in terms of the emotions experienced. Thus, a person who feels angry may in turn describe herself as an angry person. A person who feels hopeful and positive labels oneself an optimist (Rosenberg 1979). The individuals who participated in this study expressed feelings of frustration, bitterness, fear, loneliness, resignation, determination, acceptance, depression, anxiety, fear, vulnerability, hope, and decreased levels of confidence with regard to physical competence and agility. Moreover, our findings reveal that there is continuity in people's patterns of coping. The OA may serve to affirm and strengthen patterns of coping developed in the past. These findings point to future areas of research and suggest topics that require further research.

identity will be highlighted. Social identities include social statuses (for example, sex, age, family status, and occupation), and membership groups (religious groups, fellowship groups, or interest groups). The physical component of self, that is, body image will be discussed in Chapter 5.

In order to examine the ways in which OA influences the self-concept, it is necessary to have a working definition of "process". A rather simple definition from the Oxford dictionary was employed. Process was defined as a series of actions, interactions, events, or operations that are used in achieving something. Hence, the researcher attempted to identify a series of action, interactions, or events that were utilized by the individual to achieve the preservation of the self, or alternatively, that led to changes in the self.

It is also necessary to establish a conception of continuity and change for this study. In analyzing the data, two general patterns of continuity and change emerged. In the first pattern, it became evident that the relational association between continuity and change was that of polarity, and opposite states of being. Hence, continuity will be defined as the state of exhibiting no change, of remaining the same and unchanging. Continuity is defined as the absence of change. Other synonyms include consistency, and preservation. In contrast, change will be defined as passing from one form or phase into another, or to make or become different. This will be referred to as the stability versus change pattern. This pattern is important for a couple reasons. First, it provides an alternative conception of continuity and change. In contrast to continuity theory, which depicts change as a vehicle through which continuity is maintained (Atchley 1989), the stability versus change pattern highlights those kinds of changes that present definite interruptions in a person's perceptions and experiences of stability and consistency. Indeed, changes are not always incorporated in ways that preserve perceptions of continuity. Next, this conception of continuity provides a means of conceptualizing those cases in which an agent of change, in this case, OA, exerts little or no influence on the person's sense of continuity.

A second type of continuity and change became evident in the data as well. In this pattern, it became evident that continuity and change are integral to each other and interdependent in their relational association. Change is not separate from continuity. In this pattern, continuity will be defined as a perception that changes are incorporated and fit one's personal biography. Individuals face changes in ways that are consistent with their past to preserve their perceptions of continuity. This pattern will also acknowledge that change involves the state of becoming different. However, this conception of change differs from the one introduced above, because change "feeds" into continuity, or preserves continuity. Hence, change is negotiated in order to maintain perceptions of continuity. This reflects, in part, some of the basic tenets of continuity theory, that is, the negotiation of change in the present, in ways that are consistent with patterns developed in the past (Atchley 1989). This conception also incorporates processes of accommodation in its conception of continuity and change. It elucidates the ways in which individuals also engage in new, adaptive strategies, in their attempts to negotiate changes in ways that preserve their identities. Taken together, this will be called the continuity pattern.

The data reveal both types of continuity and change and it is possible to conceive of three general possibilities when examining the ways in which the self-concept is influenced by OA. First, identities are challenged, enhanced, or they become inactive. This reflects change. Second, identities are not influenced by OA in any way and the self remains intact. This reflects continuity. Third, identities are influenced by OA. However, the person manages to negotiate the reconstitution of a modified sense of self. Change is incorporated to preserve continuity.

The first two possibilities reflect the stability versus change pattern while the last one reflects the continuity pattern. Taken together, these three possibilities suggest five indicators of continuity and change. First, certain components of identity are challenged, second, certain components of identity are enhanced, third, certain components of identity are inactive or lost (lost, if the individual misses the identity), fourth, certain components of identity are not influenced by OA, and finally, certain components of identity are modified.

These patterns were identified in the data in terms of *role performances*, *role requirements*, and *role interactions*. Role performances, role requirements, and role interactions were examined because they reflect the fundamental principles assumed by interactionist conceptions of the self. For example, McCall and Simmons (1966) present the idea that role identities consist of role performances. Such performances refer to the actions and behaviours that a specific actor engages in, as he/she occupies that role. Role requirements refer to the set of expectations associated with the performances of that role. Finally, role interactions will be examined because symbolic interactionists have established that identities are inherently relational, and become known and meaningful as people engage in interaction with others.

When a respondent remarked that her ability to engage in her role identities was becoming limited and more difficult because of her OA, and that she was making greater efforts to retain many of her role requirements (that is the duties, expectations, or obligations associated with the role), the identity was said to be **challenged**. When a respondent stated that she was pleased with the changes in her performances, or with changes in her role requirements and interactions with others, the identity in question was said to be **enhanced.** When a woman stated that she was no longer able to enact certain role performances and that she had relinquished her role requirements, the identity in question was said to be **inactive**. If a respondent stated that the performance of her role identity was not limited or affected in any way by OA or that her role requirements or interactions were not significantly altered by OA, the identity was said to be **free from the influence** of chronic illness. Finally, when a woman stated that she had adjusted her role requirements, performances, and interactions in order to preserve the identity, the identity was said to be **modified**. For example, a woman may have stated that she had changed the way she performed her activities in order to allow herself to continue engaging in this role. Hence, the woman may have allotted more time to complete the task, or she may have drawn upon the assistance of others. She may have also adjusted her expectations of herself in that particular role. Moreover, the woman may have modified her interactions with others. She may have noted the way in which significant others supported her changed abilities or whether others adjusted their expectations of her as well. These indicators were utilized to determine the ways in which identities were influenced by OA. Having established these basic principles, the next section will demonstrate, in greater detail the ways in which identities were shaped by OA.

IDENTITIES AS MEANINGS: THE SIGNIFICANCE OF CHRONIC ILLNESS FOR IDENTITIES IN INTERACTIONS

The findings reveal that several components of social identity were influenced as people lived with OA. These include: kinship identities, (the mother identity and the grandmother identity); marital status identities (the wife or widow identity); unpaid labour and domestic identities (the homemaker identity and caregiver identity); paid labour identities (the retired identity and employed identity); and finally, identities located in other relational associations, (for example, friendship identities). Interestingly, life stage factors, or the age component of self influenced identity roles in terms of what

McCall and Simmons call "social roles" and "interactive roles" (1966)[2]. More specifically, the normative duties, rights, and obligations associated with a social identity, in addition to idiosyncratic role interactions, were shaped by age factors.

Following the symbolic interactionist tradition, this chapter shows that the meanings individuals attach to their identities are shaped through interactions with significant others. It will be shown that "identities are relational" (Burke 1980, 18). That is, components of identity are influenced by their relational association with the identities of significant others. It is evident that the gender component of self is embedded within several of the identity components, especially in relation to kinship identities. The ways in which components of the self are shaped by chronic illness will be addressed next.

1. Kinship Identities

1.1 Mother Identity:

The impact of chronic illness on family relationships in later life has been well researched by other authors. In particular, the influence of chronic illness on the relational dynamics between impaired elderly parents and their adult children has been the focus of much of the research. Issues related to dependency, "role reversal", shifts in the balance of reciprocal exchanges, and power/conflict struggles between older parents and their adult children have been investigated elsewhere (Dwyer 1995; Suitor et al., 1995; Brody 1990; Brubaker, Gorman, and Hiestand 1990; Cicirelli 1990; Fischer 1985). However, much of this research documents the perspectives of the adult children and

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[2] McCall and Simmons distinguish social roles from interactive roles. A social role is defined as, "a set of expectations held toward the occupant of a particular social status or position in a social system" (1966, 6). Hence, any individual who occupies a certain position is identified with the set of duties and expectations characteristic of the role. In contrast, an interactive role is "a plausible line of action characteristic and expressive of the particular personality that happens to occupy the given position and represents that person's mode of coming to grips with the general expectations held toward someone in his position" (McCall and Simmons 1966, 67).

their experiences of caregiving. Far less has been documented with respect to the perspectives of the older parents.

Matthews (1979) provides an account of the experiences of being an older mother in the "unextended extended family" from the perspectives of the women themselves. Although the author does not focus on issues related to chronic illness, the issues that are addressed do apply. In particular, she describes the precarious position of the older mother as she attempts to balance or negotiate her dwindling share of power within the family. Matthews examines these relational dynamics in the context of the exchange theory perspective. The author describes the experiences of older mothers as their personal resources and ability to reciprocate services and emotional support become challenged.

While these studies provide valuable information, there is much room for further research. This section will both extend and contribute to this literature in several ways. First, this section will uncover the experiences of older mothers and the ways in which this identity is influenced by OA. As mentioned earlier, there is a need for research which documents the views of the older mothers themselves. Next, this section will describe the strategies that are employed by older mothers as they attempt to negotiate the changes that are introduced by OA. It will also become evident that issues related to dependency, reciprocity, and changes in the balance of power between parent and adult children are significant in the lives of the respondents who participated in this study. Most important, the data from this study will contribute to the literature by demonstrating the variety of experiences of motherhood in later life, and the numerous ways in which this identity is modified, negotiated, and preserved in experiences of chronic illness.

In order to present these findings, a variety of mother identity 'types' were identified. These include the independent mother identity, the damaged mother identity, the late-life mother identity, the active mother identity, and the empowered mother identity. ***Due to the small size of the sample, these mother "types" have not been identified in order to promote the classification of normative, mother social roles. Rather, they will be presented in order to illustrate the variety of experiences that individuals undergo when they negotiate and re-negotiate their identities in the context of OA.***

In examining the various experiences of the mother identity in later life, other points will be presented. It will become evident that while the mother identity often has to be adjusted or re-negotiated with the development of OA, this identity component provides sources of both continuity and change. It will be shown that such experiences of continuity and change are mediated as the mother identity is negotiated and re-negotiated in terms of role requirements, role interactions, and role performances. These issues will be elaborated upon in the following discussion of late-life mother experiences.

a) The Independent Mother Identity: A woman is often presented with many challenges when she is faced with living with OA. The disabilities often associated with OA have the potential to threaten one's ability to manage daily life independently. In some cases, the individual requires the assistance of others. This may often involve close family members, such as adult offspring. Many of the women report feeling concerned about being a burden on their children. For some women, the threat of dependence is an issue that must be dealt with on a daily basis. The independent mother identity illustrates that individuals negotiate their conceptions of independence in order to preserve this valued attribute. Most of the individuals recognize that their children have their own busy lives, their own families, and their own jobs. And these older mothers do not wish to be a burden to their children. Hence, a variety of alternative services are often drawn upon. These include paid homemakers, community services, friends, neighbours, and government subsidized seniors' transportation services, such as DARTS. It appears then, that most individuals are able to draw upon a combination of support services to meet their needs. Some mothers do not have children living near by, or they have become estranged from them. In these instances, the independent mother identity is not an option. However, for many of the women who were interviewed, offspring are involved in various degrees. Children run errands and do the shopping. They also provide transportation to enable their mothers to travel to doctors' offices, and to take part in social activities. In some instances, children may be involved in assisting in financial matters, household chores, and personal hygiene. They may provide some social stimulation for their mothers. They may be involved in assisting their mother to live in independent living arrangements. And in some cases, residences may be shared. Finally, it is important to note that children may be involved only temporarily (for example, in the recovery stages after an operation or during an acute flare-up) or they may be involved on more of a consistent basis.

These findings are neither surprising or new. However, the threat of dependency is very significant for this mother identity. For some individuals, the negotiation of an independent mother identity is a new, interactive task. Prior to the onset of OA, these individuals may never have had to negotiate issues relating to dependence or independence with their children. The desire to negotiate an independent mother identity may even influence treatment decisions. For example, one woman who was interviewed rejected the option of having her knee surgically replaced and chose to live with the pain instead of having to depend on her children during the post-operative recuperation period:

> I don't want to be an invalid and I don't think the knee caps are going to help. I rub something on and get away with it. But I don't want to go through the operation. I know they won't take you much longer in the hospital and to come home to this is just too much. Like my daughter says, "It's up to you, Ma." Like she'd take me in, but I don't want to go to their place and upset

> their household because she works part-time. Much as they're good to me, they love me, and they'd take care of me. But I don't want to interfere in their household routine or anything (Audrey, age 83).

In contrast, another woman was more concerned about remaining mobile and independent in the long term. This woman chose to have the surgery performed and accepted the possibility that she would be temporarily dependent on her children during the recuperation period:

> I'm pushing eighty and I live alone and I don't know. I live alone and I don't think I'll be able to cope maybe alone after the surgery. I don't want to get the surgery and move and bother everybody. But if I live so long, I need two knees done. So, if it will help me remain independent as long as I can later on, that's why I'm deciding to do it (Marion, age 79).

Interestingly, both women were motivated by the same issue but they chose different treatment options. This example illustrates only one of the ways in which OA and the independent mother identity interact with one another. A variety of factors are involved, and it is possible to highlight some of them.

The research reveals that the negotiation of an independent mother identity involves several factors. These include adjusted role requirements and performances, and negotiated role interactions In the case of *adjusted role requirements*, the individual relinquishes certain tasks and responsibilities. Some of these tasks are transferred to children or they are apportioned to other members of the individual's support network. In other cases, role requirements are shared and the delegation of duties are adjusted. However, these adjusted tasks are negotiated in such a way so as to affirm the independent mother identity. For example, Maeve lives with her son and she relies on him to perform some of the household chores and to help her dress in the morning. Maeve acknowledges that she is dependent on her son.

> Sometimes I think, if I didn't have him here, I don't know whether I'd be able to stay in the house because of the things that have to be done around the house...It was the new roof on the back of the house this summer. He did the

> garage and took the siding off one and put a new one up. He took all my bushes out and put new ones in. He's very helpful. I might say to him, "If I get the wash done, will you help me make the bed?" Things like that and the vacuuming (Maeve, age 78).

However, in adjusting to these changed role requirements, Maeve prefers not to view herself to be dependent on her son. In accepting his assistance, she takes it upon herself to cook his meals and do his laundry. In this way, she defines their relationship as one that is characterized by inter-dependence. She regards their co-dependence as a form of "team work":

> We work together as a team. I do for him. Like he'll say, "Mom, you don't have to do my wash. I can do it." But that's one thing I can still do...It's co-dependency in this case. He's depending on me, and I'm depending on him (Maeve, age 78).

Role performances are also adjusted. Maria also lives with her son. The presence of her son enables her to remain in her own home. Maria is extremely dependent on her son both for transportation and for help with the management of her home. However, Maria feels that the significance of tasks lies in planning and delegating them, rather than in the actual performance of the tasks. Hence, even if Maria does not perform the tasks herself, her role in delegating and planning the task gives her a sense of personal accomplishment and mastery over her situation:

> I still take care of all my money, my housekeeping. All that. See, it's my home. My son lives with me. I don't live with him. My mind's always full of ideas to do this. Always ideas about what I'm going to do next. There's lots of things I have to do to the house. I'm always changing the house and things like that...I'm always thinking about what to do, or something to make somebody else do. I heard someone say, "There you go. What are you thinking now? Thinking about something else to get us to do?" (Maria, age 83).

In other cases, the women view themselves as being extremely independent and their view of themselves is affirmed by their children. These women report that their children desire to do more for them in managing their OA. However, the women take pride in being able to manage independently. Understandably, most of them appreciate the concerns of their children:

> I think my family has a lot to do with me coping with the arthritis. Family is most important. I don't ever feel sorry for myself. And I think that's where my children come in, because they're so caring. Each and every one of them. They either come down and visit, or they phone. Not only say they'll come and it's, "I'll do your groceries for you." They'll come. Once in a great while they'll do my big cleaning. I said I'd have someone come in and do it. But they want to do it. They say, "We're able to do it." And that helps me, makes me feel good that they care (Marion, age 79).

Children's concern and their willingness to help are important in affirming the woman's mother identity and her sense that she is appreciated by her children. In several instances, the respondents took comfort in the fact that they are free to live with their children if they so choose. One woman said:

> When I got back from my holidays, that's when my knees started acting up. That's when I started looking for another apartment. My son-in-law was indignant that I wouldn't move in with them. But my daughter said, "I know my mother. She wouldn't come and live with anyone if she didn't have to." And she's right. But it's nice to know they'd like to have me (Mavis, age 80).

Interestingly, the women's desire to not interfere in the lives of their children and to remain independent shapes their choices and they reject this option.

The development of the independent mother identity also involves *negotiated role interactions*. This often includes the negotiation of the presenting self. Accordingly, processes of concealing, and impression management are often involved. (This will be elaborated upon in more detail in a later chapter). In an effort to keep their worries from their children, some women tend to minimize the discomfort and pain of the OA. Moreover, these mothers do not always reveal the difficulties they may have experienced.

> My grand-daughter called me. And usually I say I'm okay. And I have become that I say I'm okay when I'm not. And that to me is lying. So I've become a good liar! But if it'll not create trouble, I'll keep on doing it.

> Anyway, my grand-daughter called and uh I thought, well it's time she realizes. And she's asking me how I was. Well, I was having a bad day with the arthritis and the pain. I was in a lot of pain and I said, "I'm feeling miserable". Well, we talked for a while. And usually she'd never get that from me. Usually I'd say "I'm fine" and then it's, "Oh fine, that's good". I mean, they're living an active life. It's hard for a person to understand when you're not. Before I knew it my son was in here. She called her dad and told him what I had said, and he came to check to see if I was all right. He will do that, this one son. I learned that lesson, to keep quiet and not say exactly how I feel, because there's nothing they can do. That taught me to be careful how you say it. But now they've got wise to me, when I say I'm fine when I'm not. I just don't want to worry them. I don't want to feel they have to come down here, because they can't do a thing if they come. It's my battle, and I have to fight it (Betty, age 80).

> I'm very independent. My son will say, "Why don't you ask me to do that mother? You know that's why I'm here for. Why are you trying to do that? You know you're not supposed to be doing that!" So I always do things in secret. So half the time, they don't know what I do (Maria, age 83).

In general, the women are open in sharing their *overall* experiences of OA with their children. But the expression of these experiences may be tempered, (and detailed, full-blown expressions of their painful experiences tend to be avoided). In one sense, independent mothers want to be appreciated and affirmed, and they do appreciate receiving some consideration and understanding from their children. However, these mothers do not want to be pampered, or treated as invalids or cripples.

In other cases, the negotiation of the independent mother identity involves striking a balance in "preferred dependence". Help is accepted from children when it is viewed as an expression of their consideration, or if children insist on offering these services. This may also involve strategically receiving and declining offered assistance. For example, rather than allowing her children to shop for her every week, Marian allows her children to shop for her only once a month for her "big shopping". Marian's children also offer to help her with yearly spring cleaning. This year, Marian hired someone to wash her apartment windows. Knowing that her children would be upset because she had not asked for their help, Marian said that she cleaned the windows herself. In deflecting their concerns, she said that she cleaned the windows slowly at her own pace, and that it was not a problem for her:

> I have children and grandchildren that would help me whenever they can with the housecleaning. If I hire someone to do it, my children won't even talk to me. Lots of times I get the windows and floors done, but they don't know about that. I say, "You don't need to do that because I've done it already." "I thought you couldn't do it?" "Well, it took me a few days, but I did it." (Marion, age 79).

In other cases, the women try to remain as independent as possible. However, some tasks are impossible for them to perform and the children's assistance is necessary. The independent mother identity is threatened and interactions between parent and children must be re-negotiated. Sometimes these interactions preserve the independent mother identity, especially when children assure their mothers that the task is not too much of a burden for them.

This section illustrates that the negotiation of the independent mother identity usually involves adjustments in role requirements, performances, and interactions. While the negotiation of the independent mother identity signifies a change in the mother identity, these individuals consider that they have always been rather independent in the past. Hence, processes of adjustment and modified interactions are drawn upon in order to preserve the mother's desire for personal independence. In this way, change has been incorporated in such a manner as to preserve continuity. (This reflects the second type of continuity that was identified earlier on, in contrast to the stability versus change pattern). In essence, the independent mother identity is valued by these women precisely because it preserves their relationships with their children. Many fear that burdening children with their worries and concerns might result in estrangement.

b) The Damaged, Unaffirmed Mother Identity: Other women respond differently. Some mothers believe that it is their children's duty and responsibility to care for them in old age. These women use their experiences of chronic illness as opportunities to receive the love and respect to which they believe they are entitled. When children do not attend to their mothers' needs, the women feel neglected. In short, the mother identity is unaffirmed. One woman clearly imposed her expectations upon her daughters. In this instance, these adjusted role requirements and the negotiation of altered mother-daughter interactions created much tension. As the following excerpt shows, the disabled mother identity was unsuccessfully negotiated between parent and her children:

> I feel like nobody cares. My daughters don't come to see whether I've got a loaf of bread, a quart of milk, nothing. I figure they don't care. They don't even ask me how I'm making out with my groceries or nothing. They should say, "Mum do you need any help?" They don't even ask. I always said to both of my girls, "You'll never miss me once I'm gone". And it's "Oh yes we will". And I said, "How in the heck can you miss me when you don't even phone?" I haven't heard from the one daughter you could say for a whole month practically. Sometimes I sit and think what's wrong with my two girls? Then I'll sit and cry. Why are they pushing me to one side? It's a very depressing feeling that you have. You think everybody don't care no more and your family's the most important to you right now, than your friends. I just want to see my family, but they got no time for me (Bernice, age 72).

The damaged-unaffirmed mother identity often leads to major changes in the developing self-concept. In Bernice's case, the OA had progressed rapidly over the past year, and her interactions with her daughters had soured considerably over this time. She described how she had enjoyed going shopping and making short day trips with her daughters the year before. Unfortunately, her stressful experiences of OA had sown the seeds of conflict between her and her daughters. Bernice hoped that her daughters would show more support. Their failure to meet Bernice's expectations meant that adjustments were not made in such a way so that changes would be negotiated to preserve and affirm her mother identity. As a result, Bernice's experiences of living with OA brought about much unwanted change. (This reflects the stability versus change pattern).

It is important to note that the negotiation of role identities is not a static process. Individuals employ different strategies, and are in engaged in a variety of processes. Bernice hoped that by regaining some of her previous capabilities, she would be able to repair her damaged mother identity:

> I miss shopping a lot, because I always used to meet my daughter once a week at the mall. I think they stay away now, because they don't like to see me like this. Because I've always been going, going, and going. So, right now, I think about going over to the mall. That's my goal, because once they (her daughters) all found out that I could go to the mall by myself or get out by myself, that's fine. But as long as I'm here, and they think I need help, they don't come around (Bernice, age 72).

These individuals recognize that living with a chronic illness has had negative effects on their relationships. They may or may not make efforts to re-negotiate the mother identity. For example, the unaffirmed mother may alter her strategies for dealing with this damaged component of self by striving to achieve the independent mother identity. Or she may accept and come to terms with her estrangement from her children. Accordingly, role requirements and expectations will be implicated in such processes. Interestingly, this mother "type" illustrates that there is no set, or normative social role for the older mother identity. People's roles and interactions are highly idiosyncratic and must be negotiated and re-negotiated continually.

c) The Peripheral Later Life Mother Identity: For some individuals, motherhood in the later stages of the life cycle does present unique factors that must be considered when discussing experiences of living with chronic illness. According to some individuals, being released from duties and obligations (changed role requirements) greatly facilitates adjustment to OA. Many respondents remarked that it would have been extremely difficult for them to deal with OA earlier in life. These individuals are grateful that their role performances as mothers in the middle years were not impeded by health problems such as OA. For these individuals, the later life mother identity is experienced as a natural progression. This perception of continuity facilitates their adjustment to the progression of OA. Social scripts and norms for the later life mother identity are also influential in shaping processes of adjustment. Many older women have long ago recognized and accepted that their grown children have their own separate lives to lead. Accepting this is often closely related to adopting the independent mother identity (and not wanting to burden one's adult children).

Interestingly, in some cases, OA, often in combination with other stressful life events, such as widowhood and the loss of friendships, will contribute to the development of the ***peripheral later life mother identity.*** Smaller social networks, impaired mobility, threatened activities, and confinement to the house may sensitize some individuals to the contrast between the present and the past, middle-aged mother identity. In this way, the individual becomes aware of her changed relationships with her children. She is acutely aware that her interactions with them are not as prominent or as central in the children's lives. The peripheral later life mother is not a central actor in the nuclear, private families of grown children. Some of these women may experience periods of loneliness, when the company of their grown children become ever more important to them:

> I can't say I'm happy about being a mother at this stage in life. I feel like I'm not a part of their lives as much as I would like to be. I know it's the way it's supposed to be, but I can't say I like it. And with me being like this with my knees, not being able to get out more, I guess I do think about it (Gladys, age 72).

In some cases, social interactions are severely limited due to OA, and the individual is unable to participate in meaningful activities with peers. As a result, family members become even more important in the support network. Unfortunately, family members are unable to substitute for the type of interactions that are characteristic of friendship interactions. As a result, these women become aware of the peripheral later life mother identity. For example, Violet became confined to her home because of her arthritic knees. Many of her social activities were restricted and she now spent most of her days at her son's home in order to ensure someone was there when her grandchild came home from school. Consequently, she now spends most of her time alone in her son's home. While she appreciates the company of her son and his family, the loss of her own independent social life has highlighted the loneliness of her later life mother identity:

> I'm not able to get around the same, and it certainly has made a lot of unhappiness for me. For all I'm here with my son and his wife and their little girl, and I enjoy their company but I'm all the time alone. I'm alone here until they get home from work, and then when they do come home they eat. And then they go downstairs together, and they watch TV. They talk about their day and Christine goes down with them, and she's busy talking about her day at school. And that's the way it should be, a family. Only sometimes it gets kind of lonesome, because I don't like to go down there and interfere with them. I could go down there every night, and sit there. But sometimes you think they need their privacy too. So I just like to sit up here sometimes, and read the paper (Violet, age 77).

The peripheral later life mother identity must also be negotiated in interactions with children, especially when these same individuals are making efforts to not become a burden. While these mothers would like more interactions with their children, their desire to not become a burden on their children causes them to contain this peripheral mother identity. These individuals must adjust to these changes. For example, such mothers will often adjust their expectations with respect to the quantity and quality of interaction they share with their children. Part of this process involves preparing oneself for disappointments when planned interactions are canceled:

> My son is planning on visiting me Sunday. Now, I have resigned myself should it be bad weather, should his wife need him, I can come up over that. That wouldn't wreck my whole day. Like I accept things the way they are and try not to get too disappointed that it doesn't happen. Because lots of times it doesn't, and I'm glad I've learned that more and more. I taught myself

> that more and more. To be resigned if something doesn't work out and I think you're better for it (Grace, age 75).

The peripheral later life mother identity also involves the negotiation of the *maintenance* of parent-child interactions. For some severely disabled, homebound older mothers, phone calls or letters from children are high points. Women who do not wish to impose on their children will limit the phone calls they themselves initiate, or they will "bide their time". They do so in an effort to not interfere with their children's lives. Rather, they prefer children to take the initiative:

> Yesterday I was really lonely for my kids. The phone rang and it was my daughter from New York. I really wanted to talk to her but I didn't want to phone. They had phoned me and I had seen them at Christmas and I thought, just let it go another few days, another week and then maybe you'll hear from them or you can phone. Well anyway, the daughter phoned from New York and it made me feel good. I was lonely for my kids but dear Lord, I will accept that. Like every mother has to wait until their children are ready to phone them and I'll just bide my time. Everybody has their lonely time and this is just my little lonely time (Grace, age 75).

These mothers also learn to accept these changes because they recognize that it is a natural part of one's experiences of motherhood in old age:

> Sunday is now kind of draggy. Sunday I was thinking of my kids and I thought, "Well this is it. They've got their lives now and I've had my life and I had my children and my nice husband for fifty years". What strengthens me up is to hope the kids don't forget you and don't always get into the habit of not bothering to call you. And maybe they should but let them have their life too (Grace, age 75).

These examples illustrate that adjustments are experienced as significant changes and the losses in other valued identities highlight the peripheral later life mother identity. This identity presents a source of change, especially if the mother has not adjusted to her experiences of motherhood in later life (stability versus change pattern). However, others learn to adjust their interactions with their children, or they learn to accept that these mother experiences are to be expected in later life. In this way, the changes in the mother identity are viewed as a gradual progression in the stages of motherhood in later life and perceptions of biographical continuity are maintained. (This reflects the continuity pattern).

d) The Active Mother Identity: Some women remain involved in mother identities that are more characteristic of "middle-aged" mothers. More specifically, they have children who, for a variety of reasons, continue to depend on their mothers. However, these relationships are the exception rather than the rule. For example, one woman's daughter was mentally retarded, while another woman's son suffered from schizophrenia. These women continued to act as caregivers. Because of this,. the experiences of chronic illness influenced their role identities in different ways.

One woman, Lillian, remarked that the disabilities associated with OA significantly affected her ability to look after her daughter. Because of her age and her condition, Lillian was able to secure a community living arrangement for her daughter. In this residence, Lillian's daughter would be under the supervision of social workers. Unfortunately, this plan did not prove to be as beneficial as planned:

> We are involved more than we were supposed to be. The Association for Community Living is supposed to take over and look after these sort of things. But I guess, like most people in social work, they're loaded with clients. So my husband says all we have to do is to put the key in the car, and it'll head down to her apartment. We're down there so much for one thing or another (age 72).

Another woman acknowledged that some adjustments had to made when she negotiated her disabled identity with her dependent son. He assumed more responsibility for housework and for looking after himself. In this particular case, these adjustments benefited both the mother and the son. The mother remarked that it was good for her son to learn some of the skills necessary to live independently, since there would come a time when she would no longer be there to watch over him.

In both cases, the mother identity was a very important component of the self concept. Interestingly, while OA did present some challenges, the active mother identity prevented these women from becoming immersed in their illnesses since they were still very much "other"-oriented in their social relations. Adjustments in parent-child interactions were made in order to meet the obstacles presented by OA. However, the women retained the "active" mother identity, and the essence of the relationship remained:

> Being a mother is very important to me. And to give him all the things that I didn't have. I still see that he hasn't got money I give it to him. And if there's something he wants and he can't afford it, I give it to him...So really, it's just our life around here that's important, that we can make a go of it, and keep going and have the roof over our head (Laverne, age 79).

This, is turn, resulted in the continuity of the mother role identity.

e) The Empowered Mother Identity: The last "type" of mother identity that emerged in the analysis is the empowered mother identity. This mother identity is interesting because it further highlights the variety of mothering experiences in later life. Empowered mothers illustrate that the negotiation of the mother identity in later life is not always a smooth transition. As the active mother identity also illustrates, older mothers do not always find that they are released from roles and obligations. Many individuals must actively negotiate this transition. Some women are able to use the OA experience as an opportunity to shape their preferred role identities. Hence, the empowered mother identity illustrates that identities can also be *enhanced* by chronic illness. One woman remarked that her daughters always took her for granted. She felt that her children took advantage of her willingness to help them, and that her mother identity had been over-extended. With the onset of OA and with her limited abilities, this woman finally learned to place her own needs first before "jumping" to help her daughters:

> My daughters have said that the illness has changed me completely around. At one time my girls would bug me. It was, "Mum do that, mum make that." And they bugged me at different things. I'd just ignore them, but now I tell them off. They don't back me into a corner anymore. Now they don't get me near that corner, because I just don't take any of it. Now it's like, "Don't bug me. I'll do it when I'm darn good and ready. I'm not dropping what I'm doing now to do it." Besides, I haven't got the energy now. I've learned to do things now at my own pace, and when I want to do it. They had showers and that, and I would spent three or four days baking for them. It was, "Mum, we're having a shower. Will you bake this and that?" And it kind of got to be not a couple of dozen, it was five or six dozen. I made their wedding dresses, and I baked the wedding cake too. I know people took advantage of me. But not now, not anymore (Hatty, age 78).

This mother's role requirements were substantially altered and her interactions with her daughters had also changed accordingly. She used her chronic illness to release herself from a more active mother identity. This process did not occur "overnight", and both the children and the mother had to adjust to these altered role interactions. As a result, this woman reported feeling significantly liberated in her relations with family. In this case, the empowered mother identity represented a new aspect of the mother identity and the process of change (stability versus change pattern) was experienced as a benefit to the self.

f) Role Reversal: A Valid Concept? This section will not present an additional mother "type". Rather, the concept of role reversal will be presented since it is an issue that is often addressed in the aging and health literature. More specifically, the ways in which the impaired health of older parents may increase the caregiving responsibilities of adult children is an important issue often addressed by researchers. Role reversal has traditionally been seen as describing the process whereby disabled, or ill, older parents take on the role of child, while grownup children assume responsibility for their care, in effect assuming the role of parent (Brody 1990, Jarvik, 1990, Seltzer 1990, Fischer 1986). Jarvik (1990) contends that role reversal is a viable concept. By assessing the duties and tasks that parents perform for their children with those that adult children perform for their impaired parents, Jarvik cites evidence of role reversal. Just as parents provide "first-order needs", (food, clothing, shelter and protection), and "second-order needs", (physical and emotional support, contact and interaction), Jarvik argues that adult children are often involved in providing these same supports for their older parents (Berman 1993, 105).

This concept has been criticized on many grounds. Brody (1990) argues quite convincingly that there are fundamental differences between the experience of caring for a child and that of caring for an aging parent. For the most part, the needs of children are viewed to be quite normal. As well, children grow, both physically and emotionally always becoming more independent. Indeed, it is assumed that, ultimately, children will become fully independent. In contrast, caring for old and ill parents is often characterized by increasing dependence and deterioration. Seltzer (1990) also points out that role reversal is a misleading concept. Role reversal connotes a movement from one social position (or status), to another. She argues that, as parents age, the process of *role change* better describes the relationship between aging parents and their adult children. That is, individuals adjust and modify interactions and role requirements *within* the same role identity. These points are summarized by Berman (1993).

The experiences of those interviewed for this study provide support for Seltzer's conception of role change. The older parent is aware that adult children have assumed more and more responsibility for helping her to manage her illness. The findings also reveal that the meanings and significance attributed to such exchanges cannot be characterized by a complete, reversal of roles between parent and child. For example, role reversal may be a situational phenomenon. In certain situations, the older mother is aware of some degree of role reversal:

> Oh I mean he (son) bosses me around a little bit more. But only for my own good...Well, the first time or so I might have thought, well in fact I said, "Hey, who do you think you're bossing?"...No, they respect me in that way. I'm still mother, but they'll say, "Mum, leave that, I'll do that". They try to take care of me. Yes, I'd say to a certain extent I've become the child, and they've become the adult. But not in a bossy way, or anything like that. Just to help me out (Maeve, age 78).

However, these interactions neither pervade the relationship nor are they characteristic of the overall parent-child relationship. Continuity in the mother identity is maintained. As the previous quotation illustrates, Maeve remarked a couple times during the interview, "I've become the child". However, it must noted that Maeve had negotiated an independent mother identity and that she described her relationship with her son as "team work".

The experiences of the women who participated in this study illustrate that role reversal is an exaggerated conceptualization of parent-child interactions in later life. Rather, the mother identities which were presented previously, are important in determining the various ways in which these identities are adjusted and negotiated. This supports Seltzer's conceptualization of "role change". While parent-child interactions change with the onset of chronic illness, mother identities are often preserved as changes are negotiated. In essence, mother identities are negotiated over the whole life course, and the significance of past interactions cannot be ignored. The phrase, "once a mother, always a mother" holds true. This study shows that although children may be more involved in assisting their mothers, the nature of past parent-child interactions are often preserved and provide a sense of continuity. For example, even though some mothers may not be as active in their children's lives as they once were, they still continue to feel the same kinds of concerns for their children:

> They say I'm not supposed to be the mother anymore. When they're married, they're supposed to have their own family. But you never, no matter what their age, stop worrying about them. The other day when Rob wasn't home, I was worried. I thought, "Oh dear, I wonder if he's had an accident or something." And I thought, "Oh come on." I know he's big enough to take care of himself. But I think mothers, they always have a concern for their children (Maeve, age 78).

Others comment that it *appears* that the balance of power has tipped in favour of the children, especially if children are involved in providing assistance. However, both the child and the mother still recognize who's "mother". Maria remarked a few times that, in all likelihood, she probably would not be able to remain in her own home if her son did not live with her. However, she maintained her share of power in the relationship in several ways. In reference to her home, she stated, "See it's my home. My son lives with me. I don't live with him." She also depended on her son to do the grocery shopping, and to drive her to different places. However, she emphasized the fact that she had bought the car with her own money.

Some mothers draw upon other styles of interaction in order to retain their identities. For example, OA is often hereditary, and some of the older mothers report that their own adult children have also developed this disease. Hence, these women draw upon their own experiences of chronic illness and attempt to give their daughters some advice:

> My daughter has arthritis in her knees as well. And I keep telling her. You see, the one thing I wish, I wish I had gone to a specialist right in the beginning. I keep telling her to go to one, and that she should be more careful. I tell her how important it is to try and keep active (Dorothy, age 75).

Several women also attempt to act as role-models to their children. In the case of one woman, her experience of chronic illness reinforced the importance of maintaining friendships and social networks that would endure in later life. She hoped her daughter would learn from her example:

> My daughter Michelle, she can see how nice it is to see friends coming to see me, or when somebody's phoning me. You don't think you can teach your daughter something. But in a way, I've been teaching her. Because she doesn't say nothing, but more and more she's keeping in touch with her friends, and she's making those kinds of efforts. I would never say nothing, but I used to hope and pray that she would be more active (Grace, age 75).

These examples illustrate that modified interactions between parent and child must be placed in their proper context. While adult children may be more involved in providing services for their parents, older mothers are also continuously involved in negotiating these role exchanges for the purposes of maintaining their own identities.

g) Living Vicariously: Before concluding, one last aspect of motherhood in later life is worth noting. Some mothers live vicariously through their children as a result of the losses brought about by OA. However, it would be premature to derive another mother type, since living vicariously was not the only characteristic of these mothers. Rather, living vicariously may present an additional **aspect** of motherhood experiences in later life which is worth exploring. A few mothers engaged in this process. These individuals were deprived of meaningful social interactions and they were restricted from engaging in valued role performances and related activities. Many of their valued identities had become significantly limited because of OA. The data reveal that mothers who live vicariously through their children often feel that it is no longer possible to lead fulfilling lives in their present disabled bodies. Many of their identities become inactive. Hence, to compensate for such losses, these women take comfort in the lives their children.

> I have no interests now. The only thing I'm interested in is my family, what they're doing. I live through them. What they do, I enjoy. I like to know what they're doing. Like today, I got a phone call at noon and somebody says, "Hi grandma". It's my two year old granddaughter and she says, "I go skating today". Well I get a kick out of that, the way she talks and for being so young and everything. What do I have to talk about? When you sit around in an apartment all day, see how boring you get. My daughter even says, "God

> you're boring mother". That's why I like them to phone me. Because I know they're not boring (June, age 69).

The lives of grown up children serve to reward and affirm the present mother identity. Hence, these mothers are often pleased with their children's lives. In this way, a valued, biographical identity is affirmed in spite of one's losses experienced in the present. The woman's past commitments to her role performances as a mother are being rewarded in the present. In addition, the successes of children often compensate for identities that were never affirmed in the woman's life:

> I'm happy to see that my daughter and her husband, they're very good together. They do everything together, and I look at them and I'm happy to see that. Whereas my husband and I, we didn't have that together. Theirs is different and I'm very happy to see that. So, I live for them. That's all now. And when I look at them, I am happy to see that they are happy. That makes my life happy (Audrey, age 83).

In this way, these individuals are able to derive some sense of meaning and connection when reflecting upon the less satisfying aspects of their personal histories. It is unclear whether living vicariously presents a source of continuity and/or change. However, as these women contend with OA, it is an interesting development in their experiences of motherhood in later life.

1.2 The Grandmother Identity:

The experiences of the women in this study reveal that their grandmother identities are not seriously influenced by OA. Some grandmothers are limited in their interactions with grandchildren, or they may be prevented from engaging in activities related to grandchildren. However, these restrictions or limitations usually do not alter the relationship significantly. For example, some grandmothers are no longer able to bake treats for grandchildren. Or they are prevented from going shopping with granddaughters. Some grandmothers talk about not being able to run after grandchildren.

At some stage, baby-sitting active children also became problematic. Other examples include being prevented from attending family celebrations, or grandchildren's weddings. Some grandmothers also reflect upon the image that they present to their grandchildren. Lillian had developed OA before her grandchildren were born. She regrets that they never had the chance to know her while she was still physically active, and not dependent on her walker and cane. She stated, "I would've liked them to remember me more active, but it can't be" (Lillian, age 72).

These limitations are not important enough to change the relationship significantly. Moreover, the biography of the grandmother identity must also be considered. Some grandmothers do not develop close relationships with their grandchildren for a variety of reasons. In several instances, grandmothers were separated from grandchildren geographically and relationships were not influenced by OA:

> My grandchildren are not here and when they're not here, they're doing their own life. I don't find myself with the older ones that are out with their own life. I don't think of them much. There's a couple of young ones and I wonder what's to become of them so there's a little concern there, but I don't see them as much. So, I don't think the arthritis has been important there (Grace, age 75).

In general, women are able to preserve the continuity in the grandmother identity. If adjustments in one's role performances, role requirements and interactions with grandchildren have to be made, these modifications are usually very slight. These changes can be quite subtle:

> My daughter was saying she had a class teaching the kids about handicap and how not all people look handicapped. So I said, "You know, our kids didn't have to learn about that. They grew up with it." Because I've been handicapped ever since they were babies. They just automatically adjust and if I go to get out of a chair down there, one or the other says, "Where's your cane, Grandma?" They just do it. They're little boys and they're getting older now, but when they were little, it was, "Come on down, Grandma and we'll play cars." But I couldn't. They soon learn though. They push you a

> kindergarten table over where Grandma's sitting and put a board game there and it's, "Play with me, Grandma." (Lillian, age 72).

Grandmother roles are adjusted to accommodate physical limitations in other ways as well. For example, grown children may ask their mothers to baby-sit older children. However, this type of baby-sitting does not require physical activity:

> My kids sometimes look to me to help them. If I'm sitting, I'm okay. Anywhere I'm sitting, I look after the kids. If they're in bed, I can go and baby-sit, knowing they're in bed. I'm still capable of doing things like that (Bev, age 68).

Overall, the experiences of the women illustrate that the grandmother identity is not seriously affected by OA. Continuity is preserved (stability versus change pattern). Indeed, some women derive great satisfaction from the lives of their grandchildren. And they do not necessarily need to be actively involved with them to do so. If adjustments are made, these changes are not significant and modifications are made in order to preserve the grandmother identity.

2. Marital Statuses

2.1 Wife Identity:

The wife identity is another important component of the self-concept that is worth examining. Many studies have reported that married persons are healthier than their non-married counterparts. These findings are similarly reported among elderly persons as well. It is suggested that marriage often provides sources of social integration and social support, factors which contribute to both psychological and physical well-being (Anson 1989). In particular, spouses can provide much-needed help and care during episodes of illness (Verbrugge 1979). Other studies have assessed the impact of chronic illness on the dynamics of marital relations (Cutrona 1996; Corbin and Strauss 1988). The stresses experienced by the spouse who acts as the caregiver, and issues related to shifts in the balance of reciprocity are addressed by these researchers.

This section contributes to the literature by suggesting the ways in which perceptions of continuity and change are negotiated in the context of spousal relations. While OA does pose as a disruption in the lives of married couples, it will be shown that some couples are able to adjust to these changes. Adjustments are made by the couple in order to deal with the limitations presented by OA. Such adjustments may serve to buffer the impact of living with a chronic illness. These wives note that supportive relations provide sources of desired continuity. But it will also become evident that not all forms of continuity are viewed positively by the women. Some wives note the lack of support demonstrated by their husbands in the past, and the continuation of these dynamics does not help in the women's efforts to adjust to OA. Hence, continuity is not always preferred by individuals. When women are able to interrupt the continuation of these undesired patterns of interaction, these adjustments are viewed as definite, and preferred, changes. This finding points to the importance of recognizing that some changes are preferred. *In essence, it will be argued that the way these experiences of continuity and change are perceived by the women, often depends upon the history of the marital relationship.* This point is important considering that very little is known about the role of family and relational histories in influencing caregiving outcomes in later life (Cutrona 1996; Dwyer 1995).

In illustrating these points, it is important to make a distinction between supportive and unsupportive couple identities. With respect to unsupportive couple identities, the findings reveal that such identities usually precede the onset of OA, and the experience of chronic illness only serves to highlight these identities. In essence, the continuity of relational dynamics, developed through the years, is carried over into the present. Not all wives have supportive husbands. For example, one woman reported that her husband had not adjusted his expectations of her. Changes in role requirements and role interactions were not easily facilitated. Her chronic illness only served to highlight these earlier, unsupportive marital interactions. Hence, the continuity of the marital biography remained, but this was not viewed positively by the disabled person:

> It's really hard, because he expects me to do things for him, but I can't. He thinks I should still keep on doing things that I did before, like baking, cooking his favorite meals. I'm sorry, but I just can't do it. So he feels that he's neglected. I feel that I am neglected. Fifty-three years married and I did everything for him, but he won't do nothing for me now. He never did a thing. So he still thinks I should be doing, not him. **He never helped. So really, I don't expect what I didn't get before to get something now, because I never had that** (Emma, age 78).

This finding is significant because it addresses an issue that is presently not investigated by the present social support literature. In her study of social support in couples, Cutrona (1996) reports that future research needs to address the ways in which the developmental course of relationships shape levels of social support in couples. Cutrona hypothesizes that, "couples who establish a pattern of consistent responsiveness to their partners' need (i.e., supportiveness) early in their relationship are more likely to develop a variety of positive qualities in their relationships over time" (119). Emma's experiences provide evidence for the importance of recognizing the biography of marital dynamics in shaping patterns of successful adjustment to disabilities in later life.

Another woman shared the experiences of her unsupportive couple identity and was embittered by the lack of understanding from her husband. However, she had taken measures to change the dynamics of her marriage, and there were signs that her husband was slowly adjusting. Her experience illustrates a changed, wife identity. Ellen changed her role requirements and her husband slowly adjusted his expectations of her:

> The changes are since the arthritis is, I've learned to say, "NO!" Like before, he (husband) would come in and dream of anything for me to do or cook and I'd say, "Yes" and do it. Now, I've learned there is a word called, "no" and I use it. He's not helpless. He could do things himself. He can make it so that I

> look after him twenty-four hours a day if you didn't say no. He'd go out and enjoy himself, and I was always doing work and things that haven't gotten cleaned, like sinks and he didn't really care. Now I've made a complete change, and when I say "No" he knows it now (Ellen, age 72).

These examples illustrate that sometimes, change is preferred by individuals. Not all forms of continuity are desirable. The experiences of Emma and Ellen reflect the stability versus change pattern. Their stories demonstrate that continuity is not always preferred, and that definitive changes are desired by such individuals.

In contrast, the ways in which changes may be incorporated to preserve preferred marital dynamics is demonstrated by supportive couple identities (continuity pattern). The findings show that supportive husbands adapt to the changes brought about by OA in order to preserve marital identities. The affirmed wife usually feels that her own expectations of herself and the expectations of her husband have been negotiated in such a manner as to benefit the relationship. Adjustments are made to accommodate for the OA but this does not usually disrupt the wife's identity. Hence, husbands may help with household chores, they may be important in providing transportation, they may assist in maintaining the woman's social networks, and they may help to affirm other aspects of the wife's self. That is, husbands often help to preserve the wife from the imposition of the disabled self. Other valued components of self are affirmed by the husband:

> My husband, he's really good. We share so many interests, and it's having someone to talk to that's so important. Like we both like classical music, we were both active in the church. He likes watching television, which I don't. But a lot of times, I'll join him, because I don't want him to be lonely. But with the arthritis, my husband and I don't talk about it a great deal. He keeps an eye on me, and he knows the days I'm not walking well, just looking at me. And he just automatically puts his hand out when I'm walking with a cane. And that's all I want. I don't want to dwell on it much (Lillian, age 72).

Husbands may also facilitate and ease adjustment to disabling processes:

> My husband knows I hate using this cane. I really do so he did a nice thing. He's a carpenter in his own way, and he made me this beautiful black cane.

> And it's quite elegant looking. He's really helped me get used to it (Kate, age 67).

In essence, the wife identity, in interaction with OA, provides much continuity in the self concept. This is because the woman's relational association with her "significant other" is intact. Although some adjustments have been made in the marriage, these changes are viewed as gradual adjustments. But how do these wives negotiate the acceptance of these changes? This is important to address considering the changes that may occur in the exchange of personal resources within the marriage. Indeed, Cutrona (1996) reports that maintaining equity becomes an issue that must be addressed by couples when a partner becomes significantly disabled. Often, the balance of exchange shifts as one partner assumes more responsibilities. The changes in these dynamics must be negotiated.

The data for this particular study show that most of these wives maintain the balance of equity through a variety of means. Life stage factors and age are important in helping women to negotiate these adjustments. In old age, many husbands also suffer from various health conditions. Some of the wives in this study had provided care for their husbands, although none of them were involved in caregiving for an extended period of time. Some of the wives also received assistance from other sources, and they were not exclusively dependent on their husbands. Also, the changed lifestyles of retired husbands often facilitated the couple's adaptation to chronic illnesses:

> My husband, he's a super active person. Even before I got laid up, we used to call him "Suzy homemaker" because he just can't stay put. Like even today, when he shouldn't be doing as much because of his heart condition, but by eight in the morning, he's putting all the garbage out and if it's the day that he decides to do the floors, kitchen and bathroom, by nine all the work is done. So what I would've done if I were more active I don't know. Because once he retired, this has given him something to do. So in a way, it's worked out. I do miss looking after my home. But we probably would've argued a whole lot more when he retired because I would've resented him doing so much. But now I really need him to do it (Lillian, age 72).

Finally, some wives remarked that the balance of exchange was facilitated because some adjustments were viewed to be beneficial. This also helped women to adjust to some of the changes in the marriage:

> My husband does the laundry now. And he vacuums now, which he never did before. Before the surgery and while I was recuperating, he was doing most of the cooking, which is a good thing because up until then all he could make was bacon and eggs. So I pointed it out that historically, his family were long lived. Mine tended to be early. I said there's fifteen years that I'm not going to be around. So he's learned how to do a few things, and I think it's good for him (Beatrice, age 69).
>
> I don't feel bad about the changes, because if he objected to it and didn't like to do these things, then I would feel that way. But he's a man that never ever did anything in his house his whole life. So I started showing him how to do things before I went for my knee surgery, how to make simple meals, how to use the washing machine and dryer. And he's quite willing. With him being retired, he's quite happy to learn new things. He said he never had a chance before, so it's worked out well (Gladys, age 72).

These examples illustrate the variety of experiences of continuity and change. Not all forms of continuity are desired by individuals. For other women, marital relations are effective in providing meaningful sources of support. It was also demonstrated that individuals negotiate their roles within the biography of their own relational identities.

2.2 The Widow Identity:

Several studies have assessed the relationship between widowhood and the health status of the bereaved individual. Some authors report that experiences of widowhood do not influence the health of the individual (Heyman and Gianturco 1973 in Matthews 1991). Ferraro (1985) reports that widowhood is related to decreases in one's perceived health shortly after the loss of one's spouse. However, this relationship is not significant in the long-run. But how is the widow identity related to experiences of living with chronic illness, more specifically OA? This section demonstrates the variety of ways in which perceptions of continuity and change are negotiated.

The significance of the widow identity varies among individuals. Some women have been widowed for several years, and the experiences of living with OA do not influence this identity component in any significant way. For others, the widow identity is indeed associated with the chronic illness experience. Before proceeding, one must keep in mind the fact that the negotiation of the widow identity is a complex process, and that this study highlights only one area of this process- the widow identity in the context of chronic illness.

The biography of the marriage is important in shaping the ways in which the widow identity interacts with OA. With reference to OA in particular, some women report that it would have been extremely difficult coping with the arthritis if they were still married because of the circumstances of their past marriages. Some of these women recall extremely stressful caregiving experiences, and they have come to terms with the widow identity:

> I was getting very crippled up before my husband died. And he was ill, and I was doing what I could, which was making me worse. It was the stairs that was getting me bad. My husband was of a very set mind, and he did not want to move. So the doctor suggested that the stairs were not good for me, but my husband did not want to. So that, actually, when he passed away, I moved in here. I could cope better for myself here, whereas it was hard coping with another one that was ill. I think I'd be dead by now if my husband was still alive. I don't think I would've been able to cope in that house. I wouldn't ever want to go through with that again (Betty, age 80).

Changes in the responsibilities and duties of one's former, wife identity are beneficial in helping the woman deal with her OA. However, it is important to note that this finding is not meant to negate the significance of the impact of widowhood in other areas of the woman's life.

In other instances, the widow identity heightens the woman's awareness of the chronically disabled identity component. This is often true in marriages where the husband assisted the wife in various areas of daily living. It is not surprising that, under these circumstances, widowhood presents a source of significant change. Husbands may have played an important part in helping their wives adjust to various limitations when their role requirements, role performances and interactions were influenced by OA. Hence, changes in one's ability to perform various tasks may become highlighted by widowhood. For example, widows who change residences upon the death of their husbands may have to adjust to new living arrangements. While this may facilitate the negotiation of the disabled self, it may also present new challenges. For example, Grace's husband was instrumental in assisting in the maintenance of her homemaker identity. After his death, it was no longer possible for her to remain in the house:

> I had this house and I had a big front room, a den, a big kitchen, big bedrooms upstairs. It wasn't a big house but it housed eight kids. I had nine, but one girl married and one baby came so it all- I had ten of them, so it was enough to house us all. How long could I stay in a house like that all alone when I couldn't even walk? Downstairs to the laundry and upstairs to the bedrooms? (Grace, age 75).

As a result, Grace sold the house she had lived in for forty-six years to move into an apartment. The layout of the building was not suitable for someone with her type of disability. In addition, the fact that she was confined to a wheelchair also made her fearful of a fire:

> Before I moved here, I sold the house and moved into this high-rise. It was terrible. It was going downhill and the elevator wasn't working half the time. I was on the seventh floor and once in a while the wheel would get stuck on the elevator door and the thing would knock, like scare me. Because I'm allergic to elevators. I don't like them. I'm sitting in a chair and the door's shutting on me? It's an awful feeling...There were stores around there. I played cards once in a while. But being on the seventh floor, the fire alarms were going off all the time. Sometimes it could be a fire, and sometimes not.

> And I would be like this because you're not supposed to go to the elevator. You're supposed to go down the stairs. I couldn't go down the stairs. I'd be trapped. I thought I was being trapped (Grace, age 75).

Tasks that her husband once assisted with also became problematic and the changes in her role performances became evident:

> Yeah, well I stayed, at first I went down. I walked. I put the laundry in here and I put the basket on here and I would go down holding on to the back of the chair. Each step was horrible. I'd get on the elevator and then wonder if it was going to stop. And I'd die right there if it stopped. But it would get down to the bottom and I would be just like that. And then I'd go down to the laundry and the machines are one on top of another and for the drying machines, I could hardly reach. I couldn't stand long enough to get it in. It would be that high. So anyway, somebody would be there and say, "Can I put that in for you?" You wouldn't know if you got that in the right slot. And then you had to push that in and I couldn't stand long enough. Then I'd have to stand long enough to get it out of the washer and into the basket and into the dryer. I found it very hard. Once in a while, I had a homemaker and there was other things to do. They did the dusting, polishing. They would've done the laundry, but that would've taken time up where I would have her do things I couldn't do. And I could do my laundry so I don't know how I managed now that I think about it. How did I get those laundries down those stairs? And I'm sitting in a wheelchair (Grace, age 75).

Moreover, because of the lack of social interaction within the building, she found it difficult to adjust to the loss of her husband. As a result of these changed interactions, this woman experienced much loneliness, and the building only served to highlight her experiences of social isolation. Hence, her impaired mobility was reinforced by this experience:

> A seniors' apartment is all right, where you can go down, play cards and meet up with a couple friends in the lobby, so you can chat. But where I was, it was just a regular high-rise. I lived there fifteen months and I didn't even know the lady across the hall. It was a really lonely, time. I was used to hub-bub and then you're eating at least with your husband. All of a sudden, you're eating at the corner of your table by yourself. I could be out shopping and be with my friends and they would come and visit me, **but it was me that couldn't get out** (Grace, age 75).

Others remark that the loss of a significant "other" (relational association) also increases one's awareness of OA:

> If my husband hadn't passed away, I wouldn't be thinking so much. See, I got more time to think about what's wrong with me. If my husband was ill, I wouldn't be thinking so much about what's wrong with me. This condition wouldn't have worried me so much, 'cause I'm alone and we don't go out like we used to in the car, taking the dog out together. I miss that kind of thing, the companionship (Maria, age 83).

Similarly, others describe experiences of loneliness, and changed patterns of social interaction. For widows who relied on husbands for transportation and companionship, participation in social activities, clubs, and other enjoyed or valued activities are often curtailed. Others report that they do not feel confident going out alone. Some women would prefer the company of their husbands, and many events are no longer enjoyed. A few widows remarked that it is difficult adjusting when one has been used to going out "in couples", with "other couples". Increased confinement caused by OA emphasizes such changes in people's patterns of social interaction.

Certainly, these negative experiences do not characterize the experience of all widows. It will be shown that while significant changes are often experienced as major breaks in the continuity of one's life, individuals are able to negotiate these stressful changes to preserve continuity. Interestingly, some widows may experience situations like those described above. However, they may learn to adjust to the changes and the challenges presented by OA. Various strategies were revealed by the study. Individuals learn to adjust to the ways in which widowhood has influenced their experiences of OA by negotiating new task performances and roles. Tasks once performed by husbands are learned by the widows themselves, albeit it in adjusted form. Or, having delegated these tasks to others, the widow discovers that she has managed to move on independently and that her disabled self has been successfully negotiated.

Next, individuals may learn to accept the widow identity by recognizing that it is a natural part of the life cycle. Hence, difficulties in later life, such as OA, in combination with the loss of a spouse, are accepted. One woman commented on her experiences of moving houses after the death of her husband, and her increased confinement because of her OA:

> Honey, wouldn't I be ridiculous at eighty to expect things to be like when I was young? The bible says, after three score and ten years, your life can be problems and something else. Nobody's life is going to be perfect forever. I'm just so happy that I had fifty-seven years on earth with my husband. After he died, it just seemed like the natural thing to do was to move....I don't get out much now, but what do you expect at my age? (April, age 85)

Significantly, individuals also reconstruct the ways in which their widowhood experiences interacted with their arthritis. Individuals engage in these processes in order to preserve their perceptions of continuity. The impact of significant events and the ways in which these experiences broke the thread of biographical continuity tend to be ignored. One woman drew upon the process described in the example above. However, the actual difficulties she experienced when adjusting to these changes were overlooked. This was revealed by the contradictions that were apparent in her interview. When asked what it was like adjusting to the new apartment after the death of her husband and the added stress of the multiple hip operations she had undergone, this woman downplayed the impact of these experiences. She evaluated her past experiences in terms of how she felt at the present time (she was much better adjusted at the present time). However, many times during the interview, she revealed, rather unconsciously, what the experiences were really like. For example, this woman contended that the move to the new residence was not a difficult transition. However, she revealed later on that perhaps she made the wrong decision when choosing her new residence: "I was still lonely for Bill when I made the decision. It was just an awful building, but I learned that the hard way." (This woman described later on the ways in which the residence was not amenable to the disabilities incurred by her hip problems). Moreover, she admitted that her doctors also recognized that her recovery from the hip surgery had been slowed down because of her difficulty in adjusting to the loss of her husband. Nevertheless, at the present time, this woman enjoys a sense of continuity because she has been able to re-construct the "multiple losses" often experienced by individuals in later life.

Finally, individuals are able to preserve their sense of continuity by locating their past wife identities in present illness biographies. The history of the OA may be constructed by integrating the role of significant others in shaping the biography of the illness. In this way, structure, meaning, and a coherent and logical sequence of events has been created. In particular, when late husbands are incorporated into these biographies, especially when their role has influenced the widow at the present time, the sense of continuity is maintained. Grace recalled how her husband played a pivotal role in helping her to adjust to her wheelchair. She is extremely thankful for his contribution, and does not know how she would have coped with her OA in the present without his help then:

> Something about wheelchairs. I used to rather crawl around in pain with two canes than be in a wheelchair. But it was my husband that got me used to one, and he did it so well. Like gradual for me, you know? We were planning on taking trips, but he said we wouldn't be able to go anywhere with my knees bothering me and I left it at that but then he mentioned the wheelchair again, and he suggested we could just have it for emergencies. So I went along with him because he never went anywhere without me. Like I couldn't walk, so to appease him I went in the wheelchair. I did feel bad being in one, being wheeled through the mall. That was the first big step for me. An emotional upset, but we'd go out gradually with it, so it was good he did that because it got me used to a chair. So there wasn't that big transition. Nowadays, I'm so glad he did that when he did. Because, honestly, I don't know how I would've adjusted to the chair later on, with him being gone and all (Grace, age 75).

These examples illustrate that widowhood, in conjunction with OA present a variety of patterns of continuity and change. Some women became widowed several years before the onset of OA, and this identity is not influenced by OA. Others reveal the challenges of adjusting to changed role requirements, performances and interactions when widowhood occurs. This presents a significant source of change (stability versus change pattern). However, some of these individuals learn to adapt to these changes in order to restore perceptions of continuity (continuity pattern).

3. Unpaid Labour: Domestic Identities

3.1 Caregiver Identity:

It has frequently been noted that caring has been delegated into the domain of women's work. Certainly, much has been documented about the role of adult daughters in caring for their aging parents (Brody 1990). The role that spouses play in caring for their ailing husbands in later life has also been well documented (Huyck 1995; Roy 1994). Within the informal networks of care among married persons, spouses often serve as the primary caregivers (Huyck 1995, 194). Those studies that have assessed the experiences of such caregivers report mixed findings. Some studies contend that spouses benefit from the emotional rewards of caregiving (Fitting et al. 1986), while others describe the stresses and burdens that result from this role (Horowitz 1985). Others report that spouses engage in caregiving responsibilities until their own health problems prevent them from continuing this role (Dwyer 1995). Hence, the caregiver identity in later life may present additional challenges since older caregivers are likely to suffer from their own chronic health problems.

Indeed, later life presents unique factors that must be considered. In particular, health problems are more common in old age. Hence, it was not surprising that many of the older wives in this study acted as caregivers for terminally ill husbands. The experiences of the respondents provide support for those studies that document the stresses associated with the caregiving role in later life. This type of caregiving was not characterized by equal exchanges. These caregivers had to contend with their own chronic illnesses, while simultaneously caring for severely ill husbands. This often represented a stressful, and **new** extension of the wife identity.[3] Often, the history of the chronic illness was explained by locating its progression within the context of the caregiving experience:

> My husband died at home, and I looked after him. And I think I neglected my knees. But I think that lifting and supporting him, when he got out of bed or anything like that, I think that hurt, really brought it to a head. Now it probably would've happened anyway, but maybe not as quickly because the cartilage deteriorated in my knees. I think that's why everything went to pot at once, because, when you're doing other things, you sort of don't think about yourself as much. I just didn't pay attention to my arthritis (Dorothy age 75).
>
> I think some of the stress of taking care of somebody else, of being a caregiver, I think that has contributed to the arthritis. I think the stress of having gone through certain things, I think that adds to your arthritic condition (Maeve, age 78).

Interestingly, many of the caregivers did not recognize the significance of this identity, in conjunction with OA, until after their husbands had died. Hence, the development of the OA was reconstructed at a later time, before its significance was fully understood:

> At the time, I guess I didn't think it was that bad, my arthritis. I was just busy with him, and I didn't have time to think about it, I guess. I knew I was tired, but I just kept going. I didn't ever think that my arthritis was that, bad but it must've been getting bad, because it was right after he died that it got really, really bad (Maeve, age 78).

In some cases, treatments for OA were postponed or given up because of the need to provide care. Some individuals managed to balance treatment regimens for the OA while caring for husbands at the same time. However, this often presented a stressful "juggling

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[3] All the women in the study who acted as caregivers were now widowed. A number of women who were caring for sick husbands at the time of the study declined the interview. Consequently, the experiences that are documented for this study reflect reconstructions of past experiences of caregiving.

act". Some individuals were also forced to give up the caregiver role, because the tasks and responsibilities, in combination with OA, become too much for them.

Not all women were actively involved in caring for dying husbands. Rather, these wives were involved in visiting their husbands in hospitals on a daily basis. Even these experiences affected the downward progression of OA:

> I was going down at a pretty fast rate doing things while he was there in the hospital, before I fell and did this. My neighbour said, "Well, you would've had a heart attack if you didn't fall and break your hip" because I was going up to the hospital for the hand treatments, and I was trying to visit him. And look after things alone. And I was pushing myself. So then all of a sudden I can't do it (Mabel, age 80).

Often, the caregiving experience also sensitized one to the imminence of death. Husbands are aware that it will become increasingly difficult for their disabled wives to manage certain affairs alone. Hence, both husband and wife negotiate the future widowhood identity:

> My husband was dying of cancer. And I was looking after him at home, because I wanted to do it. My arthritis wasn't bad then, but it wasn't good either. Once I fell off the ladder when he was sick, and he made me promise I'd never go up on a ladder again. So he knew I was getting on with the arthritis. That's why we talked about during his illness, what we would do if something happened. We agreed that I would sell the house and move into an apartment after he passed. I didn't want to move, but he understood that I couldn't cope alone (Marion age 79).

Clearly, these few examples do not explore the full complexity and variety in people's caregiving experiences. However, they do illustrate how the experiences of chronically ill, older women are shaped by certain life stage factors. Moreover, the caregiving identity often presents a new identity component (a source of change in terms of the stability versus change pattern). This identity may be viewed as a stressful source of change, and as a break in one's biography. However, as the widow identity shows, it is possible that these changes are negotiated and, consequently, re-written and woven into the fabric of one's personal biography.

3.2 Homemaker Identity:

As one would expect, the homemaker identity is a common one among many of the older women who were interviewed. Interestingly, many of the studies that assess homemaking issues in later life have examined patterns of homecare use among ill or disabled persons (Benjamin, Fox, and Swan 1994; Diwan 1994; Wilmoth et al. 1992; Kirwin and Kaye 1991). However, the ways in which the person's self-concept is influenced by the reliance on such services are not examined. Mac Rae (1990) reports that the homemaker identity provided an important source of continuity in the self-concepts of the older women she interviewed. However, Mac Rae did not focus on issues related to health. And the impact of physical decrements for threatening this identity is not explored. In their studies of the experiences of older woman living with chronic illness among older women, Belgrave (1990) and Robert and McGraw (1991) found that the woman's ability to perform household duties and to maintain her home independently was positively related to her self-concept.

While Mac Rae (1990) and Roberto and McGraw (1991) report that the homemaker identity is either an important component of the self-concept, or that the ability to engage in the performance of homemaking duties is related to positive assessments of the self, the findings from this study reveal more varied results. The experiences of the women who participated in this study show that OA influences homemakers in a variety of ways, and these changes or adjustments are perceived differently. In general, the homemaker role is modified, challenged, clung to, or relinquished gladly. These findings uncover the ways in which this identity is threatened, and the strategies that are used to preserve this identity. This study also uncovers those cases in which the loss of this identity is not perceived as a threat to the self-concept.

For many, impaired body performances are accentuated by the homemaker identity. Changes in task performances are clear indicators of the progression of OA. Most individuals continue their household duties, but these role requirements, role performances, and standards of evaluation are **modified.** Individuals are often aware of their changed performances. For example, changes in the length of time required to complete a task, in the effort necessary to complete the task and in the perceived task difficulty highlight the problems caused by OA. Significantly, changes are perceived differently from person to person. Some individuals are acutely aware of the changes in their performance levels:

> I'm thinking that no matter what you do, it's a big chore. Something that used to be a minor thing to me can now be a huge thing to have to do, like standing washing the dishes. Like before, I could just stand at the sink, and wash the dishes and have them put away all at once and do the laundry at the same time. Now I put in a few dishes, well then my back gets sore and I have to go sit down and take a rest before I can do more. Things you were able to do, and think nothing to doing, now you just can't jump up and just do it. You have to think about it first, to see if you can really do it. That's a big change (Violet, age 77).

In light of these changes, many individuals modify their role requirements and role performances in order to accommodate the limitations imposed by the OA. This serves to preserve this identity (continuity pattern). For example, these women re-define homemaking to suit their abilities so that they may continue this prominent identity. As stated before, Maria retained her homemaker identity, but she contended that her duties consisted of the planning and delegation of tasks and duties. This preserved her identity and she derived satisfaction from these modified role performances. Many individuals also move from houses to apartments. Thus, their homemaker responsibilities are reduced appreciably. Moves to smaller living spaces often help people to adjust to the physical limitations imposed by OA. These modifications may serve the purpose of preserving this identity. It is also interesting to note that these moves are often related to later life stage changes (for example widowhood, older mother identities, and released responsibilities and obligations).

It is also important to note that the processes involved in modifying the homemaker identity differs among individuals. Some individuals find these adjustments very difficult and the process is not always a smooth one. These adjustments are viewed as unwanted changes, and perceptions of continuity are not preserved (stability versus change pattern). What conditions account for this experience? The data reveal that women who have not adjusted their expectations of themselves find it difficult adjusting to these changes. These women may find it difficult to have to accommodate to the limitations presented by OA, particularly if they derived much personal satisfaction and gratification from the homemaker role. Valued attributes were affirmed through this identity and the women derived a sense of accomplishment from this identity.

For example, one woman took great pride in her homemaking abilities, and adjusting to the limitations imposed by OA was a very stressful experience for her. These threats to her identity resulted in feelings of worthlessness. She reported feeling useless and unproductive. In the early stages of the OA, she had pushed herself to maintain her past levels of performances. This became increasingly difficult and resulted in greater turmoil and physical stress. Gradually, this woman learned to adjust her expectations of herself and over time she accepted the decline in her homemaking abilities. However, this was not an easy process:

> I used to be able to get down and wipe up a kitchen floor like this in twenty minutes. No problem. That was ten years ago. But, as they say, there's been a change in me because my body won't let me do what I want to do anymore.

> I used to get busy and hurry up and do a bunch of housework, because on a good day, I felt better, eh? So I'd push myself to get everything done on that day. I found out what the outcome was. I was just, the next day or so, I was really in dire straights. I learned that the hard way...It's degrading. You say to yourself, "Now what? I can't do this." And you feel really browned off. Fed up. What good are you? Then you have to learn to adjust to that. That I can't do that anymore. It wasn't easy, let me tell you, but you get to the point where you have no choice. You have to accept it, or else drive yourself mad that you can't do the same things you did (Ellen, age 72).

Others cling to the homemaker identity, even though physical limitations severely restrict their role performances. These women refuse to alter their expectations of themselves, because this identity is so central to their self-concepts. One woman recognized that her arthritis, in addition to her other chronic conditions, was threatening her ability to maintain her home and run her own errands. The challenges in her ability to drive presented a great threat to her ability to manage her own home as well:

> It's just determination to keep going I guess to stay out of a nursing home and to continue to drive. I had to try for my license twice, and it was quite stressful. It'd be terrible if I didn't have a car. You're really restricted and isolated in this area. There's no stores anywhere near (Mabel, age 81).

This woman had lived in her house for several decades. It was also her childhood home. Most important, her past wife identity, mother identity, and daughter identity were tied up with this home. For her, the loss of the homemaker identity (the inability to maintain and live in her home independently) signaled the loss of self. She also believed that moving into an apartment represented "one step short of going into a nursing home":

> I'm determined to keep going. People say I shouldn't be in this house. I should get a one-level apartment. I say no. I go up and down those stairs a dozen times a day, and that's my exercise...But it'd be terrible to move. I couldn't handle it. It's been my home for practically my whole life. When we first got married, we lived in the east end for twenty-three years. But then, my parents died, and we came back here. So, it's home (Mabel, age 81).

These factors explain why some women hold quite tenaciously onto this challenged identity. Ironically, these attempts to preserve one's sense of continuity often result in the awareness of one's changed abilities and lifestyle. The challenges of maintaining one's own home present a source of great stress, and the limitations presented by OA are only accentuated. This may present maladaptive efforts to maintain self-continuity.

Other individuals relinquish the homemaker identity quite willingly. What factors dispose individuals to do so? These women describe how they have held homemaking responsibilities for years and that it is, in fact, quite liberating to be freed from such duties. Such individuals feel that at this point in the life cycle, they are entitled to fewer responsibilities and obligations. Changing personal expectations of one's homemaking abilities is therefore not difficult. These women also note that their priorities have changed. They realize that with their limited capacities, it becomes more important to devote their time to other valued and enjoyable pursuits. Hence, individuals are likely to relinquish this identity if the efforts that are necessary to modify and preserve this identity are no longer worthwhile. In short, the gratification derived from these performances are no longer sufficient enough to motivate the woman to continue to invest her efforts. The relinquished homemaker identity presents a source of preferred change:

> I really don't miss the homemaking. I've been cooking and cleaning ever since I was a teenager, and frankly, I couldn't be happier having my husband do it. I think when you reach this age, you've been doing for so many years that it's nice not having to do it anymore (Gladys, age 72).

These examples illustrate that the homemaker identity is influenced in many ways by OA. Some individuals modify role requirements and standards of evaluation in order to preserve an adjusted homemaker role. Some have more difficulty modifying their identities and these experiences present sources of unwanted change. Others cling to the homemaker identity in order to preserve their self-concepts, even though OA challenges this identity. Still others retire from this role. For them, the relinquishing of the homemaker identity is viewed as a positive change.

4. The Public Self

4.1 The Past, Employed Identity:

The past, employed self is often implicated in experiences of chronic illness in several ways. First, individuals often attempt to locate the cause of their OA by reflecting upon past, employment circumstances:

> I think it's all the wear and tear on the joints over the years that does it. I used to work in a store, and I'd be standing all day. And then I'd come home and do the cleaning for my parents, then for my own home. So I think all of this builds up over the years (Maeve, age 78).

> My nurse said to me, "Of all the jobs that you had, did you ever have a sit down job?" I said, "No, I always stood." I worked at two factories and I stood. I worked in retail, I stood. I was always on the go, on my legs without resting so I think that's what did them in (Bernice, age 72).

Most of the respondents noted that their past, employed identities were not influenced by OA since they developed this chronic condition, after their retirement. However, some individuals reveal that they were forced to retire a few years earlier than they had planned, because of their limitations. Some individuals welcomed the opportunity to devote more time to dealing with their arthritis. Other changes, such as being released from obligations and responsibilities were also welcomed.

For others, forced early retirement was an unwanted change. For these individuals, work identities were often central, defining features of the self, and the loss of this work role was quite difficult. Individuals described having to adjust to their retired identities while contending with their OA at the same time. They recall having to adjust to new routines and alterations in the management and structuring of time. Individuals were also forced to adjust to new time schedules because of the unpredictable nature of their condition. This is most evident when one compares the present structure of time compared to past work schedules.

> Well with the arthritis, I've certainly slowed down quite a bit. I guess the retirement was good in that I'd have more time to do the things around here that I absolutely have to do. But I miss how you'd get to work, and the day would absolutely whiz by. So at first, it was really boring. It was the boredom that got to me, and then you get used to it. You settle into a routine (Kate, age 67).
>
> I think the way it has most affected my general routine is that I have a great deal of difficulty now keeping myself on any kind of schedule. I went through a period of quite intense pain which upset my whole sleep pattern and it has never come back to normal so I'm up a couple times during the night, and then I might need to sleep during the day. I used to have a job where I was up at a certain time and that sort of thing so I don't have that kind of regimentation in my life anymore (Beatrice, age 69).

Interestingly, although these individuals have been retired for several years, and their peers are certainly retired as well, some women continue to experience some of the losses incurred by forced, early retirement. For instance, early retirement may contribute to having a very limited income in later life. Such persons are limited in their participation in social activities in the present, because of the financial costs of these pursuits. At times, others miss the gratification and rewards of their previous occupations.

While forced early retirement presents a break in one's biography, a source of change, individuals attempt to resume their daily lives. However, OA may seriously hamper enjoyment of retirement. On the one hand, retirement facilitates the management of chronic illnesses by allowing flexible time schedules. On the other hand, many individuals are unable to enjoy their later years to the extent that they had hoped to. Individuals say that they had always hoped to travel, engage in leisure activities, social interactions, and other enjoyable pursuits. Unfortunately, enjoyment of these activities is often affected by arthritis.

This section demonstrates that employed identities are implicated in experiences of OA in a variety of ways. Some people welcomed the opportunity to relinquish their occupations and these changes were preferred. Others were not pleased with the loss of this identity and the related changes were unwanted.

5. Other Relational Associations

5.1 Friendship Identities:

Friendships play a variety of roles in the lives of older persons. Various studies have documented that social support buffers the stresses associated with declines in mental and physical health. Social support also helps individuals to adapt to physical illness (Crohan and Antonucci 1989). Aside from the valuable functions that are facilitated through friendships, the concept of "populated biographies" illustrates how friendships are integral to personal identities. As people pass through their lives, they develop various relationships and interactions. These experiences form the personal histories of each person. Such experiences, which are often mediated through relationships, are said to form the "populated biography" of each person (Matthews 1986, 120-121). The concept of "populated biographies" shows how friends play an important role in the development of the self-concept.

How then, are friendship identities influenced with the onset of chronic illness? The literature shows that illnesses affect friendships in a variety of ways. Matthews (1986) reports that friendships in later life are indeed shaped by declines in mental and physical health. Opportunities to interact with friends, and even the ability to communicate are often affected by such changes (115-117). However, Allan and Adams (1989) cite previous studies which have shown that illness or disability provide opportunities to maintain or cultivate friendships.

The data from this study provide support for the findings outlined above. It will be shown that life stage factors interact to shape friendships in conjunction with OA. Moreover, it will become evident that friendships are modified, preserved, and lost throughout experiences of living with chronic illness. In some cases, new friendships are also formed. Several processes of continuity and change are also mediated through friendship identities and interactions. Such processes include social comparison and reflected appraisal. (This will be discussed in more detail in a later chapter). Most significantly, the findings show that friendships present the opportunity to affirm other valued components of the self-concept.

Generally, the data show that if friendships are influenced by OA, this is often the result of impaired mobility. For many of the women, it became increasingly difficult, if not impossible, to visit friends and to engage in meaningful, face-to-face interaction. Participation in seniors' clubs, church groups, and outings with friends to shopping malls or shows also became more difficult. In these ways, the women's social networks were often affected. Impaired mobility and illness meant that some of the women were confined to their own living quarters, with limited opportunities to maintain their networks. Social networks are often shaped by the extent to which the individual is able to venture out of her personal living space into the social worlds of others, and the extent to which the individual is willing and able to invite others into her own living space. In some cases, individuals were forced to become more dependent on the efforts of significant others to maintain the network, for example, in the ability and willingness of friends to visit. However, because of various later life factors, the friends of a chronically ill person were often limited in their own mobility. Many suffered from their own physical or mental health problems. Some were unable to drive, or had no access to other modes of transportation. In many cases, female friends were busy caring for ailing husbands, and did not have the time nor the energy to visit a woman friend with OA. Friendship networks also become fragile in later life as friends were lost through deaths. Hence, opportunities for social interaction were often limited by OA in combination with other life stage factors:

> The DARTS used to come, and I used to call them and go visit a friend. But they've cut social visits. That's a shame, because lots of people need a little outing. So I can't get out much. I could phone somebody, and say I'd come with DARTS to visit them but now I can't. Even if I didn't go, I'd feel I could go. But that's been curtailed now and it's not always convenient asking someone to come here when they've got their own health problems (Grace, age 75).

> See, my friends are widows and their husbands drove them everywhere. So they don't drive. See, I used to drive over and visit them, because I was the only one who could drive. Now, I don't trust myself to drive with the eyes and the arthritis. So it's curtailed my social life quite a bit (Helen, age 77).

In most of these cases, patterns of interaction are **modified.** Friendships are maintained through telephone contact, or patterns of interaction are re-negotiated. For example, friends who are mobile may volunteer to visit the chronically disabled person in her home. Alternatively, individuals who are not completely homebound may negotiate drives:

> I am very independent and I find it very difficult asking others for a drive. Once there was a social at the church, and I asked Violet to drive me. I find it very difficult to ask anybody. So what happens is, if it's a day time thing and I feel I can drive, then I phone her and ask if I could pick her up. That way I won't feel bad asking her to pick me up all the time (Maeve, age 78).

Friendship interactions can also be modified, both consciously and unconsciously, in order to provide a sense of continuity. For example, many of the women commented that they did not like to dwell on their chronic illness while socializing with friends.

While some women confided in friends, this did not constitute a large part of their interaction:

> I get enough thinking about and dealing with the arthritis on my own that the last thing I want to do is talk about it to my friends. When I'm with my friends, I'd rather talk about something else, to get my mind off it. There's more important things I'd rather talk about anyway. Besides, who wants to hear a person belly-aching about their own problems? Everybody's got their own cross to bear (Laverne, age 79).

Many older persons also believe that health problems are a common part of aging experiences. Hence, a group of friends will make a conscious effort not to dwell upon health issues, and interactions are modified accordingly:

> Well we're all in that age group now, and we all have things happening now. Like we talk about who passed away, so you're going to get death and health problems. So the big topic is who has died, or who is in the hospital. But we don't talk about it for long. Like we only have two hours together, and we're not going to spend it all on that. We catch ourselves. We're all in the same frame of mind like that. Like somebody will start saying something, and then it's, oh, enough about that. Let's play cards and have a laugh! (Grace, age 75).

Most interesting, the data show that in some cases, friendships provide a sense of continuity. Often, other important components of the self-concept are affirmed in friendships and this diverts the imposition of the disabled identity component. In particular, life-long friendships often affirm the biographical self. While shared, past experiences are not always the focus of these interactions, they do provide a thread of continuity. Older friends remember the disabled person's previous identities and are able to affirm the person's biographical self. In this way, the disabled self, which may be very prominent in the present, is placed in its proper context, and does not become primary in defining the person. In this sense, older persons are advantaged in having longer pasts to draw upon.

In contrast, some individuals become so immersed in their illness experiences that their social interactions are changed significantly. One woman became so dissatisfied with her present self, that she stopped making any effort to socialize with the other women in her apartment building. She did not have any desire to interact with people who had not known her past self. This woman believed that her present self was not worth affirming:

> The ladies in the building. One of them comes up to see me. We have nothing in common to talk about because I haven't been intimate with them. Like with Doris, that's different. We talk about old times. We've been traveling together. And it's different things we've done together. But with these people here, there's nothing in common with them. I don't know their life, and they don't know my life. So you just don't bother. What's there to talk about anyway? I haven't gone out. I haven't done anything. It's the same thing everyday (Audrey, age 83).

Audrey only made efforts to maintain her long-term friendships. Audrey was also separated from her old friends by distance, and one close friend was severely confined in her home for health reasons of her own. As a result, Audrey was very aware of the changes in her personal life. Another woman was so overwhelmed by her chronic illness that her friendships suffered greatly. She said:

> Lots of times I just sit here and think, where is the people? I used to have company all the time, but it's not the same anymore. I'm lucky if I get a call. At first, they used to call, and they'd ask how I was. But I'd have the same old story all the time. I guess they got tired about hearing about it. But what can I talk about? If you haven't been anywhere, what have you got to talk about? I've got nothing to talk about. I've been nowhere (Bernice, age 72).

One woman commented that she had drifted away from the friends she had prior to the onset of her OA. Gradually, as she became more confined to her home, her friendships dwindled since she was unable to participate in their social activities. As her friends continued on with their lives, this woman became more and more involved in her personal experiences of living with a chronic illness and her friends gradually lost contact with her. Hence, this example illustrates that friendships can also be lost. These experiences often present sources of great change.

Finally, some women report that new friendships are formed. These women find meaningful friendships at support groups, and at exercise classes. Home visits by volunteers also serve as meaningful sources of interaction. Interestingly, these friendships illustrate that while changes are experienced with the onset of a chronic illness, these changes can lead to the cultivation of new friendships.

SUMMARY

This chapter explored the ways in which patterns of continuity and change are revealed in components of the extant self. Two general conceptions of continuity and change were introduced and this study provided support for both patterns. The findings reveal that OA has the potential to produce significant changes in one's identities. Sometimes, identities are not influenced at all and continuity is preserved. Individuals are also able to incorporate experiences of change in order to preserve their perceptions of continuity.

Previous research has examined the influence of chronic illness and disability on the relationships and daily activities of people. However, this study provides an alternative conception by identifying the processes involved in patterns of continuity and change. In order to identify these patterns of continuity and change, five general indicators were uncovered. It was demonstrated that identities may be challenged, enhanced, become inactive or lost, remain unaffected by OA, or modified. Moreover, these patterns were identified in the data by exploring the ways in which role performances, role requirements, and role interactions were influenced by OA. Taken together, it was shown that experiences of OA do have the potential to change valued identities in that identities may be challenged, become inactive and lost, or become enhanced. Hence, changes may be viewed to be disruptive in the person's life, or they may be viewed as a catalyst for positive changes. Interestingly, it was also demonstrated that, sometimes, patterns of continuity are not desired by individuals. This conception of continuity and change illustrated the stability versus change pattern.

It was also shown that changes are often necessary for the preservation of continuity. The women modified their role performances, role requirements, and role interactions in such a way to fit their personal expectations and biographies. Such adjustments served the purpose of preserving perceptions of continuity. This conception of continuity and change illustrated the continuity pattern.

But most important, these patterns and indicators emerged from the examination of specific identities. Kinship identities, marital status identities, unpaid labour and domestic identities, paid labour identities, and identities located in other relational associations were explored. In addition to uncovering an alternative conception for understanding patterns of continuity and change, this examination both supports and contributes to the literature in several ways. A review of the significant findings will be presented next.

With respect to kinship identities, it was noted that the impact of chronic illness on family relationships in later life has been well researched by other authors. Issues related to dependency, role reversal, shifts in the balance of reciprocal exchanges, and power/conflict struggles between older parents and their adult children have been investigated by other authors (Dwyer 1995; Suitor et al., 1995; Brody 1990; Brubaker et al., 1990; Cicirelli 1990; Fischer 1985). While the data from this study shows that the grandmother identity was not significantly affected by OA, the mother identity presented interesting findings. The findings contribute to the literature by documenting the perspectives of the mothers themselves. This chapter also described the strategies employed by older mothers as they attempted to negotiate the changes introduced by OA. But most important, the data from this study contributes to the literature by demonstrating the variety of experiences of motherhood in later life, and the numerous ways in which this identity is modified, negotiated, and preserved in experiences of chronic illness. Hence, a variety of mother types were presented.

With respect to the wife identity, it was noted that previous studies have assessed the stresses experienced by the spouse who acts as the caregiver, and issues related to imbalanced reciprocity (Cutrona 1996; Corbin and Strauss 1988). In her study of social support in couples, Cutrona (1996) concludes that further research needs to address the ways in which the history of relationships shape levels of social support. This chapter demonstrated that perceptions of continuity and change greatly depended upon the biography of the marital relationship.

The data also showed that the widow identity, in relation to experiences of living with OA were not uniform. Some women became widowed several years before the onset of OA and this identity was not influenced by OA. Others revealed the challenges of adjusting to changed role requirements, performances, and interactions. However, some of these individuals had learned to adapt to these changes in order to restore perceptions of continuity.

The experiences of the women who acted as caregivers demonstrated that life stage factors must be considered. Since health problems are more common in old age, it was not surprising that many of the older wives acted as caregivers for their husbands, while simultaneously contending with their own chronic illness. The challenges associated with this role were documented.

With respect to the homemaker identity, it was noted that several studies leave some questions unanswered. Belgrave (1990) and McGraw (1991) found that the woman's ability to perform household duties and to maintain her home independently was positively related to her self-concept. However, these authors did not uncover those processes of adjustment that enabled the women to continue their role performances. Mac Rae (1990) found that the homemaker identity provided an important source of continuity in the self-concepts of the women she interviewed. While Mac Rae emphasized the importance of this role for providing a source of continuity, she did not address the ways in the inability to engage in this role (due to health problems for example) would influence perceptions of continuity.

While some of the data from this study provide support for the literature, it was noted that the findings also contribute to the literature by showing more varied results. More specifically, the data demonstrated that OA influenced homemakers in a variety of ways and that these changes or adjustments were perceived differently. Interestingly, this study showed that some women did not view the loss of this identity as a threat. Indeed, some women relinquished this role gladly. Finally, the ways in which the homemaker identity was challenged was also demonstrated. Most important, those strategies that were used to preserve this identity was also uncovered.

The past, employed identity also demonstrated a variety of experiences. Some individuals welcomed the relinquishment of their occupations and these changes were preferred. Others were not pleased with the loss of this identity and the related changes were unwanted.

Finally, the examination of the friendship identity revealed many patterns of continuity and change. In general, it was demonstrated that the findings provide support for the literature. Matthews (1986) reports that friendships in later life are indeed shaped by declines in mental and physical health. The author reports that opportunities to interact with friends, and even the ability to communicate was often affected by such changes. This chapter presented similar findings. However, it was also shown that patterns of interaction were often modified in order to preserve friendships. Friends also provided a source of continuity. In particular, older friends were important in affirming other valued components of the self. In this way, the disabled self was diverted.

Perhaps one conclusion is most revealing. Many previous studies have not assessed the impact of chronic illness on the **totality** of identities and statuses occupied by one person. Most studies focus on a single identity. For example, a study may focus exclusively on the mother identity and the dynamics of parent-child relations in later life. This approach is useful because it allows the researcher to examine the topic in greater detail. However, by focusing on the impact of illness or disability on a single identity, the reader is provided with only one aspect of the subject's self-concept. Such approaches do not appreciate the fact that a single person occupies several social positions. While some of his/her identities may be influenced by an illness, the other identities may remain unaffected. Hence, one person will often demonstrate a variety of patterns of continuity and change depending upon which identity is under examination.

The next chapter will recognize that each individual may experience several patterns of continuity and change. Accordingly, a more global conceptualization of the self-concept will be adopted in order to explore the connections between the multiple identities of each person. In doing so, the ways in which a person's various identities interact in producing an overall, or general impression of continuity or change will be assessed.

CHAPTER 4

INTERACTION BETWEEN COMPONENTS OF SELF: HIERARCHIES OF IDENTITY

INTRODUCTION

In the previous chapter, the significance of OA for the development of discrete identity components was examined. This chapter builds upon the findings of the previous one by assessing the ways in which components of the self-concept interact. The data reveal that the self-concept may be conceptualized in terms of what Rosenberg calls "the global structure of identities" (1979, 18). Hence, in addition to conceptualizing the self-concept at a more specific level, that is, by breaking down the various identities of a person, and assessing each identity as a separate, single, or discrete identity (as demonstrated in Ch. 3), the experiences of the respondents suggest that the multiple identities occupied by an individual must be considered as well. An examination of the global self, will serve to expand our assessment of the self-concept. In short, the global self represents an additional conceptualization of the self from which to analyze processes of continuity and change.

The data reveal that the global self is indeed implicated in processes mediating patterns continuity and change. Hence, the ways in which the interaction between a person's identities influences perceptions of continuity and change must be analyzed. OA may influence only one component of a person's self-concept, or it may influence several of them. The identity which has been affected may be important to the person, or it may be peripheral. These factors will contribute to the way the person experiences either continuity or change in her self-concept and gives more reason to assess the relationships between a person's identities.

Interestingly, studies pertaining to chronic illness and identity have not addressed these issues adequately. Charmaz (1991, 1987, 1983), and Corbin and Strauss (1987) do not focus on the ways in which a change in one component of the self-concept is related to the person's other identities, or to the person's global self-concept.

The chronic illness and aging literature also falls short in this respect. For example, Roberto and McGraw (1991), Eisenhandler (1992), Blackwell and Levy (1987), and Belgrave (1990) provide general and abstract conceptualizations of the self-concept, and they do not examine the ways in which specific identities, and the related role performances are affected by chronic illness. Neither do they assess how it is that the person's overall sense of self is changed or preserved.

This chapter will contribute to the literature by suggesting the ways in which each component of the self interacts with each other and how these dynamics shape patterns of continuity and change in the self-concept. It will be demonstrated that the global self-concept is indeed implicated in the negotiation of the disabled self, in the person's perception of the intrusiveness of the OA, and in the ways in which continuity and change are affected. In order to assess the global self-concept, the *hierarchical* organization of the self-concept will be examined. The processes that are involved in shaping the hierarchical organization of a person's self-concept will be examined in relation to the ways patterns of continuity and change are mediated.

Hierarchies of Identity:

When describing the organization of components of the self, symbolic interactionists often speak of the hierarchical organization of the self-concept. Rosenberg (1979, 1986) builds on this idea in his conception of *psychological centrality*. Other identity theorists refer to the hierarchical organization of the self in terms of *prominence hierarchies* (McCall and Simmons 1966, 1978), and *identity salience* (Stryker 1968). While these theorists agree that the components of the self are arranged in a hierarchical structure, there are subtle differences between the various approaches. These distinctions must be clarified in order to present the findings of this study.

According to Rosenberg's conception of psychological centrality, components of the self vary in the extent to which they are central or peripheral to the self. Some components are favoured over others, and the more significant ones may contribute to a greater sense of integration and consistency. One's assessment of self is based on those components of the self that are more valued, that is, those qualities "that count" (1979, 18). Hence, Rosenberg contends that processes of continuity and change are shaped by the extent to which certain identity components are central or peripheral to the individual (1979, 76).

McCall and Simmons conceive of two basic hierarchies of identities. In the hierarchy of prominence, identities are located in relation to each other according to the amount of self support and social support that is received for the particular identity, the degree of commitment to and investment in the identity, and the intrinsic and extrinsic gratification derived from the identity (Stryker and Serpe 1994, 17). Each identity component differs in its relative importance to the person, and is ranked accordingly. The hierarchy of salience is the second model that is presented. This refers to the situational self, and accounts for immediate, short-term, situational behavior. "Other factors, closely linked to the person's short-run life situation, very often cause less prominent role-identities to become temporarily quite salient in the person's actions" (McCall and Simmons 1966, 87). Hence, hierarchies of prominence reflect long-term, enduring, and stable hierarchical arrangements of one's identities (McCall and Simmons 1966, 85-87).

In contrast, Stryker's conception of identity salience is defined as:

> a readiness to act out an identity as a consequence of the identity's properties as a cognitive structure or schema. **Various identities thus are organized by the probability of their being invoked in a given situation or in a series of situations...**the relative salience of identities is a function of commitment to the roles to which the identities are attached (Stryker and Serpe 1994, 17 emphasis added).

Significantly, Stryker's conception of salience differs slightly from the conceptualizations presented by the other theorists. Unlike Stryker's formulation of identity salience, the principles formulated by Rosenberg, McCall and Simmons, (that is, psychological centrality, and prominence) refer to the ranking of identities in order of importance. The principles put forward by Rosenberg, and by McCall and Simmons are similar, because they highlight the "self-attributed importance of elements of self as the central character of the organization of the self" (Stryker and Serpe 1994, 17). An identity is elevated in the hierarchy, or becomes more central, in direct relation to the individual's positive response to the identity (Stryker and Serpe 1994, 17). While the principles put forward by Rosenberg, and by McCall and Simmons focus on the individual's perception of what is important or preferred for the self-concept, Stryker's conception of salience does not assume that the individual must be aware of the salience of his/her identities.[1] Nevertheless, these concepts are often used interchangeably in the literature and this has resulted in much theoretical and empirical confusion (Stryker and Serpe 1994, 19).

These distinctions are important in framing the findings of this particular study. More specifically, the subjective experiences and perceptions of living with chronic illness were highlighted in this study. Accordingly, the significance of continuity and change

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[1] These differences are very subtle and Stryker acknowledges that behavioral choice and levels of commitment may be influenced by the centrality of the identities. Hence, the relationship between the centrality or prominence of an identity and the probability that the identity will be invoked in a situation or across situations is a complex theoretical issue that has not been adequately addressed by identity theorists thus far (Stryker and Serpe 1994).

was examined with respect to the importance attributed to components of the self by the individual herself. Hence, a **general** conceptualization of the principles formulated by McCall and Simmons and Rosenberg is suitable. A basic formulation of these principles will be adopted since the parameters of this study limited the opportunity to measure, quantitatively, the actual *amount* of support received for the identity, the *degree* of commitment and investment in the identity, and the intrinsic and extrinsic gratification derived from the identity. Nevertheless, the basic principle of prominence hierarchies, that each component of identity differs in its relative importance to the person and is ranked accordingly, and Rosenberg's contention of psychological centrality, in which some components are favoured more than others, the more significant ones contributing to a greater sense of integration and consistency, is relevant to this analysis. The pioneering work of McCall and Simmons establishes, for many identity theorists, the factors that are involved in determining the importance of identities. Rosenberg's work establishes the significance of psychological centrality. Hence, this chapter will *not* focus on the factors that are involved in *determining* the prominence of an identity, as delineated by McCall and Simmons. (That is, the amount of support and degree of commitment and investment). Instead, individuals were simply asked to state which identities they believed were important to them. However, this chapter will extend these principles by examining what actually happens when valued identities are influenced by chronic illness. In addition, this chapter will suggest other processes that may be involved in shaping the prominence of an identity.

This section will answer the following questions: What processes of continuity and change are evident when prominent and central components of the self-concept are influenced by OA? What happens when experiences of chronic illness threaten the hierarchy of identities? Our findings reveal two general prominence hierarchies. In the first model, identities within the hierarchy retain their relative order of prominence. This is called the *non-shifting hierarchy of identities*. In the second model, identities are re-arranged and shifted in their order of prominence. This is called the *shifting hierarchy of identities*. Both models illustrate the processes by which continuity and change are negotiated.

Before proceeding, a few definitions must be established. A *prominent identity* will be defined as an identity that is preferred, and that is important to the individual. In relation, a *peripheral identity* component will be defined as one which is perceived by the individual to be insignificant and less important. Next, identity components can be *active* or *inactive*. An identity is active when the individual's ability to perform and engage in these roles is not limited by OA. Identity components are inactive when the individual is unable to perform these roles because of the limitations imposed by OA. It is important to note that identities may remain important to the individual, even though the person's ability to engage in these identities are significantly limited. Hence, identity components can be prominent-active, prominent-inactive, peripheral-active, and peripheral-inactive.

In order to assess the centrality of identity components, as well as whether these components are active, or inactive, individuals were asked to list their identity roles in order of importance and/or preference. The individuals were also asked to explain the various ways in which prominent identities had been influenced by OA, that is, the ways in which role performances and opportunities for role enactment had been compromised by OA. (See Appendix 1 for the List of Guiding Questions, #10-12). The three patterns do in fact exhibit non-shifting hierarchies, in addition to two patterns of shifting hierarchies.

NON-SHIFTING HIERARCHIES OF IDENTITY

In this model, identities within a hierarchy retain their order of importance. Those identities that are more valued and more central to the person's sense of self are located higher in the hierarchy. The findings reveal three general processes. These processes show how identity components undergo continuity and *change.* However, the overall hierarchy remains stable.

1.1 Continuity: Identity components remain in the same order of prominence and only peripheral, less central components of self become inactive or limited:

This pattern is more typical of people with mild cases of OA. The arthritis has not significantly altered the individual's lifestyle. Identities and role performances are not influenced by OA, and the individual's perception of continuity has not been disrupted by experiences of living with a chronic illness. This type of continuity reflects the "stability versus change" pattern, as discussed in the previous chapter. Put simply, this type of continuity reflects the absence of change. Important changes have not been wrought by OA.

For example, Lily reported that her social life, her friendships, and her relationships with her family had not been altered by her experiences of living with OA. She had relinquished her homemaking duties, but this role was not important to her and she did not perceive this change as a loss. Rather, her goal of reserving her energy for more valued activities, such as visiting her daughter, was more important to her:

> I'm eighty, and at this stage you have to be careful about your body. I'm careful not to do more than I should. Why should I strain myself? I figure, if a box is too heavy, or if it's too hard to do my laundry, why shouldn't I get my homemaker to do it? It's not that important anyway (Lily, age 80).

In general, Lily stated that OA did not limit her activities. She noted that she did have to take some precautions and take into account that her hips would become stiff if she overexerted herself. However, these precautions were not intrusive.

1.2 Continuity and Change: Central, active components are influenced by chronic illness. Some components are adjusted and retained in their order of prominence and activeness. Other components are not modified or adjusted and they may become inactive. There is a sense of change since these inactive components are still important and prominent to the individual. However, those components that have been modified and preserved may serve to buffer the sense of loss or change.

As was shown in the previous chapter, identities are often modified in order to help with adjustment to the challenges of living with OA. Often, central components of the self are implicated and the individual's capacity to perform these roles are constrained. As a result, role requirements, role performances, interactions and standards of evaluation are modified by self and others. These changes preserve the identity component in terms of its activeness and prominence. The experiences of some individuals illustrate that it is not always possible to adjust or negotiate all of the components that have been influenced by OA. Rather, some of the central components are preserved, while others become inactive. Nevertheless, the prominence hierarchy remains because these inactive components are still important to the individual. In this sense, individuals are aware of the changes. However, the overall perception of continuity is maintained because other identity components have been successfully preserved. Continuity is also facilitated because the identities which have been preserved are more central to the person. (These points will be clarified with examples in the next pages). This pattern of continuity reflects the second conception of continuity and change that was adopted for this study. That is, modifications, or adjustments are made in order to accommodate to the changes introduced by OA.

What evidence is there that identities are modified or adjusted? First, the individual states that certain role requirements, that is, the duties, expectations, or obligations associated with a certain role have been changed. Next, the person indicates that role performances have also been altered. The woman may allow herself more time to complete tasks, or she may require the assistance of others when engaging in a performance. Third, the woman's standards of evaluation when assessing her own performances are modified as well. The woman indicates that she has changed her expectations of herself. Her criteria for deeming an act to be successful may change, and she may adjust her levels of personal satisfaction by taking her limitations into account. Finally, interactions with others may also be adjusted. The person will indicate that she has made adjustments when performing in front of others. (For example, she may engage in concealment or in efforts to normalize her condition). Or, the woman will reveal the way in which significant others have supported (or failed to support) her changed abilities, or whether others have adjusted their expectations as well. This is a general overview of the ways in which roles are modified in order to preserve the identities. These processes will be discussed in more detail in the next chapter as well.

Some individuals are able to negotiate these processes for those identities that are most important to them. In doing so, the extensiveness of the impaired, physical self-concept is limited and prominent identities are preserved. Several women remarked that the mother identity, the homemaker identity, and friendship identities were most important to them. Friendships and relationships with children were major sources of social support. In the efforts to maintain and affirm the gratification received through these relations, identities were modified in a variety of ways and their prominence and activeness were preserved. For example, Marion revered her mother identity. Fondly, she recalled pleasant memories of her past motherhood identity and it was evident that she took great pride in her role. Family relationships continued to play a significant role in her present life. Accordingly, Marion successfully negotiated a preferred, independent mother identity, and her positive and affirming relationships with her adult children provided a great source of comfort despite her limited mobility:

> I think my family has a lot to do with me coping with the arthritis. Family is most important. I don't ever feel sorry for myself and I think that's where my children come in, because they're caring. Each and every one of them. They either come down and visit, or they phone... It means a lot to me, but I never make a nuisance of myself. I try not to. If it wasn't for my family, because they help me a lot. So little things I let them do for me, and that makes me feel good. But other things, I try not to give them because I think they're getting on, and they have their families. So you have to think about them too (Marion, age 79).

Evidently, this identity received much support through these mutually affirming relations, and this facilitated its preservation. Marion had also moved into a seniors' building and her new living space was more suitable for her limited homemaking abilities. Marion adjusted her role requirements as a homemaker, and also changed the way she evaluated her performances:

> I had the home, and it was a large home with five bedrooms. I didn't need that, because I was alone. And I don't expect my children to come once a week to clean my place. Here, I'm on a floor, I have a large apartment, and I have a place to move around...I always, from day one, I liked to be tidy and do the best I can. I might not get everything done in one day, but I have the time. As long as I can't write my name in the dust on my table, I'm happy. Here, it's manageable. So I figure that moving into an apartment, where I'm able to go out for a walk or get a bottle of milk, that satisfies me (Marion, age 79).

In addition, the seniors' building provided her with opportunities for social interaction. This was especially important since she was often confined to her apartment. New friendships were forged, and this was especially beneficial during those times when she was unable to socialize with her life-long friends. Her enriched social network also served to divert the later life, peripheral mother identity. Hence, although Marion derived much emotional support from her family, she was also able to preserve her independence by maintaining her own social life:

> I am involved with my children, because they tell me things and they call all the time. But I try and stay away from them. I don't want to mix in their lives too much, because for an older person like I, I'm from the old school and we'd have different ways of living. It's just a different generation. That's why I like living here. If I ever get worse, I'd never want to live with my children. Here, I walk down the halls, I walk downstairs to meet people, to talk to people and that helps a lot. We have a euchre club here, and a few of us get together and rent videos and we watch that together. I fully agree with that, talking to people Because when I walk down here and downstairs, people come in and out. Some are probably in the same position and that helps (Marion, age 79).

Taken together, these primary identities were adjusted to accommodate the challenges of living with OA. In this way, the disabled identity was diverted and the perception of continuity was maintained.

The previous example illustrated the ways in which identities were adjusted and modified for their preservation. However, it is evident that it is not always possible to preserve all of one's valued identities. Rather, some of the central components are preserved, while others become inactive. The prominence hierarchy remains because these inactive components are still important to the individual. The individual is aware of the changes. Interestingly, the person's perception of continuity is maintained, because other identity components have been successfully modified and preserved. These preserved identities maintain the overall sense of continuity.

For example, Helen had always been socially active. She described herself as an independent, outgoing person. She had always had a car and had driven herself whenever and wherever she wanted to go. However, with the progression of OA, Helen no longer trusted her reflexes and she had given up her license the year before. More and more, Helen found herself confined to her home, and at times, it was difficult for her not to feel frustrated and angry. To her dismay, her inability to walk any great distance prevented her from performing simple, everyday tasks, such as going to the bank, which was located just one block away. Consequently, she was forced to depend on her daughters to drive her places. In addition, her social life was restricted and many of her valued identities were significantly limited:

> What I'm most frustrated in my life is the lack of transportation to go anywhere to do the things I want. I can't drive anymore, and that is the biggest thing. And I find asking my family is really, really, I don't like doing it and I find I have to do it all the time. So it affects me that way. For instance, I would like to visit friends whom I haven't seen, who are in the same predicament that I am in. I'm elderly, and my friends are in my age group. So I find it has affected my social life. I used to play cards, and holding the cards and shuffling, I can't do that, because of my hands. So it's embarrassing. So I don't do that as frequently, because of the transportation. My sister is also in a retirement home, and she's in the early stages of Alzheimer's. Well, I would like to visit her once a week. And I really can't, because of transportation. So that's something I resent (Helen, age 77).

This excerpt shows that the opportunities to engage in these identities in order to maintain these identities were limited. As such, Helen was acutely aware of her disabilities and the changes in her lifestyle were perceived. However, these changes were mediated by her ability preserve her other identities. For instance, she was often responsible for looking after her grandson. In addition, her homemaker identity was still prominent and active. Even though some of these role performances were constrained by her OA, Helen managed to adjust and to preserve the prominence and activeness of these identities. For example, she allotted more time to certain household tasks. In some cases, she enlisted the help of her husband. In addition, Helen managed to de-emphasize her limited capacities by stressing the continuity of her past, work styles:

> I'll never get caught up with all the work I have to do. I am slower, and there are certain things I can't do. But really, I'm attempting to do far more than I'm

> able to do. I never want to be able to get everything done that I want to do. I hope my reach always exceeds. Because I think that makes life worth living. It's always been like that for me (Helen, age 77).

More important, her relational "otherness" with the most significant people in her life had been preserved:

> If I did not have my grandson and my daughter living with me, with whom I have many, many problems. But, if I didn't have them living with me, what kind of a life would I be living without their company? It has its drawbacks, but being confined more, it's a good thing too (Helen, age 77).

In this way, family identities and relationships buffered the full impact of other major losses. Those identities that had been preserved helped in mediating the perceived changes in other prominent ones.

1.3 Continuity and Change: Prominent components are influenced by chronic illness and most identity components become inactive or significantly limited. There are 2 possible outcomes:

a) Continuity: The changes in individual components are perceived. However, the prominence hierarchy remains and many of these inactive components are still valued. In essence, the person feels the same overall, but is said to be in "retirement". This is facilitated by the process of biographical continuity.

This pattern highlights the significance of age and life stage factors. Various components of the self, which have been acquired over the course of one's life become limited or inactive in the present due to chronic illness. This often occurs in combination with other losses associated with later life, such as widowhood, retirement, or the loss of friends. Nevertheless, the individual continues to derive satisfaction from her past commitments to role identity performances and interactions. As a result, present losses or changes in the self-concept are mediated by the biographical self. This is not to suggest that the negotiation of these changes is not difficult for these persons. Limitations and lost abilities are perceived. However, the woman manages to preserve her overall, global sense of self. This pattern of continuity reflects the second type of continuity delineated in the previous chapter. That is, changes are incorporated into the individual's biography in order to maintain perceptions of continuity. In this case, changes are incorporated through the process of biographical continuity.

An individual who exhibits the process of biographical continuity tends to have the following characteristics. First, the individual states that she is satisfied with her past, identity performances. Second, she continues to derive some sense of satisfaction from these past performances. Third, the person states that she was able to fulfill most of her valued identities when she had the chance. There is no sense of missed opportunities. Finally, the person states that she has come to terms with the changes or losses in her present self. This is facilitated by her belief that these kinds of changes are to be expected in later life.

One woman noted the changes in her prominent identities. Her living space had shrunken appreciably, and she experienced little gratification of her social self. Maeve was becoming ever more confined to her home, and it became increasingly difficult for her to attend club meetings and social gatherings. Moreover, she had always been an active member of her church, and her participation in this group had also declined. Her homemaker identity, which had always been important to her self-concept, was severely curtailed by the OA. In addition, many of her life-long friends had passed away, or they were similarly confined to their own homes because of various health conditions. Finally, her widow identity also presented a significant source of change as she was still in the process of adjusting to this new identity. Many of her prominent identities had been profoundly influenced by OA and by other losses. Despite these changes, Maeve was able to negotiate these losses by drawing upon her sense of biographical continuity and her acceptance of life stage transitions:

> Well, this is all part of life. You're just at the beginning. I'm at the end. I've done those things. I've gone through those stages. I did volunteer work when

> I was able to, I worked when I was able to. So I've done the whole gauntlet...Life's a progressive thing. So I feel, I've had a full life. I did those things when I was able to. I can honestly think back and say I've had the active years, and now I'm slowing down. And it's a part of life. This is what I have to expect. If I'm going to live a little longer, I'm going to have to expect a little more of this, I would think (Maeve, age 78).

Maeve's experience illustrates the significance of chronic illness in later life, and the various ways in which some older individuals may draw upon their biographies in order to keep their sense of continuity intact. Interestingly, this woman drew upon her age group identification, yet she did not adopt a personal aged identity. She still continued to derive satisfaction from her past identity performances. Her pleasure in the successful lives of her children, and grandchildren also helped to preserve the prominence of this identity. In this way, Maeve's past commitments to role identities continued to generate gratification and rewards in the present. Interestingly, past identities, not directly influenced by OA, also served to buffer the losses experienced in the present.

April's experiences shows this quite clearly. This woman was no longer able to leave her apartment, because she was unable to walk any great distances. Her fear of falling kept her confined to her home. April could no longer attend her church and her social clubs. When asked how she felt about the changes brought about by her chronic condition, it became clear that her sense of biographical continuity served to minimize the intrusiveness of her OA:

> I used to be always so active, but they said you gotta keep going. I have always tried to keep going. And up until last year, I could walk up-town with my walker and go to the market and back home. Now, it's more difficult and it sort of takes the staunch out of you. That's why I sort of feel, now when I say I'm ready to die, I don't mean to say that I'm fed up with the world, but I feel that I'm getting more tired out. I tell my kids, "When you see me the way the arthritis is, and my thumb, and my shoulder, and walking badly, and having to have that walker, I want you to be happy that right now I'm with dad and I'm out of pain." I've done all those things that I'm physically able to do when I was able to. It's kind of nice when things sort of dove-tail in, when you're through doing all those things, and then you get in a nice place where

> there's no obligations....See, I've had a very happy life and a contented life. That's why I don't feel a bit left out, because I can't go and do some of the things I used to do. Why feel bad? I know I've had a tremendously successful life. I had a wonderful marriage and a wonderful family (April, age 85).

April also continued to derive satisfaction from her past identity performances in the present. She emphasized the success of her children:

> I'm just so happy with my children. Mike is all a son could ever be. He was married before he was nineteen, and he was a millionaire at forty-three. He was so good to me and my husband, and he took us down to Florida and gave us spending money. He also threw a huge fiftieth wedding anniversary for us. And he hired an orchestra for us, and he paid for the whole thing. So really, there's nothing I'm concerned about. My family's perfect and they love me. I guess I just have so much to be thankful about. My son is a millionaire and nobody was ever better to their parents. So I can't bitch about anything, honestly (April, age 85).

While April was aware of the changes in her lifestyle over the past few years, she was able to accept her limitations by drawing upon her biographical self.

1.3b) Change: The change in the identity components are perceived. Role modifications are not made in order to facilitate changes, or it is not possible to do so, or role modifications are viewed unfavourably. Components become inactive or limited and these changes are viewed as a loss. These identities continue to be important to the individual and the prominence hierarchy remains. However, due to the chronic illness, these performances are constrained. Other identities fail to buffer these changes.

This pattern illustrates the significance of non-adaptive change, that is, the individual does not view changes to be beneficial. This type of change clearly reflects the "stability versus change" pattern. Changes are not incorporated to maintain continuity and the disruptions wrought by OA are experienced as breaks in one's biography. In some instances, role adjustments are made, but these modifications are viewed unfavourably. For example, one ever-single woman was forced to become more dependent on her siblings for help with the management of her home. Reluctantly, she had to rely on her brother for transportation and for help with various household tasks. In addition, her social life had been limited and she was unable to visit with her friends as frequently as she would have liked. These changes became sources of great anger and frustration, since her past role performances were preferred. In addition, Marge believed she should still be able to perform these activities, without having to experience the difficulties caused by OA. This was compounded by her bitter disappointments with the ineffective treatments she had received, which only served to complicate the management of her illness. Marge's experience demonstrates that, when individuals are displeased with their modified role performances and with their inability to meet past role requirements, the inability to engage in these valued role performances presents sources of unwanted change. This is especially true when these identities continue to be important to the individual:

> It's missing what you used to be able to do, because I still want to do them. I want to be able to go out with my friends, and take my nieces out...The housework is still mine to do, and I hate that I have to ask my brother to help me with things (Marge, age 70).

In addition, Marge insisted that she re-gain some of her past abilities. She hoped that her next operation would make this possible.

Some individuals are unable to engage in valued activities at all. For example, Emma's role identities were greatly impaired and her limited abilities became evident throughout the interview. For example, with regard to homemaking she said:

> There's a big difference, because before, you could go in a big house and do anything you want. I used to do big cleaning, I used to bake twice a week, and now I don't bake now at all. I don't cook none now, because my elbows, my wrists, my knuckles are so sore that I'm afraid I'll break my wrist. And I don't want that to happen. It's a lot of things I would like to make. Soups, you have to stand and stir it and I can't stand long enough over the stove...It just makes you feel useless (Emma, age 78).

With regard to her social life, she said:

> I used to go twice a week to play crib. I don't go to euchres no more and no more bingo. I never go because you have to sit for three hours and it's hard to sit for that long and then you have to get there and come back. It's just too much now...I am more lonely now than I was because before, I could go anytime, any place I want as long as I did my housework. But now I can't, so I don't see my friends as often. I used to drive a car and visit them because some of the are widows are they don't drive. So they can't come as often to see me (Emma, age 78).

These identities were central to Emma's sense of personhood. She perceived her limitations as major losses. Emma cried throughout the interview, and it was evident that she was grieving the loss of her role identities. She was unable to negotiate these unwanted changes for a few reasons. First, Emma was unable to adjust her expectations of herself. Nor could she accept alterations in her role requirements. Next, she was unable to find suitable activities to replace her lost ones. Her constant pain, coupled with the rapid declines in her physical capabilities, were more than she could cope with. Finally, her interactions with her significant others were strained because of her disabilities and this had become a source of stress as well. For example, Emma was extremely unhappy that she had been forced to enlist the help of her son in order to complete certain house chores. In addition, her husband was not supportive in helping her to adjust to her limitations. Her strained, marital interactions made her experiences of living with OA difficult. Emma did not find that it was possible for her to engage in the performance and negotiation of prominent identities in meaningful and fulfilling ways. She was also unable to draw upon life stage factors to negotiate these changes:

> You know, a lot of people think it's because of age. I don't think it's the age. I mean, you think when you are older you can't do as much. At my age, I know I can't do what I did at fifty or sixty, but still I was doing my cooking, my cleaning, my washing, my ironing, I was going out. Now, I can't do nothing, and the difference is just too much (Emma, age 78).

This example illustrates that individuals may become painfully aware of their limitations and their inability to engage in meaningful identities. These changes are especially pronounced when lost identities are still important to the individual. The prominence hierarchy remains, but the fact that many of these identities are inactive leads to a sense of loss. Hence, it is evident that the importance attributed to an identity is not necessarily dependent on the continued support and gratification, that is normally derived from its performance. Rather, the inability to engage in valued identities may only serve to highlight its importance.

Emma's experience may characterize those individuals with particularly severe forms of arthritis. With extreme disabilities, it is difficult to establish alternative activities and it is also more difficult to modify role performances in order to preserve them. However, having severe OA does not necessarily lead one to adopt the pattern displayed by Emma. Some women with severe disabilities were able to draw upon their sense of biographical continuity. Others were able to draw upon their friends and family to buffer them from these negative experiences. Hence, not all individuals who experience severe disabilities display this pattern. In some cases, this pattern is only temporary. Sometimes an individual will experience a deep sense of loss at the peak of her illness biography, just prior to receiving effective treatments. If the OA is successfully managed, this individual may re-gain, to a certain extent her past abilities. She may also learn to accept these modified identities and she may be able to replace lost identities with alternative ones, as the next section demonstrates.

SHIFTING HIERARCHIES OF IDENTITY

In this model, the prominence of identities are shifted in the hierarchy in order to facilitate processes of continuity and change. Two general patterns are revealed by the data.

2.1 Continuity: Prominent components are influenced by OA but the individual enacts other central (or peripheral) identities in order to compensate for the unwanted changes. These identities become more prominent and active.

As the next example will illustrate, hierarchies of identity are very fluid and individuals may choose to draw upon this feature in order to achieve a preferred sense of continuity. The data reveal that some individuals invoke other identities when central ones are threatened. Not only does this serve to buffer the sense of loss, but these other identities actually come to be more valued by the individual. In this way, the identities are shifted in the hierarchy so that the individual can maintain a preferred self-image. *Identities will be said to become more prominent when there is evidence of a new role that the individual finds to be particularly gratifying, or when previously less important roles become more active. In addition, the individual states that these identities have become more valued than in the past.* This pattern of continuity reflects the second type of continuity adopted in this thesis. Modifications have been made to restore perceptions of continuity.

For example, some of Maria's valued identities were threatened by OA. She was no longer able to run errands and complete her shopping independently. As a result, Maria had to depend on her son. Many household chores were also transferred to him. Valued activities, such as sewing and gardening, were also threatened. As the previous chapter illustrated, Maria modified her role performances and succeeded in preserving her threatened identities. In addition, Maria enacted a previously peripheral identity in order to divert the intrusiveness of her OA. Having devoted most of her time to her husband and her family, Maria did not have many friends. Her interactions with others, outside her family was peripheral:

> I never did belong to anything (social groups or clubs). All my life, my life was my husband. My husband. I worked on him, hand and foot. Then when we were young, we had all those children (Maria, age 83).

In her attempts to overcome her chronic condition, Maria started to visit her neighbours and she volunteered her time in order to help others in need. She also became a volunteer, "visiting friend". This was effective in diverting her attention from her disabled identity:

> When I lost my husband and I kept having those falls, six months in bed and I couldn't recover, finally I had to get out of bed...I knew I had to go out and do it, so I'd walk up and down the street and I didn't know anybody on the street, because although I'd been here seventeen years, we weren't outgoing people. I'd walk up here, and I started to do things for other people. I met an old, old lady who lived up here all by herself, and I understood she needed somebody in there. She was lonely, so I used to go up there. There's another lady down there now who's just took her bed. Really, that helped me coming out more than anything else. Helping other people, it does. You'd be surprised how much it takes you outside of yourself, when you see other people worse than yourself...It makes you forget what's wrong with you (Maria, age 83).

In this way, Maria engaged in a new activity and this helped her to deal with the limitations of OA, along with the changes presented by the loss of her husband. What was once a peripheral identity, (her relationships with her neighbours and her volunteer work identity) became more prominent. In addition, Maria's perception of continuity was maintained, because her reasons for engaging in these new activities were rooted in her religious identity. This identity had been established long ago, and provided a source of continuity. Hence, changes in her present life were adjusted and re-directed in order to allow her to maintain her sense of continuity.

2.2 Change: Prominent identities are influenced. Prominent role are lost and become inactive. Certain components lose their prominence. The individual loses her interest in most of her identities and the disabled component increases in prominence. Result- immersion in the illness identity, leading to a changed, general self-concept.

When role performances become constrained, the gratification of these identities are often unsatisfactory to the individual. The accounts of some women indicate that, when this occurs, the importance of these identities may decline. These women state that they have lost interest in engaging in these identities. This type of change reflects the "stability versus change" pattern. Clearly, adjustments fail to accommodate the changes introduced by OA. Audrey's story conveys this well. Her gradual loss of her sight, coupled with the progressive development of OA contributed to her life of confinement. Her efforts to maintain her social life were given up, and she no longer participated in the social activities of her building:

> I don't go out anymore. I don't plan anything. Like I used to go downstairs to play Bingo. Not that I care about Bingo, but it was just the idea of getting out and going downstairs. Like my daughter bought me the cards with the larger numbers on them, but I went down twice and I couldn't stand it, because when you're sitting there for two to three hours in one position my legs got really tired and I had to give that up. (Audrey, age 83).

This woman had also been an avid traveler, and at one time she regularly went on seniors' day trips. She could no longer take bus trips:

> Well, I was active. But I can't remember now. What did I do? I did a lot of traveling and later on I used to do day trips. That was important, but it's getting difficult, like to get on the bus and all that, it's too much (Audrey, age 83).

She was no longer able to attend the communal meals of her seniors' building:

> Every two weeks they have their lunches and Christmas dinners, but I don't eat downstairs. I feel embarrassed when you can't see food, what you're eating. It's kind of awkward, so I don't like to go down and eat. Tell you the truth, last Thursday they had stew, and it didn't interest me anyway (Audrey, age 83).

Audrey managed to accept the loss of these activities by adjusting her level of interest in them:

> This is my life. There's nothing to it. I'm here. This is my life. I sit here, or I get up and walk around, because if I sit too long it gets tiring. And I listen to the TV, the soaps and then I just leave it on. Sometimes I don't even pay attention to it. This is it. I mean, you can't do much. That's all I can do is accept it. I accept my life, whatever it is now. What am I going to do? Sometimes I think about wanting to do those things. But I know that I can't, so I don't. I don't think about it anymore. You lose interest, and you learn to accept it (Audrey, age 83).

In addition, many of Audrey's friends had passed away, and her one remaining friend was also impaired. It is clear that Audrey was not happy with her present life, and she had ceased to make any efforts to socialize with the other women in her building. Audrey no longer had any desire to affirm her present self. Instead, her past self was more desirable and it became evident that new friendships proved to be of little value for gratifying this component of self:

> These ladies in the building. One of them comes up to see me. We have nothing in common to talk about, because I haven't been intimate with them. Like with that Doris, that's different. We talk about old times, we've been traveling together, and it's different things we've done together. But with these people here, nothing in common with them. I don't know their life, and they don't know my life. So you just don't bother (Audrey, age 83).

Given these changes, Audrey relied on her relationships with her children. This woman adopted the vicarious mother identity and it represented one of the few identities that remained prominent. At the same time, Audrey feared that she would become a burden on them. Accordingly, Audrey also adopted the independent mother identity. Hence, most of her energies were expended on managing her chronic illness and on efforts to divert issues of dependence. Although this central identity was preserved in its prominence, it was not effective in buffering this woman from the impact of the changes in her other identities. The narrowed scope of her interests and endeavours was too great. And the fact that her children were now her only interest only served to accentuate this change. In addition, her relationship with her daughter had been adjusted because of the OA. Audrey was no longer able to visit her daughter's home as she used to, and she was pre-occupied with not becoming a burden. Taken together, Audrey was very much aware of these changes in her self-concept:

> That's all I live for is my children, just the two of them. That's my only interest now. There's nothing else left for me. So this is it. My life has changed a lot. You just can't do the things you want to do, even if you want to do it. I just make up my mind that I'm going to take it, and leave it at that. I put up with the pain, because I don't like to bother people, even my family...I've changed. I can't get away from it. My life has changed, 'cause now I'm this way. I'm living this way, whereas a few years ago, I was still alone, but I lived differently. I could go out and go on trips, or even day trips, or do whatever I wanted to. Things like that. Before I didn't have to say anything to my kids. If I made up my mind to do something, or go away, I just went. Not that I didn't tell them, but I went on my own, and did it on my own. (Audrey, age 83).

Audrey's case illustrates that, at times, it is just too painful to pine for identities that are no longer possible. Rather than setting oneself up for repeated disappointments, it is safer to relinquish any desires or hopes of re-capturing past lifestyles. As individuals attempt to come to terms with the loss of cherished identities, their interests may decline. Charmaz (1987) similarly found that people who were pre-occupied with the losses associated with their illness were unable to preserve valued self-concepts. Ironically, this process often serves to highlight the sense of change. One woman was devastated by the repeated failures of her surgeries. Her disappointment was evident:

> I feel the surgery took so much out of my life. Part of me went with that operation, because it didn't turn out as I thought it would or should...Prior to that, I had the cataract surgery, and that didn't turn out well. I think a combination of these things finally got to me, that I realized that no matter what I have done to my body, nothing is getting any better (Gladys, age 72).

As a result of these experiences, many of Gladys' identities decreased in prominence. She lost interest in receiving visits from her family, she no longer entertained, and she gave up her hobbies and interests:

> I used to be active in so many community groups, and I belonged to a quilting group....I had an interest in everything that went on around me. But now, I'm losing interest. I never really was a person much for TV, and now I'm getting that, you know. I watch a lot of TV programs now. You don't have the same interests because it's an effort (Gladys, age 72).

In addition, Gladys lost her interest in venturing outside her home:

> I feel most comfortable at home. I know my way around here. I know where everything is, and it doesn't take the effort it would if I were trying to get around outside my home. I think I've changed in that way. Before, I liked going out of the house. I didn't like staying at home all the time (Gladys, age 72).

Having lost interest in her past identities, Gladys devoted most of her time to the management of her chronic illness. Much of her time was reserved for therapy and water treatment programs. In short, being as comfortable and as pain-free as possible became her primary goal:

> My disabilities have taken over my life. I spend all my time just catering to the chronic illnesses...I've tried all the things I could think of to make life more comfortable. That's all I would like. To live pain free and in comfort (Gladys, age 72).

These examples illustrate that not all individuals are able to rearrange prominent identities in order to divert the effects of chronic illness. Instead, efforts to preserve and to fulfill these identities are no longer appealing. As a result, the illness identity becomes ever more pervasive and eventually claims a prominent position in the hierarchy.

VARIATIONS AND ADDITIONAL COMMENTS

It is important to note that these processes are not always mutually exclusive. That is, the experiences of some individuals demonstrate that patterns are often combined or exchanged. For example, many individuals display pattern 1.3b for certain stages in their illness biographies. One woman described the debilitating effects of her arthritic hip. The OA progressed rapidly and for one year, Beatrice was confined to her home. Consequently, she was unable to engage in her most valued activities. The prominence hierarchy remained, and the loss of these identities was felt even more acutely, since they remained important to her sense of self-hood. After a successful hip operation, Beatrice regained some of her abilities, and she progressed onto process 1.2. This woman managed to adjust her activities and the activeness of these identities was reclaimed.

Finally, a few comments must be made concerning the conditions that influence which pattern individuals display. First, the severity of the OA plays a role, although the importance of this factor must not be overstated. For instance, individuals who exhibit pattern 1.1 had mild forms of OA. The disease did not influence the day to day affairs of the women, nor were relationships significantly altered. Valued identities were not implicated in the experiences of living with OA. This was usually facilitated by mild forms of OA. However, the severity of OA did not always determine the type of pattern that was displayed. For example, women with the most severe forms of OA displayed patterns of continuity by engaging in those processes characteristic of 1.3a, 1.2, or 2.1 In contrast, some women with less severe forms of OA experienced profound changes in their self-concept and they were characterized as displaying pattern 1.3b or 2.2.

If the severity of the OA is not a necessary condition for determining the type of pattern, then what factors are involved? The findings reveal that the person's ability to adjust personal expectations and the capacity to derive satisfaction from modified activities (as shown by pattern 1.2), the ability to draw upon strategies to accept limitations (such as processes of biographical continuity, as demonstrated by pattern 1.3a) and the woman's willingness to engage in alternative activities (as shown by pattern 2.1) are important for shaping processes of accommodation, and in relation, the type of pattern exemplified by the individual. The data reveal that failure to engage in these processes result in patterns of unwanted change, as evidenced by patterns 1.3b and 2.2. These points will be described in more detail in the next chapter.

SUMMARY

This chapter has explored processes of continuity and change and how these are facilitated within hierarchies of identity. The patterns which were presented constitute the findings of this particular study and they are not intended to provide exhaustive and inclusive accounts of all experiences of chronic illness. Nevertheless, many valuable insights have been gained and these further our understanding of the *structure* of the self-concept. Identity theorists have highlighted the hierarchical organization of the self-concept, and the importance of recognizing the prominence or centrality of identities (Rosenberg 1979; Stryker 1968; and McCall and Simmons 1966). However, very little has been documented to further our understanding of the ways in which the various identities within a hierarchy are implicated in producing patterns of continuity and change in later life. Breytspraak (1984), briefly discusses the importance of considering the ways in which older persons re-adjust the importance they attribute to valued identities, in their attempts to deal with the losses commonly associated with aging. However, very little is known about the processes that are involved in the shuffling of identities within hierarchies. The findings from this particular study contribute to our understanding of shifting and non-shifting prominence hierarchies, and their role in facilitating patterns of continuity and change in the self-concept.

More specifically, this chapter has demonstrated several things. First, the level of analysis has been expanded by drawing upon an alternative perspective of the self, that is, the global self. While the previous chapter explains how specific identities are shaped by OA, this chapter demonstrates the importance of recognizing that individuals possess multiple identities. These various identities are structured in hierarchical arrangements, and the data reveal that the dynamics of shifting, and non-shifting hierarchies of identities are implicated in patterns of continuity and change. Interestingly, a person may experience changes in some of his/her identities, but his/her overall perception of change may be quite different. This points to the importance of making the distinction between specific components of the self-concept, and the global self. As was mentioned in the introduction of this chapter, researchers who have assessed identity in relation to chronic illness have not addressed this issue adequately.

With respect to non-shifting hierarchies, several processes were evident in the mediation of continuity and change. It was demonstrated that role requirements, role performances and interactions are negotiated and modified for the preservation of the identity. To this, we might add that these processes are negotiated in order to preserve the prominence of the identity. As mentioned above, individuals possess multiple identities. It became evident that changes in one component may be offset by the preservation of another valued component. Third, it was shown that identities often retain their prominence, even though opportunities to engage in these performances have declined. That is, the importance attributed to an identity is not necessarily dependent on the continued rewards that are normally derived from its performance. Rather, some identities remain important to the individual, even though they have become inactive.

This may present a source of unwanted change, and the experience may be quite traumatic for some. In other cases, identities that are no longer active in the present may still be supported because of past commitments to identity performances.

With respect to shifting hierarchies of identity, two patterns were presented in order to uncover the processes involved in mediating perceptions of continuity and change. It was illustrated that prominent components may become more important. Individuals may replace inactive identities with ones which were previously peripheral in order to maintain preferred perceptions of continuity. The findings also suggest that prominent identities may decline in their order of importance when their performances are compromised. A few women lost interest in some of the identities which had been compromised by OA. This often led to the perception that one's sense of self had been "lost" because of OA. Such experiences contributed to perceptions of overall change.

These findings demonstrate the role of shifting and non-shifting hierarchies in shaping perceptions of continuity and change for the global self. While conventional logic would assume that the maintenance of a stable hierarchy facilitates patterns of continuity, our findings suggest that this is not always the case. Accordingly, our findings reveal that both shuffled, and non-shuffled hierarchies produce patterns of continuity and change in the general self-concept.

CHAPTER 5
THE DYNAMICS OF IMPAIRED BODY PERFORMANCES: IMPOSED BODY LIMITS

INTRODUCTION

In the previous chapters, the significance of chronic illness for the development of discrete identity components was examined. Processes of continuity and change were also examined within the context of hierarchies of identity. It was shown that identities are enhanced, identities are lost or become inactive, and identities are modified in the process of dealing with OA. It was also evident that these processes are implicated in shifting and non-shifting hierarchies. This chapter will sharpen the focus of the analysis by examining the experiences of living in an impaired body and the ways in which disability influences the negotiation of valued identities. How do individuals adjust to changes in their ability to engage in valued activities and to maintain valued identities? In what ways do individuals modify their performances and expectations of themselves in light of the changes brought about by OA? Do older persons utilize strategies of adjustment that are unique to them? In addressing these issues, the strategies that individuals devise as they modify role requirements, their role performances and the standards of evaluation that are used will be examined in greater detail. The processes by which disabled individuals preserve, modify, lose, or even enhance components of their valued identities will be examined in the context of their day-to-day experiences

Imposed Body Limitations

The imposition of an impaired, physical self-concept has the potential to significantly alter one's sense of self. Indeed, the studies discussed in the review of the literature suggests that an individual's initiation into a life of chronic illness involves several stages. These include periods of uncertainty, confirmation, normalizing, and the negotiation of the re-constitution of the self (Conrad 1987; Corbin and Strauss 1987; Kotarba 1983; Strauss 1975; Wiener 1975). What at first is experienced as a temporary ailment becomes an additional, permanent fixture in the individual's biography. Body performances that are crucial for the maintenance of one's self-concept are disrupted or threatened and the individual must learn to adopt to his/her new body. This involves re-learning the capacities of the impaired body. The limitations of the disabled body are established and then they are re-negotiated and revised. Throughout these processes, the individual may attempt to search for an explanation of the chronic illness. Moreover, the acceptance of the chronic nature of the condition is mediated at different points during these stages. As such, the individual's conceptions of his/her disabled identity are continually modified depending on the success of treatments, satisfactory adjustments in body performances, and the progression of the illness (Corbin and Strauss 1987).

Most important, the literature reviewed in Ch. 1 suggested that chronic illnesses may seriously alter the individual's sense of self. Corbin and Strauss demonstrate that individuals must engage in "biographical work" in order to regain their disrupted identities. These intrusive experiences must be negotiated in the context of the person's biography so that he/she can re-claim perceptions of continuity. Essentially, Corbin and Strauss illustrate that identities are reconstituted as individuals re-learn the capabilities of their altered bodies. Priorities, values, goals and objectives are modified, and the loss of one's previous capacity to carry out past levels of performances are mediated as one learns to replace past activities with modified versions (1987, 273).

While this body of literature uncovers the processes that are involved as people adjust to chronic illness, this research does not focus specifically on age-related factors. This chapter will contribute to the literature by examining the ways in which these findings apply to experiences of chronic illness in later life. Other researchers have assessed processes of adjustment to age-related changes in later life, but questions remain. Brandtstadter, Wentura, and Greve (1993) report that older persons are more likely to adjust their preferences, lower personal aspirations and modify standards of self-evaluation in their attempts to accommodate to the losses associated with health declines. However, the researchers do not uncover the factors which enable older persons to engage in such accommodative processes. Belgrave (1990) provides some insight. She reports that when older women accept the belief that the loss of certain activities, and slower life-styles are to be expected in later life, the self-concept is protected from perceptions of change. Belgrave notes that relatively little is known about the experiences of living with chronic illness in later life (1990, 479). Hence, her findings warrant more attention. Accordingly, this chapter will examine whether age-related factors do indeed facilitate the negotiation of change

Before presenting the findings, a brief overview might be useful. In the previous chapters, the ways in which various identities were influenced by OA was examined. It was argued that role performances, interactions and standards of evaluation were adjusted and modified. This chapter will explicate these processes in greater detail. *First, the ways in which OA disrupts what Corbin and Strauss (1987) call body "performances" will be described. Next, the strategies that are involved in the negotiation of impaired performances will be highlighted.* In the first section, the experiences of living in an impaired body will be discussed. Three sub-topics will be presented in order to demonstrate the ways in which OA can become an important source of change. These include *mind-body discord*, *fragmented body moves*, and third, *changed perceptions of body performances.* These concepts will assess the processes by which the limitations arising from OA interrupt the performance of activities that are necessary for the maintenance of valued identities. In the second section, the mechanisms that are involved in adjusting to these changes will be discussed. Two sub-topics will be presented. These include *adjusted tasks and activities* and second, *adjusted expectations and interests.* These topics will demonstrate the ways in which individuals adjust, (or fail to adjust) to their disability. And, the strategies that are implicated in maintaining perceptions of continuity will be examined.

LIVING IN AN IMPAIRED BODY

The importance of a healthy, functioning body is perhaps appreciated most when taken-for-granted abilities are threatened or lost. Activities which were at one time performed with ease and with little thought become new challenges and it may become necessary to create alternative strategies in order to achieve these performances. Corbin and Strauss point out that Mead's conception of mind and human action provides a viable framework to understand the significance of impaired performances (1987, 256-257).

An act is defined as "a functional unit of conduct with an identifiable beginning and end that is related to the organism's purposes and that is oriented toward one or more objects" (Hewitt 1991, 76). Moreover, action is viewed as a constant process. Acts overlap and they are linked to each other. Put simply, one act progressively leads into the next one. Hence, "acts are social objects the actor pulls out of the stream of action in order to decide something in the present. Each act...is named, its name is social, and it changes as our use for it changes" (Charon 1992, 121). These definitions show that acts can be conceptualized at different levels. More specifically, it is possible to isolate a single act from the broader "stream" of action for analytical purposes. Mead's conceptualization of the *stages of an act* illustrates this well:

> An act starts with an impulse, which occurs when our existing adjustment or line of activity is disturbed. It proceeds quickly to a stage of perception in which we begin to name or designate objects and thus give our acts direction. It proceeds through a stage of manipulation, when we take concrete steps to reach our goal. And it ends with consummation, when our original adjustment of line of activity is restored (Hewitt 1991, 76).

This is a basic conceptualization of action, and a number of theorists have revised the ideas developed by Mead. Some have acknowledged that perception and definition do not necessarily precede manipulation. Rather, these stages may occur simultaneously in the successful performance of an act. Nevertheless, this formulation is important because it highlights the ways in which individuals are actively engaged in perceiving, defining and manipulating their environments in order to accomplish goals (Charon 1992, 127). Through these mental processes, that is "mind activity", one is able to direct the actions of the self in order to control, plan and structure one's responses. Through mind activity, individuals define their situations They then plan their courses of action accordingly. Mead's definition of mind activity describes this well. In essence, the mind is defined as symbolic action taken toward the self (Charon 1992, 99). More specifically:

> It is this process of talking over a problematic situation with one's self, just as one might talk with another, that is exactly what we term mental. And it goes on within the organism (Mead 1936, 385 in Charon 1992, 101).

Corbin and Strauss (1987, 256-257) contend that these principles are important for understanding the significance of acts which are interrupted because of chronic illness. This is especially the case when people's identities are threatened by disrupted performances. In these instances, situations become problematic, and individuals may be forced to develop new strategies and plans of action. Quite fittingly, Mead contends that mind action emerges in such situations:

> Consciousness is involved where there is a problem, where one is deliberately adjusting one's self to the world, trying to get out of difficulty or pain. One is aware of experience and is trying to readjust the situation so that conduct can go ahead (Mead 1938, 657).

Indeed, these basic principles are useful for understanding the significance of acts which are interrupted by chronic illness. How are disrupted actions negotiated in order to re-capture perceptions of continuity? How are identities implicated in these processes?

Mind-Body Discord:

The experiences of the women interviewed in the course of this study reveal that chronic illness often presents a profound source of separation between the mind and the body. The individual's desires, and ability to achieve certain goals are impeded by the disabled body. Often, the performance of certain identities is intricately related. When the body fails to obey the commands and desires of the individual, this often results in what will be called *mind-body discord.* Phrases such as, "my head won't go with my body anymore" are common. This disjointed relationship between mind and body often means that even the most basic acts are interrupted. As a result, the body becomes alienated from the individual's sense of self. This finding is also documented by Corbin and Strauss (1987) and Charmaz (1994). The following examples will illustrate this changed, mind versus body relationship:

> I have ideas but I found out that my head won't go with the body. I have ideas about wanting to do things. But then I get pain, and I can't do them. Common sense tells me to stay in my apartment. Like the other day, I was invited to go down for coffee. I was prepared mentally to go. But my body told me to stay home, because it just was not safe for me to go (Betty, age 80).

> Ooh! You're sitting here like this, watching your homemaker and thinking, "If I could only get at it myself and do it!" But, see, I can't (Laverne, age 79).

Maria's experiences reveal that the mind-body discord characterizes even the most mundane or basic tasks:

> You see, the hands give way. You think, "Oh I'll pick that up." And then you haven't got the strength in your hands. Then it's gone, so I drop things all the time (Maria, age 83).
>
> It's just hard to believe that I can't lift one foot out of the bed...Always bad in the mornings. I'm just sitting there waiting, waiting for this foot to let me move it, move it like that down to there. And then I'll get that one over the bed, and then how are you going to get up? So, I finally get onto the cane. Now the knees going next, and so I walk to and fro, to and fro with the two canes. I keep going and then after a little while, I'll be able to walk with one cane... . It's very hard when you can't move and do things... . But I still push (Maria, age 83).

Evidently, when the body fails to cooperate, the deviant body parts are perceived to be disjointed from the rest of the person:

> It's the pain and the clumsiness. This left leg. Downtown, this toe will catch somehow. It's the one that wants to drag for some reason. Once, I caught my toe, and I went down (Ellen, age 72).

Individuals who have undergone unsuccessful surgery also feel disconnected from their bodies. In addition, the specialization of medicine often means that different doctors are called upon to treat different body parts. This also serves to "fragment" the body:

> Once I fell underneath my walker, and I couldn't get up. I have an artificial hip see, and I had the operation in '83. Before that, they put a piece of metal all down there. I stood it for a year, and I couldn't stand it anymore. I called the doctor who did it. He said, "Well I'm not working on hips anymore. I'm working on hands". So, I phoned my own doctor, and there was another doctor who was teaching students on hips. He told me to come in right away (Laverne, age 79).
>
> Even now, I never get comfortable. I can feel foreign objects in my hips. You know something's there. They don't feel natural. I asked my doctor what would happen if I ever went on a trip, on a plane. I said I wouldn't get through their detectors. I often wonder about that (June, age 69).

The split between the mind and the body is also characterized by several other features. These include what will be called *the inescapable mind-body association, the forced mind-body association,* and *the desynchronized self* The *inescapable mind-body association* was evident when individuals remarked that the arthritis "always lets you know it's there". While the degree of awareness varied, most individuals reported that they felt confined by their physical bodies. Phrases such as, "You just can't get away from it", or, "I wish I could just go through one day without any pain and discomfort" were common. Sometimes, individuals escape this mind-body association temporarily, only to be abruptly reminded of their present condition. In these instances, the individual is for a short period of time, unconscious of her limitations. The individual engages in the performance of routine activities without much thought, only to be sharply reminded of the limitations of her body:

> You just can't get away from it. You know you can only go so far. Sometimes you forget, and you go all the way. And you just let one hell of a yell out of you! You can't stop it. It just comes automatically with the pain (June age 69).

The *inescapable mind-body association* is also accompanied by a *forced, mind-body association.* While the body becomes increasingly alienated from the individual's ideas of what the body should be able to do, a new association emerges. The individual is forced to become conscious of her body limitations. Actions that were once fluid and effortless now require the individual's full attention and concentration:

> It's more slower and careful. I'm always looking. You know at malls, there's always a mob of people going in there and I'm always watching. I'm all eyes trying to watch where you're walking, careful that I won't fall (Ellen age 72).

Finally, the mind-body discord is characterized by *the desynchronized self.* Put simply, the individual's inner desires and motives are relatively unchanged and lag behind the reality of the limited capacities of the impaired body. Charmaz contends that experiences tend to unfold faster than the person's tendency to change his/her picture of the self (1994, 228). This provides one explanation for the desynchronized self. It is not surprising then, that these individuals believe they should still be able to perform tasks as they did in the past. In essence, the changes in the individual's physical body progress faster than her process of adjustment to these changes:

> I still think I could still do the same things. I could run over there and do eight hours a day work. But I couldn't stand on my legs long enough to do all the things. Up here, I can still do the same things. I can still go on, but when you go out there to walk and try to do what you normally done, that's a different story. It's because of my knees. I mean personally in myself, I'm the same person. From the knees up, I'm good. From the knees down, no (Bev, age 68).

Interestingly, the findings from this study show that the desynchronized self is often related to age identity. Often, individuals do not "feel" old, but their bodies remind them of their chronological age. In this sense, the individual still has the same interests and desires as in the past, but is prevented from gratifying them. This will be addressed in more detail in the next chapter.

Fragmented Body Moves:

Disability also disrupts the flow of action that is necessary to achieve an individual's goals. The person's desires, purposes, goals, and intentions may become frustrated by the inability to successfully manipulate the environment (in this case, the body), in order to achieve these goals. The "stream" of continuous acts becomes fragmented, and the individual becomes aware of this broken momentum. Charmaz (1987) and Corbin and Strauss (1987) also report similar findings. This will be called *fragmented body moves.* Hence, what was once viewed as a single unit of action, becomes broken down into its various sub-units. For example, doing the laundry (a single unit of action) becomes a multi-faceted task, which involves collecting the soiled laundry, dumping the laundry into the machines, folding the clean laundry, and placing the articles in their appropriate places. Hence, movements become fragmented:

> For me to go over to the sink, I gotta watch how I do it. I gotta lift myself off this chair, I gotta take that walker, I gotta go out there, I can't reach the tap with my right hand, so I have to turn a bit, and reach it with my left. That's what I mean by being awkward (June, age 69).
>
> Even when I go on the bus, if they park, like the bus parks away from the curb and I have to get down and get up and I can't reach because my legs, knees won't bend that far (Marian, age 79).

Tasks are often "broken-up":

> If I stand to do my dishes, I'm leaning over the sink with my elbows trying to wash my dishes and I'm ready to sit down just from doing that. For dusting, I just do my coffee table, sit down. Stereo, sit down. I can't do too much all at once. If I do my vacuuming in here, I can only go about half way, and sit down (Violet, age 77).
>
> Just doing one job, when I have to go downstairs to do the wash, I have to go downstairs backward. I have to hang on to the railing and pull the laundry basket one step at a time. Trying to get up, it's the same thing. One step at a time, pulling the basket up (Maeve, age 78).

As a result of fragmented body moves, individuals with disabilities become aware of the multiple steps that are required in order to complete a single task.

Changed Perceptions:

Fragmented body moves is an important concept, because such actions often shape the individual's perception of her situation. In contemplating the utility of attempting to perform a certain act, the costs and benefits have to be weighed. Fragmented body moves have to be taken into account in these decision making processes, because the impaired performances alter the ways in which levels of activity and the difficulties inherent in these activities are perceived.

Some activities become much more difficult to perform and present new challenges. Shifts in the perceived difficulty of tasks are common. Some tasks become laborious. Even simple activities, such as walking, are viewed differently. For example, there is evidence of *spatial distance shift.* Lustbader (1991) and Corbin and Strauss (1987) also report similar findings. Distances which, at one time, were seen as short now appear much more daunting:

> If you go grocery shopping, you could push the cart, and that helps a lot because you've got something to push. But then you can't be too long. You'd be surprised how far you walk, going up and down the aisles in a grocery store or somewhere else like that (Maria, age 83).

The living space of the individual also narrows because of the person's inability to walk great distances. Hence, strolling along apartment corridors, taking trips to the laundry room, or going to pick up the mail are all the exercise that the individual can manage. During difficult periods of the illness, shifts in perceived distances are even more acute. One woman described her experiences recuperating from a hip operation, and how she had to "walk about a mile from the bedroom to the dining room" (April, age 85).

The perceived difficulty of tasks also changes. Hobbies which were once enjoyed become difficult to engage in. For example, one woman remarked that her knitting was limited since purchasing the yarn became a feat in itself. Social outings and family visits also become strained:

> Well, when you don't walk well, you can't go downtown. You can't go and play euchre and that because you gotta get up. If you win, you gotta move table, table and table. And I just could not do that anymore, because it's too difficult. And if you moved from the bottom table, then you had to go right up to the top of the line. So I haven't played that and of course I haven't played bridge since (April, age 85).

> I have an invitation to go to a Christmas dinner and I have told them that, well, I don't like to say no to them, because maybe I'd have a spurt of being able to go. But there's too many complications if I did go. Yes, they might get me there. But I wouldn't be able to cope, and they'd have to bring me back. Rather than spoil it for everyone, I would rather stay right here. It's been hard to accept (Betty, age 80).

Inaccessible and accessible places are now carefully noted and the difficulties involved in getting to particular places are acknowledged:

> Getting on a train is a major undertaking for me now. Last time I went to Montreal I flew down because there was no way I could get on the train, transfer in Toronto, get up and down those steps, the stairs in the station. You never think of it until you can't do it. The Montreal train station it pulls in level, but in Toronto, it doesn't. You have to climb up the steps (Lillian, age 72).

Taken together, the mind-body discord, and fragmented body moves show that chronic illness may obstruct the "stream" of action. The individual's desire to achieve specific goals and to engage in certain activities is disrupted. The perception of the situation is altered, and the ability to manipulate the environment is often compromised. These changes have the potential to significantly alter valued identities. Homemaking activities, hobbies, family gatherings, and social activities are often affected. Moreover, as the previous chapters have illustrated, significant others are also involved. Hence, family identities and friendship identities are also shaped in important ways by impaired performances.

This section has described, in considerable detail, the various ways in which activities (which are related to role performances) are influenced by OA. Up to this point, it is important to note that the findings provide support for the work of Corbin and Strauss (1987), which does not focus on issues related to age. Several concepts were also described, such as the inescapable mind-body association, the forced mind-body association, and fragmented body moves. The next section expands upon the findings presented in the previous chapters by exploring the processes that are involved in adjusting and modifying the performance of those activities which are vital for the maintenance of valued identities.

PROCESS MECHANISMS: RE-LEARNING THE CHANGED CAPACITIES OF THE DISABLED SELF

The concept of fragmented body moves was presented in order to describe the ways in which OA often interrupts the flow of an individual's actions. Fragmented body movements often cause the person to become more aware of her actions and in some cases, this results in a changed perception of activities which were once taken for granted. Often, activities which are integral to the performance of role identities become problematic. Hence, individuals may be compelled to manipulate their situations in order to overcome these challenges. The findings show that, despite physical limitations, some individuals are able to adjust to these changes in order to preserve their perceptions of continuity. Tasks and activities are modified, individuals deploy various strategies when attempting to perform certain acts, and finally, personal expectations and the criteria used for self-evaluation are adjusted as well. In these ways, both role performances and the standards of evaluation are often modified in order to preserve identities. These adjustments provide support for the ones introduced by Corbin and Strauss (1987). But most important, it will also become evident that experiences of OA in later life present strategies of adjustment that are shaped by life stage factors. This will be described in the following section.

Adjusted Tasks and Activities:

The previous section illustrates that the physical capacities of some individuals are threatened by OA. These individuals may experience gradual (or more rapid) declines in their abilities to perform certain activities. This will be termed, *funneling body* *capacities.* One by one, activities become increasingly difficult to perform and they are relinquished:

> Over the years, it's just kept on getting more and more. I have tried. I have worked hard at trying to keep going. But it's been a battle for a long time. I've been trying, but now, I am limited. I wouldn't dare. I mean, the danger of the knees giving out and falling. I had two falls, and so that you just have to live with it. At one time, I was taking trips from the building here. There was bus loads that went down to Cape Cod and different places. I kept going as long as I could. I used to go swimming twice a week. I was fighting, believe me. I just tried to keep doing things. I didn't want to give up and it's only been the last three years that my hands have got to the stage that they cramp up so badly. I miss being able to do crafts, because I was right into it. Gradually, the things become that I can't do them (Betty, age 80).

The *funneling effect* presents a potential source of change. It is also important to note that the extent of this funneling effect varies for each individual. The extent of the funneling effect is usually determined by the severity of OA. That is, severe forms of OA are more likely to lead to the loss of activities than less advanced forms of OA. However, the severity of the chronic condition does not necessarily mean that every person experiences the consequences of the funneling effect in the same way.

As the following section will demonstrate, the woman's ability to adjust to the changes in her performances, is more influential in preserving perceptions of continuity. And, the severity of the OA alone does not determine perceptions of change in the self-concept. Rather, various strategies are used in order to adjust to the changes in body performances. For example, some individuals capitalize on their fragmented body moves. Tasks are broken up so that the activity can be preserved:

> If you go two places, I've found the best thing to do is plan to go to one place and then come home. And go the next place the next time. Two days ago, I went to Ottawa Street, my favourite place for buying material for my dresses and things and that was enough for one day. I'm riding in the car. When I get there, I walk around the store two or three times. It was one of my bad days and I was glad to get home (Maria, age 83).

One woman had always been an avid homemaker. Some tasks had been transferred to her brother. However, Marge insisted that she do the ironing and washing, since she felt that "you can't expect a man to do that kind of work". Hence, Marge fragmented the task, and, by so doing, she was able to preserve it:

> I do my ironing, but I don't do it all at once. I break it up and when I feel like I'm getting tired, I'll just leave it and come back to it again later (Marge, age 70, never married).

Another woman made a similar kind of adjustment:

> When I do the laundry, I find that when I want to hold up the sheets to fold them, it's just difficult. So I wash oftener. Instead of washing once a week, I wash three times a week, in smaller amounts. I find that goes better for me (Ellen, age 72).

Other individuals actively resist the funneling effect in order to preserve their activities. This will be called *stretched and attenuated activity adjustments.* When valued activities are threatened, individuals will make certain adjustments in order to facilitate the continued enjoyment of these activities. Some people will go to great lengths to preserve these activities. For example, gardening is extremely important to Maria's sense of self. For years, she has been an avid gardener. Recently, Maria's gardening skills were even more valued, because she has received a great deal of satisfaction from filling the homes of her friends and neighbours with her flowers. Recall that Maria had been successful in diverting the imposition of her illness identity by taking on a new identity, that of helping others and becoming socially active. Visiting sick neighbours and giving them flowers was one way this identity was affirmed. Hence, Maria went to great lengths to preserve this activity:

> Just now I'm having my son alter the garden, because I couldn't kneel down. If I got down, see someone would have to pick me up, and uh, anyway, I persuaded him to change the garden for me. So we've dug up the garden, and we've put it in sections and we've got a little walk. A section, then a little

> walk, so I'd be able to walk up the sections, and I'd be able to weed with the hoe. Whereas when I had it all in one place, the weeds went all over the place.

At one point, the garden has been a source of conflict between Maria and her sons. They wanted to "put it back to grass" because it required a great deal of labour in the summer. However, Maria was adamant about preserving her garden:

> My sons want me to take away all the flowers now, and put it back to grass. I don't want that....so they won't have any gardening to do...See, if I don't have the garden, they won't have to help me see. I know what they're up to, but I won't let them do that. Not as long as I live here.

Activities are adjusted in other ways. The individual may attribute more importance to those activities he/she is still able to perform, or activities which are no longer possible to engage in are replaced by new ones (Corbin and Strauss 1987, 273). The women in this study also reveal strategies that are similar to the ones presented by Corbin and Strauss (1987). Some individuals are able to reconcile the loss of activities by appreciating those activities that still remain in their repertoire. In addition, these activities may be engaged in more frequently. For example, individuals may read or sew more than they did before. Where OA has seriously restricted a woman's daily activities, the basic tasks that she is still able to perform are highlighted. Hence, making one's bed, preparing light meals, or doing the laundry are retained and valued:

> I can still make up my own bed, and I do that. I hold onto the bed, and I make it. And I make my own meals. Of course, the meals, I don't prepare like I used to when my family was with me, but light things I can do. I like to do things myself, as much as I can (Audrey, age 83).

One woman had lost most of her homemaking abilities. Many of these tasks were now transferred to her husband. However, she retained those tasks she was still able to manage:

> Once my husband retired, he took over. He does all the cleaning and cooking which I miss. But I do some laundry because I have a little washer and dryer

> in the bathroom and I refuse to let him do that. That's mine because then I have at least something to do (Lillian, age 72).

When various activities are limited by chronic illness, the selection of activities from which one can choose from also changes. This study shows that new activities replace the ones that the individual is not longer able to engage in. For example, one woman was no longer able to perform her homemaking duties as efficiently as she had been able to in the past. This was a source of great distress since this valued identity was threatened. However, in negotiating these changes, Ellen joined a seniors' club and took up new hobbies. What had once been a peripheral identity (her social activities and interactions) now became more prominent. This change served to compensate for the loss of some of her abilities. In fact, Ellen believed that she had been enhanced by her experience.

Engaging in new activities can also serve as a temporary escape from the disabled body. That is, new activities may be beneficial in diverting attention from the disabled self. For example, Beatrice found that participating in water exercises was therapeutic:

> If you're feeling that you want to still accomplish physical things that you used to be able to do, find substitutes for them. I cannot any longer do a lot of things physically, unless I'm in the water. So I enjoy going to my water classes. It's good for my body and it also gives me a sense of being more able-bodied again, temporarily. You find you can do more in the water because of the buoyancy. So there's a freedom there (Beatrice, age 69).

Not all individuals derive benefits from replaced activities. Bernice was disenchanted with her craft work, and other women found that they spent more time watching television or reading. These activities were not satisfying, and the loss of valued activities had not been offset by new ones. Interestingly, this study reveals that changes in one's abilities were noticed when replaced activities failed to satisfy the individual.

The performance of tasks and activities is also adjusted by allotting more time to their performance. This will be called *relaxed task schedules.* This strategy often complements the strategy of fragmenting tasks in order to be able to complete them:

> At one time, I used to do everything in the house from top to bottom, which was stupid. But I used to do it, just to get it done. Now I don't. I just have to pace myself. Like one day I'll do a little bit of laundry, and the next day, I'll just do some light cleaning or windows, or things like that. I don't do it all in one day anymore. I just pace myself. And if I find myself getting tired, then I know that I have to stop, and go back to it maybe another day. If I feel like doing it, I do it. If I don't feel like it, I don't (Marge, age 70).

> There is a difference. I think now that I just think I don't feel like doing that. I'll do it tomorrow or something. I'm not driven that it has to be done today. That's a change. I was more, everything had to be done. My husband used to say everything had to be done yesterday with me. If I started something, I wanted to do it. I wanted to get it over with. But I'm not like that now. I don't have any deadlines to meet or anything like that. Nobody's pushing me, and I have plenty of time (Dorothy, age 75).

Relaxed task schedules reveal those adjustment mechanisms that may be advantageous to older persons. The findings show that retired lifestyles and the fact that many of the women are released from obligations, (more characteristic of later life) often facilitate this process.

In addition, since more time may be required to perform certain tasks, this often means that the number of tasks performed within a given time period decreases. This is called *expanded task schedules.* For example, an individual may schedule very few activities in a day because of the time necessary to perform them. One woman described how attending her pool exercises consumed much of her time. Getting changed into her bathing suit alone required a great deal of time and effort. Tasks such as walking to the corner store to buy a bottle of milk or changing the sheets on a bed may consume substantial portions of a morning.

Expanded task schedules are also related to the funneling effect. As individuals are left with fewer activities to choose from, they may find themselves with more and more time on their hands. Some individuals attempt to structure their schedules so that they can feel they are being productive. Hence, simple tasks serve to occupy the person's thoughts to "fill" the day:

> I think about having to write my cheques, and I have to get these things done and things I need. I have to get my pill box fixed every day. I have a pill box with every day of the week. And I have to fill that. I have to see what pills I need. I have to phone the drug store and get my prescriptions renewed. They're coming with the ones I need today. So these are the kind of things I'm sitting and thinking, I've got this and that to do (Laverne, age 79).

Others participate in activities at a leisurely pace. In this way, activities are "expanded" in order to fill the day. Such expanded activities also suit the lifestyles of many of the older women:

> When I go to the store, it's consuming. It consumes my day. It makes it shorter. I go downstairs, and I'm taking time out of the day's boredom if I stay home. It takes up my time, because I can't do the things I've done so this, if I go downstairs say to the laundry room, there's ladies and men there, and I know a lot of them. By the time I get back, the time has gone. There's less of a day left (Marian, age 79).

> When I was working, there was more of a reason to push myself to get things done, even if it was taking me longer to do them. Then when I retired, I guess I didn't have to push that much. Now I do my reading, or my crosswords, or I'll read the shopping catalogue and that will pass the time. It's more of a slower, come what may kind of life (Laverne, age 79).

In light of funneling task options, some individuals manage to master their situations by prioritizing their duties. The *prioritized task schedule* represents another mechanism of adjustment. In the *prioritized task schedule,* individuals commit themselves only to those tasks that are most important to them. In some cases, it is only possible to commit oneself to those tasks that are absolutely necessary. Hence, the individual concentrates on looking after her own personal needs, and tending to the basic chores and duties that are necessary for daily life. Some individuals feel deprived, because they are unable to partake in other valued activities and the loss of activities is perceived. Others feel that these prioritized tasks are all they can manage and they are relieved with their narrowed task options:

> I used to be quite active in organizations, and went out to meetings and gatherings. I don't do that anymore. It's too much of an effort. I just as soon stay at home, where I'm warm and comfortable. There isn't much that I have to do anymore, and some days I just do the necessary things. I look after my own personal needs, and that's all. I never thought I'd see the day when I wouldn't be doing what I'm doing now. But the only thing I want, in my mind at least, is to feel comfortable (Gladys, age 72).

In the prioritized task schedule, individuals also exercise the option to *open and close* their task options. That is, individuals may volunteer to perform certain tasks, or they may assume certain responsibilities if they feel that these tasks are within their capabilities. Activities and engagements that are easy to cancel, or easy to back out of at short notice, are also included in open task options. In the case of closed task options, individuals refuse to commit themselves to certain tasks and activities, because they cannot guarantee that they will be able to their obligations Individuals may desire to be released from certain obligations, and they do not want the added burden of feeling committed to them. Violet's experience illustrates closed task options well:

> Well, I stay at my son's home to baby-sit and I'll dust or do little things like make up Christine's bed. But I don't vacuum or clean the floors here, because, somehow or other, I feel the more you do, the more you will get to do. It's just something I couldn't handle. If you start washing and mopping the floors, then it'd get to be that's "my job". And I don't want that. I just don't want to feel obligated to do things, when I never know from one day to the next how I'm going to be. One day I might come here, and I'm not bad. But another day, I might come and I'm not good at all (Violet, age 77).

This study provides evidence that older persons may have more opportunities to exercise the option to open or close their task options. With the exception of a few women, most of the respondents stated that their relaxed role requirements were beneficial:

> I like to make sure that I have supper ready for my son when he comes in. I like to do it. But I know he doesn't expect me to do it. After all, he is able to take care of himself and he even tells me. But still, I try. If I feel like I'm not able to do it, then I won't. Many times I can't, so I just decide that day whether I'm up to it (Beatrice, age 69).

Finally, part of the process of discovering and establishing new limits also involves reconciling past performances with present ones. This findings is documented by Charmaz (1987) and Corbin and Strauss (1987) as well. Some individuals cannot help but compare the differences in the amount of time required to perform certain tasks. They recall how they used to be able to engage in several activities at once. They contrast this with their present fragmented performances. This will be called the *simultaneous versus the single task activity model.* Individuals may also compare past task schedules, which were characterized by their efficiency, in comparison to their present, relaxed and expanded task schedules. This serves to remind the woman of the changes in her physical performances:

> When you're normal, you can jump up and say, "Oh, that dish is dirty." And I can get down, and do that. And I'll make the beds, and then maybe I'll run the vacuum over the living room. And dust the furniture. All these things. Now, you have to say to yourself, "Can I do this? Can I get the dishes out of that dish washer and get them put away?" Well, I'm going to try it anyway. But maybe I'll bend over a few times to get into the dishwasher. They're dry and ready to go into the cupboards, and by the time I get down over there, and put the dishes up, I think, "Oh gee, that's fifteen minutes." I'm going to have to go and sit down, and finish it later. Just that one thing (Violet, age 77).

How did the women adjust to the changes in their performances? As Ch. 7 will demonstrate, many individuals chose not to dwell on these comparisons. Some did not engage in comparisons at all. However, those who did engage in such comparisons reconciled these perceived changes by adjusting their personal expectations. This will be discussed in a later section of this chapter.

Taken together, these concepts demonstrate that despite intrusive limitations, and threatened activities, individuals are able to devise adaptive strategies in order to adjust to the changes in their physical self-concepts. It was also demonstrated that unwanted changes may be perceived, more specifically when the woman is not satisfied with her replaced activities, or when she compares past performances with present ones. Interestingly, the data reveal that in some cases, even those who reported having severe forms of OA maintained perceptions of continuity by engaging in strategies of adjustment. Hence, it is evident that the severity of the woman's OA alone does not determine her perception of change, as much as the processes of adjustment she chooses to engage in. *The findings also show that the older women engaged in strategies of adjustment similar to the ones introduced by Corbin and Strauss (1987).* However, the respondents had the advantage of relaxed task schedules, expanded task schedules, and the option to open and close their task options. The next section examines other processes that are involved in adjusting to these modified performances and people's attempts to preserve perceptions of continuity.

Adjusted Expectations and Satisfaction with Modified Body Performances:

As the previous examples illustrate, some individuals are able to modify those activities and performances that are necessary for the maintenance of valued identities. Perceptions of continuity are also facilitated when individuals are able to adjust their personal expectations, preferences, and interests. These processes of adjustment are documented by other researchers as well (Charmaz 1987; Corbin and Strauss 1987; Kotarba 1983; and Strauss 1975). It is important to note that these authors do not focus specifically on older persons. Brandtstadter, Wentura, and Greve (1993) investigate processes of adjustment in later life. They report that older persons were more likely to adjust their personal goals, aspirations, and criteria for self-evaluations as they confronted changes than their younger counterparts. However, they do not uncover the factors that facilitate such adjustments. This section will uncover the ways in which personal expectations, preferences, and interests are modified in order to deal with OA. But most important, this section will address whether life-stage factors influence these processes of adjustment.

Personal expectations are adjusted in several ways. First, expectations can be lowered. The individual may adjust the criteria she uses when evaluating role performances. Role requirements may also be changed. For example, many women reported that their homemaking abilities had been severely affected by OA. Some women learned to accept these impeded role performances by adjusting their expectations of themselves. Individuals also learned to be satisfied with "doing less" and taking longer to do it:

> Beforehand, a good day was when I could do everything I wanted to do. But now it's curtailed. I can only do what I can, and then finish up what I can't. Before, I would've stayed up til' midnight to finish whatever project I was on. Like, I wouldn't go to bed until all the cleaning was done. That doesn't worry me anymore. They get done when I feel capable of doing them. I do what I can, when I can (Ellen, age 72).

In essence, holding on to past levels of performances only serves to frustrate the person more. Instead, the identity is preserved when the individual has adjusted the requirements of the role to match her modified abilities. As the previous chapter showed, some individuals relinquished a few of their role identities altogether. Individuals adjusted personal expectations by decreasing the importance they attributed to the role. However, individuals drew upon other identities in their hierarchies in order to mediate perceptions of continuity and change.

Social interactions, hobbies and other activities may also be limited by OA. Again, some individuals are able to adjust to these limitations by adjusting their expectations of what they can expect to participate in, realistically:

> Well, I think back, and I wish I could do this. I wish I could do that. Get around. But it's no use complaining. You can't do anything about it. Like my daughter, she phones and sometimes on a Saturday, she'll have me down for dinner. But lately, I haven't been down because my leg. Like when you go to her home, there's a hallway, and then four steps leading into her living room. Well, I couldn't go up those steps. My leg wouldn't go up that far. So I couldn't go. Yesterday, on the phone, she was thinking about Christmas. Usually we have Christmas, and I go to their place. But then, if it's slippery, I might not be able to go with them, even if they take care and look after me. I'm afraid to go out in icy weather. So we're hoping it won't be bad weather. If it's bad, I won't be able to go Christmas. But they'll drop over. So it's things like that that you have to learn to expect. You have to learn to accept things like that (Audrey, age 83).

> My granddaughter is getting married, and they're talking about the cake and the dress and a place. And they're trying to rent a place that I can get into, that's accessible. I said to them, "It's your wedding. Don't worry about me. You want a place that you like. Not a place that Grandma can get into." So anyway, the plans are on for two weddings. So that keeps me thinking, even if I'm not involved at all. Both grandchildren want Grandma to come. It's going to be such an event that grandma's got a chair, and she might not be able to come. I might even work on that, that I'm not able to go, because if someone's going to be fussing with me a bit, and get the wheelchair out of the car and we have to get a motel because it's out of town. So I just stayed quiet. I thought I just might not be able to go. I'm going to be disappointed, but I won't. I can get over that (Grace, age 75).

Interestingly, some individuals display the remarkable ability to find satisfaction, even in the face of substantial losses. One woman had been deprived of many of her valued identities. However, through the process of biographical continuity, she had adjusted her expectations of what she could expect in later life. As a result, she had learned to accept some of her limitations:

> I value each day that I have more. I used to take things for granted. Now, when I get out of bed, sure I have aches and pains, and I can't bend. And I

> drop things. But then I think, no, I'm thankful. I've been able to put my feet on the floor, and I've been able to have three meals a day. So I'm appreciating life a little more (Maeve, age 78).

Some individuals are thankful for any improvements they experience. Hence, individuals who exhibit signs of "relative disability" have adjusted their expectations, so that they prefer to live with their present capabilities rather than the previous state of disability:

> I know I'm not walking like I used to. When I move, it's more awkward and the limp is still there. But I've improved so much since the surgery. The pain was just excruciating before that. I could barely stand for five minutes, and I was in bed most of the time the months before I had the hip replacement. I told one woman the other day that I felt like bionic woman. So, I know it's not what I was before, but I'm happy with the results (Beatrice, age 69).

Next, the process of adjusting to modified performances and impaired abilities also involves *compromised preferences.* Individuals are often forced to draw upon the assistance of others. Unfortunately, these "helpers" may not always perform the tasks to the individual's liking. Paid homemakers may not perform certain tasks the way the individual has traditionally done them. Or they may not complete the tasks as efficiently or as meticulously. Many of the women remarked that they had to learn to adjust to these changes:

> Things like, you can't go down and do you own washing anymore. So my son goes down and does it. But they're all in too big of a hurry to do things. They don't want to do things the way you want to do it. Then you get things, hang something up, and it's all wrinkles or something. I have to keep telling him, "You have to pull it, pull it to get the wrinkles out". He says, "It'll do" And I say, "No, it won't do". You think, "Is it worth all this just to get your clothes washed?" But I can't wash them. But he will take something and wash it by hand if he thinks it shouldn't be in the machine. So he's learning (Laverne, age 79).

Other examples include those individuals who rely on friends or family for transportation. Often, the disabled person must negotiate time schedules that are convenient for the driver. Hence, the individual must compromise her schedule to suit that of her driver:

> For rides if I have to go anywhere, appointments. This morning I had to ask my brother to take me. And then he has to wait for me, and he's got things to do too. I don't like that. I get all uptight when somebody's waiting for me. I like to do things at a leisurely pace, and not have to depend on anybody. Whereas before I could take the bus, just take my time, and do whatever I wanted to do. But this way I feel I have to hurry (Marge, age 70).

In addition to compromised preferences and adjusted expectations, interests are also modified. The strategy of taking up new activities in order to replace lost ones, involves the adjustment of one's interests. Hence, Ellen's new interest in the arts and crafts programs at the seniors' centre, and Maria's interest in visiting sick or lonely neighbours illustrate the ways in which interests are modified. These adjustments illustrate successful attempts to deal with the challenges presented by OA. Ellen's homemaking identity was a central component of her self-concept. As OA continued to impede her role performance, this stressful process was mediated by relaxed task schedules and lowered expectations. She also modified her interests:

> I finally saw the light, that the only thing in life is not staying home and cooking and cleaning house. Yes, it took me a long time to see it. My neighbour Cecile put me wise to it. She retired like before me, and she says, "You know what? You should go out more." So she was always after me to join this seniors' club. So I went there for tea and they made an announcement for new members. I told Cecile that I was going to join. She wanted to come to my crafts. So you see! That's how us little old ladies stay together (Ellen, age 72).

These findings provide evidence for the many ways disabled persons are able to adjust their expectations, interests and preferences and provide support for previous studies (Charmaz 1987; Corbin and Strauss 1987). But more pertinent to this analysis, one might ask whether these processes of adjustment influenced by life stage factors. Although the successful engagement in processes of adjustment did not necessarily depend on age factors, the findings demonstrate that lowering personal expectations, (for example in taking more time to complete tasks, relaxing certain role requirements, or recognizing that activities are no longer possible) were often mediated by factors associated with later life. For instance, many of the women noted that OA had slowed them down considerably. However, these women were able to accept these changes, because they believed slower life-styles were common in later life:

> Well the arthritis has certainly slowed me up. It just slows you up and you have aches and pains you never had when you were young. You just can't get up and do things at the last minute like you used to. But I think you have to expect that sort of thing when you get older. Everybody that's my age, they're the same way too, even my friends who don't have arthritis (Dorothy, age 75).

Many woman were also able to adjust their role requirements because they believed such changes were to be expected in late life:

> With the arthritis, I guess it has limited some of my responsibilities, but I guess when you get older, you think some things aren't as important as they used to be. Before, I was the kind of person that had to get everything done around the house right away. When you're younger, you think, if you're having company, you have to have everything spic and span. But then I hear about what my friends, who are the same age as me, what they accomplish around the house, and I think I'm doing pretty good (Dorothy, age 75).

These findings support the research conducted by Belgrave (1990). When changes in one's performances were viewed to be common, and appropriate for women at that age, adjustments were not as difficult to make. However, the findings from this thesis present additional information. In some cases, individuals held beliefs about what was to be expected in later life, but this did little to facilitate processes of adjustment. This will be called *ineffective age-associated expectations*. Interestingly, these women believed that their experiences of illness and disability exceeded the boundaries of what they perceived to be within the confines of "normal" aging:

> I never thought there was anything wrong with getting older. I just don't like the way I'm doing it. I see some couples in their eighties and they're still in love, walking hand in hand. See, I think that's beautiful. Some of the women in this building are in their eighties and they're still zipping around. Sure, you slow down, but my case is totally different. There's too much I can't do that I still want to do (June, age 69).

> I think at this age, there are things I wanted to do. I think I should be able to enjoy my retired life and take trips, or join clubs. But see, I can't. And at this age, I think I should be able to do those kinds of things (Gladys, age 72).

These findings show that the acceptance of common beliefs of aging does not always assist in processes of adjustment. This is an interesting finding considering that Belgrave (1990) reports that the women were able to accept the losses in certain activities, because they were "able to define the relinquishing of activities as appropriate for women" that age (496). While the findings in this study support this finding, the excerpt presented above shows that there are certain roles that are specific to older women (such as the retired-leisure identity), the loss of which is not easily reconciled by the acceptance of common beliefs about aging.

The findings show that processes of adjustment may be hampered by other factors as well, factors which are not necessarily related to age-associated factors. Disappointments over ineffective treatments or unsuccessful operations can also dash people's hopes of an improved quality of life. Un-met expectations from an unsuccessful treatment are even more disappointing when the treatment intervention is particularly invasive and consumes a significant amount of the individual's time and energy. Some surgeries require months of post-operative therapy and the recovery period can be quite difficult. When these interventions are not successful, the individual is forced to lower her expectations and the disabled physical self-concept may be quite salient during the difficult period of adjustment:

> I had the operation because I wanted to be able to get around more. I was told that the operation would ease the pain a great deal, and that I'd be able to

> walk better. Because my knees were just getting that they were wearing out more and more. So I wanted to be able to get around comfortably. I had visions of getting myself a classic cane, and also some relief from the pain. I didn't expect to get it back to like when I was young. But I definitely had hopes. It took time for it to sink in that I wasn't going to be a heck of a lot better, not ever, and adjust to it (Lillian, age 72).

> I had a complete knee replacement on my right knee and it was a very traumatic experience, because I expected such great results... . I feel it took so much out of my life... . I think I've come to terms with that in the last year or so. I realized that I'm getting this stiffness, and when it first started out, it would be stiff for a while and then go away. Now it's constant. I don't have the pain I had before. It's just that it's stiff, which I didn't expect at all. I think that was one of the hardest things for me to reconcile. This surgery-that it wasn't going to be what I thought (Gladys, age 72).

Interestingly, in some cases, unsuccessful surgeries contributed to the women's beliefs that they had deviated from "normal" experiences of aging:

> I didn't think about my aches and pains as much before the operation. I thought that was just part of life and living. I was of the opinion that well, even a machine wears out so why wouldn't your body, with the wear and tear over the years wear out too? But after I had the surgery, like I say, I felt old. It took so much of my time. Everything fell by the wayside. That's when I felt things didn't go the way they should have, because if they did, I would be able to go on like normal, and be like the other women who had their hips done and they're going fine (Gladys, age 72).

These examples show that not all processes of adjustment contribute to the preservation of perceptions of continuity. Indeed, the ability to adjust one's personal expectations varies from individual to individual. Some individuals lower their personal expectations, only this serves to highlight their sense of loss even more. Individuals who have lost interest in most of their valued identities tend to be characterized by this type of resigned acceptance. These individuals lower their personal expectations and hopes of ever re-gaining elements of their earlier ways of life. Hence, their attempts to escape frustration and further disappointments tend to lead to various forms of apathy. Phrases such as "I accept my life, whatever it is now" characterizes these persons.

Finally, the data reveal that unadjusted, or lost interests also serve to hamper processes of adjustment. Women who perceive profound changes in their self-concepts have not been able to modify their interests in ways that were conducive to adapting to OA. Some individuals lose interest in most of their activities and valued identities. As demonstrated in the previous chapter, the loss of one's interests signifies an important change in one's self-concept. This, in combination with un-met expectations, and tragic disappointments serve to contribute to the person's sense of loss even more. This often characterizes individuals who become immersed in their experiences of illness (Charmaz 1987). A few women remarked that maintaining one's interests only led to more disappointments and frustration, since it was no longer possible to gratify them:

> I think a lot of interests are disappearing. If you say, "Let's go out", like my daughter and son was here, and they asked me to go shopping and I said, "No you go. I'm staying home." Because I wasn't sure about my walking at the time. I can build it up, and build it up. And then, all of a sudden, to heck with it (Cynthia, age 83).

> I feel I should be up and doing. Maybe doing knitting or something. But somehow or other, when you have arthritis, it seems to take away a lot of your incentives. Like I'd like to sit and knit but do I really feel up to it? With my hands and my eyes, do I really feel like I want to do that? (Violet, age 77).

In addition, the amount of effort that is necessary to expend in order to take part in these activities makes them unattractive. Hence, the likelihood of gratifying these interests wane as well:

> Last night I was all ready to go down to the meeting, because we have a committee here, and I was even thinking of running again. It came time to go down, and I just didn't feel like it. Well, for one thing, I was worried about the chairs down there, if I was going to be able to sit on it or not. And one thing is, am I going to be able to get my girdle on, because it's tight and it might bother my incision. So I just didn't feel like trying... . Some of the ladies, they say to me, "Oh why don't you come downstairs? Don't stay in your apartment." I don't want to be bothered going downstairs right now. I'm

> not comfortable going downstairs, because I know I won't enjoy myself. So I just as soon stay up here when I can. If I want to lay down, I lay down (June, age 69).

This section demonstrates that adjusted expectations, compromised preferences, and modified interests are important for mediating experiences of change. Indeed, the ability of the woman to adjust her personal expectations, interests, and levels of satisfaction with her limited physical capabilities was extremely important for negotiating experiences of change. It is also important to note that a number of respondents, who reported having only moderate forms of OA, experienced great change because of their inability to adjust their interests and personal expectations. It became evident that these processes were more influential in determining perceptions of continuity and change than the severity of the OA alone. But most important, it was also demonstrated that when women believe that the changes in their performances are to be expected in later life, the adjustment of one's expectations are facilitated in ways that preserve perceptions of continuity. At the same time, it was also noted that not all women were able to draw upon these beliefs to negotiate their own losses. This occurred when women believed that their experiences of illness and disability went beyond the limits of "normal" processes of aging.

SUMMARY

This chapter sharpened the focus of the analysis by examining the experiences of living in an impaired body and the ways in which disability is negotiated into day-to-day body performances. In the previous chapters, patterns of continuity and change were examined at both the specific (that is, discrete) and global levels of the self-concept. The examination of discrete identities showed the ways in which identities are challenged, enhanced, modified, lost, or become inactive. The examination of the hierarchical organization of the self-concept revealed that the woman's ability to adjust her expectations, modify her activities, and engage in alternative activities were influential in determining patterns of continuity and change within shifting and non-shifting hierarchies. This chapter provided a more detailed assessment of the processes involved in adjusting to the changes in one's ability to engage in activities necessary for the maintenance of valued identities.

It was illustrated that chronic illness often disrupts the "stream of action". Accordingly, the mind-body discord, and fragmented body moves were conceptualized. A detailed account of the strategies for preserving continuity in terms of adjusted tasks and activities was provided. Hence, fragmented tasks, stretched/attenuated adjustments, expanded task schedules, relaxed task schedules, and prioritized task schedules were presented.

In addition, those processes that contribute to perceptions of change were also noted- for example, when women made comparisons between past and present performances, as demonstrated in the simultaneous versus single task activity model. Finally, it was also noted that some adjusted tasks and activities present sources of both continuity and change. Hence, it became evident that replacing lost activities with new ones are also potential sources of change if the person is not satisfied with her new activities.

It was also shown that expectations, preferences, and interests are modified as well. These concepts were presented in the hope of describing sources of change (lost interests, and un-met expectations) and those strategies that preserve continuity (adjusted expectations, relative disability and modified interests).

Other researchers have reported that the modification of activities, and the adjustment of personal expectations, interests, values, and priorities are important if individuals are to adapt to the limitations that arise from chronic illness (Brandtstadter, Wentura, and Greve 1993; Corbin and Strauss 1987). The data from this thesis provide support for these findings. Perhaps the most interesting finding relates to whether experiences of chronic illness in later life present unique opportunities to adjust to various changes. This study shows that older women engage in processes of adjustment that are similar to the ones introduced by Corbin and Strauss (1987), who did not focus specifically on age. Activities, tasks, personal goals, and expectations were modified in similar ways. However, the findings also show that in addition to these strategies, older persons may have some unique advantages. This is an important finding considering that relatively little is known about the subjective experiences of chronic illness in later life. In particular, when the women perceived that changes in the performance of activities were to be expected in later life, perceptions of continuity were maintained. Hence, relaxed tasks schedules and expanded task schedules were made possible by retired lifestyles, and levels of responsibilities and obligations more characteristic of later life. This provides support for the findings presented by Belgrave (1990).

However, the data from this thesis also provide additional information. More specifically, Belgrave (1990) reports that a few women were overwhelmed by their illnesses, but the author does not provide any explanations that would account for these observations. Were the women overwhelmed by their illnesses because they were unable to accept physical losses as an inevitable part of aging, *or because of other factors*? This chapter provides one partial explanation. Indeed, the role of lost interests, un-met expectations, and personal dissatisfaction with modified activities for contributing to perceptions of change was illustrated. It was noted that these processes were not necessarily related to the woman's perception of her age-related circumstances. However, with particular reference to age factors, the findings demonstrate that while most of the women accepted the belief that changes in health were to be expected in later life, the perceived intrusiveness of OA was significant when women believed their experiences of illness and disability greatly deviated from their beliefs of what constituted "normal" processes of aging. That is, when the limitations and losses presented by OA went beyond the confines of what the woman perceived to be acceptable, or expected in later life, perceptions of change were significant.

Taken together, this chapter has examined the strategies that are involved as older individuals adjust to the losses, commonly associated with experiences of aging. The women who participated in this study demonstrate that a variety of strategies are involved in shaping perceptions of continuity and change, some of which are influenced by life-stage factors.

CHAPTER 6

OTHER PEOPLE MATTER: SOCIAL COMPARISON AND REFLECTED APPRAISALS (Process Mechanisms cont'd)

INTRODUCTION

It has been shown that the impact of chronic illness in shaping conceptions of self is revealed at various levels. In addition to patterns of continuity and change both within discrete identities, and between identities, that is, in hierarchies of identity, the negotiation of OA is mediated by other processes as well. These include efforts to re-learn the capabilities and limitations of one's changed body and to adjust personal expectations, interests and preferences. It was also demonstrated that age factors play a role in shaping the person's perception of her experiences of living with chronic illness. Women who believed the changes associated with OA were to be expected in later life, were able to adjust their expectations and interests in order to deal with their limitations. This finding suggests that the woman's perception, or the way in which she defines her situation is an important factor which must be considered.

But what processes enabled older women to believe their experiences of OA were common in later life? For those who believed that their disability deviated from "normal" experiences of aging, what processes contributed to these perceptions? By what criteria did the women evaluate their performances? Did these evaluations contribute to perceptions of continuity and change? Belgrave (1990) reports that the "usualness" of health problems in later life served to minimize the perceived intrusiveness of disability. Drawing upon the experiences of others who were in similar situations provided a supportive network. This was important for mediating experiences of chronic illness.

This chapter supports Belgrave's findings by providing further evidence that social comparisons play an important role in shaping perceptions of continuity and change. Three types of social comparison will be presented. These include *positive, negative*, and *same boat* social comparisons.

Next, the process of reflected appraisal will serve to demonstrate the importance of social interactions and the role of significant and generalized "others" in shaping the person's definition of her situation. In examining the role of reflected appraisal, it will become evident that the judgments, or perceived assessments of others can both affirm and threaten the self-concept of the disabled person. Certainly, these findings are not new. Issues pertaining to stigma, and strategies of concealing have been documented by other researchers (Corbin and Strauss 1987; Strauss 1975;Wiener 1975; Goffman 1963). However, this chapter will introduce new types of reflected appraisal (that is, *hypothetical, selective*, and *reversed* reflected appraisal) and their role in mediating continuity and change. The *ends versus means strategy* will also be presented as a mechanism by which the women in this study adapted to their dependence on aids and devices, and in relation, the threatening appraisals of others Finally, this chapter will examine strategies of concealing. This study will note those conditions that foster the engagement of such strategies, and those that do not warrant such performances.

Taken together, it will be demonstrated that the processes by which disabled persons adjust to changes, thereby negotiating their sense of continuity, is often influenced by the way the individual perceives her situation. And, the role of social comparison and reflected appraisal in shaping such perceptions will be examined.

IT'S ALL RELATIVE! SOCIAL COMPARISON

Individuals often compare themselves with others. Through these comparisons, individuals learn more about themselves. Moreover, they also evaluate and judge themselves with reference to "the standards set by the individuals employed for comparison" (Rosenberg 1979, 68). Rosenberg identifies two types of social comparison. "One marks individuals as superior or inferior to one another in terms of some criterion of excellence, merit, or virtue" (1979, 68). In the second type, "the issue is not whether one is *better* or *worse* but whether one is the *same* or *different*" (1979, 68 emphasis not added).

Certainly, the literature provides evidence that social comparisons play a role in the development of the self-concept. But what role does social comparison play in later life? Heckhausen (1990) reports that most older people evaluate themselves more favourably when they compare themselves to others in their same age group. Brandtstadter, Wentura, and Greve (1993) propose that "negative stereotypes of aging may provide a background for self-enhancing downward comparison" (334). Hochschild (1973) investigated an old age community and she discovered that the members were stratified according to what she calls "the poor dear hierarchy". Being older, in poorer health, and having fewer meaningful relationships meant that one was relegated to the lower ranks of the hierarchy. Such unfortunate ones were called "poor dears" (58-62). These findings provide evidence that social comparisons are indeed utilized by older persons to facilitate positive evaluations of the self. However, the findings are not so simple. Other researchers note that older persons may not have as many opportunities for such comparisons. Shrinking social networks, and impaired mobility are cited as some of the reasons that may limit such opportunities (Tobin 1991; Suls and Mullen 1983).

What implications do these findings have for this study? First, the data from this particular study provides support for the role of social comparison in contributing to positive assessments of the self. Moreover, while previous research suggests that older persons are more likely to compare themselves to others of the same age group, this study reveals that older persons also compare themselves with their younger counter-parts. These comparisons are made when they serve to enhance the older individual. And, contrary to the findings of Suls and Mullen (1983), this study demonstrates that older persons are able to find sources of comparison, in spite of shrinking social networks and decreased social interaction. Finally, the findings from this study show that social comparisons are just as effective in contributing to negative assessments of the self.

These findings are important, considering relatively little research has been conducted to assess the role of social comparison in mediating, more specifically, experiences of chronic illness in later life. The data from this study show that social comparison is often a powerful determinant of how a person defines her experiences of living with a chronic illness. (Interestingly, this concept was not anticipated in the early stages of the research. Instead, the importance of social comparison became evident during the interviews. It emerged from the data time after time). In particular, the data show that the significance and perceived intrusiveness of OA are often evaluated through processes of social comparison. This contributes to the negotiation of the individual's impaired, physical self-concept. But most interesting, the findings reveal that beliefs concerning the "usualness" of health problems in later life are mediated by social comparisons (that is, by the same boat mentality). As mentioned earlier, Belgrave (1990) reports that when women believed that their limitations were to be expected, and common in later life, conceptions of the self were protected from threatening changes. This study provides substantial evidence that social comparisons contribute to such beliefs. These findings will be demonstrated next.

Positive and Negative Social Comparisons:

The findings reveal that social comparison presents both positive and negative sources of self-evaluation. Social comparison is beneficial when it preserves or enhances the individual's assessment of herself. This will be called *positive social comparison*. In contrast, social comparison is detrimental to the individual when the comparisons that are drawn upon only serve to promote negative portraits of the individual's disabled self, and her ability to deal with OA. This will be called, quite simply, *negative social comparison*.

The data reveal that individuals often engage in a combination of positive and negative social comparisons. However, it is evident that an individual tends to make one particular type of comparison. In addition, the extent to which individuals draw upon negative versus positive comparisons is not always influenced by the seriousness of their OA. Individuals with milder forms of OA may engage in negative comparisons, while those with higher levels of disability will continue to make comparisons with other people, who are in worse predicaments than themselves. This form of positive comparison often serves to enhance the individual's own assessments of herself. The next examples show the dynamics of social comparison.

In positive social comparison, the disabled individual compares herself with those who are more ill, or with those who are in similar predicaments. This often serves the purpose of allowing the woman to assess her own situation more favourably. The intrusiveness of the chronic illness can then be downplayed or de-emphasized. This, in turn, helps individuals to deal with their own difficulties. The prevalence of health problems in later life also means that some older individuals have plenty of opportunities to make positive comparisons. Several women remarked that most of their friends also had arthritis. Significantly, friends often provide sources of positive social comparison:

> Very few people don't have a certain amount of arthritis at my age. The fact that I had it a little bit earlier doesn't mean that much either, because there are people who've had it even earlier. I think maybe my view of arthritis is somewhat tempered by the fact that I had a very dear friend. She died a couple of years ago. But she had arthritis so badly. You've never seen anything like it. Like she couldn't even wear shoes. She had money, and she had everything that you would possibly want. But she didn't have health, and her arthritis started in her late thirties. I just think of her that this, that I could've been like her. So I don't really have arthritis, compared to her (Helen, age 77).

Grace is confined to a wheelchair, and, while most people would consider her to be severely disabled, her own assessment of her situation was shaped to a considerable extent by the process of positive social comparison. Notice how she does not place herself in the same category as her friends:

> When I looked at my friends last night, I thought, "God am I ever lucky." I went to say it, because we tease each other. I went to say, "I'm the only healthy one among you." But it wasn't the night to say it, because the one has got bladder infection and the other one, they have things I guess, with age. We try to laugh it off. But it's not funny, if you have pain. So, most of my friends have more troubles than me. One of them said, "Boy, what a bunch we are." I went to say, "Speak for yourself." But again, I didn't want to say nothing, because I felt the luckiest of them. I wouldn't want to trade with any of them (Grace, age 75).

When friends or family members suffer from various ailments, this often helps the individual to accept her own chronic condition as well:

> When you've got this, you've got it every day. So you have to throw it out of your mind, and learn to cope. Like my brother's wife, she was out here. We're the same age, and she says, "Ellen, you mean to tell me that you have pain all the time?" I says, "Yes, and some days it's far worse." But you know what she has? She has this skin psoriasis all over her body and she's gotten some cream. I saw her arm one day, when it was lifted up here and it was all... . You know what I mean? So see what she has to contend with? That's

> no bed of roses. She can't go swimming or things like that. So everybody has something to put up with, don't they? (Ellen, age 72)
>
> I've a sister-in-law who's been in a nursing home with Parkinson's and that I would never like to go through. She's eighty, and she's just a vegetable now, just vegging away. I wouldn't want to be like that. So there is worse things than arthritis. Lots worse. When you see people like that, it makes you realize you're not so bad after all. So why should I grumble? (Bev, age 68).

These examples demonstrate that some older persons have many sources of positive social comparison to draw upon. This is especially true, considering the prevalence of health problems in later life. While Suls and Mullen (1983) report that older individuals may not have many sources of social comparison upon which to draw, because most of their friends have passed away or they have lost contact with their significant "others", the findings from this study show that even acquaintances, strangers, or generalized "others" can also be used when making comparisons. Some women compared themselves with the other tenants in their buildings, or with people they happened to come across in the course of their visits to the doctors, or to other public places:

> Some of the ones I hear about. And, uh, what I have seen. You see them in the hospitals, on the streets with their walkers and canes. I give them lots of credit for trying, But I don't need a cane, or a walker, or a battery-operated machine to go. I seen them at Limeridge, going all over the place. So they've got something. I wouldn't say they got arthritis. They might have some other thing (Florence, age 77).

Social comparison is also important when the individual is engaging in "biographical work" and is attempting to restore perceptions of continuity. Recall how Maria was able to repair the damage to her biography by developing the habit of visiting her sick and lonely neighbours. Positive social comparison was an integral part of her efforts:

> That helped me coming out more than anything else. Helping other people. You'd be surprised how much it takes you outside of yourself, when you see other people worse than yourself. You think how lucky you are, even if you can't walk properly (Maria, age 83).

Some of the previous examples also illustrate that age is implicated in processes of social comparison. While most of the previous research contends that older persons tend to compare themselves with members of their own age group, the findings from this study show that younger persons can also serve as sources of positive social comparison. Very often, when individuals compare themselves to other disabled people who happen to be younger, the significance of positive social comparison is reinforced:

> I am grateful, because when I see young people, especially when you go to therapy. Sometimes they send me there for a month, daily. That's for physiotherapy and hydrotherapy. When you see young people, and how they are, and what they have! Well, I think to myself, "I'm so lucky that I lived so long and I'm better off than they are." But it makes me very sad to see young people, and the way they are. I say, "Well, gee whiz. I'm old and look at me and look at them." They didn't deserve that. But what could you do? You feel very sorry for them (Marion, age 79).

> That's why I count my blessing for. When I see these young people coming along, all crippled up along with arthritis, I say I can count my blessings that I wasn't like that then. Just think how much worse they're going to keep getting. Oh no, that's one thing you're thankful for (Ellen, age 72).

The importance of age and life stage factors was even more significant in Ellen's case, because a younger member of her own family had recently undergone hip surgery:

> Middle age, that's the time when you would like to have children. That's the years that you like to go dancing with your husband. And that's the years that you would be working to make money to have, not only for necessities, but to travel. That's why I'm so thankful none of my daughters have it. My son-in-law that's just been in an accident, there he is sitting in the house, and he can't work or anything. So I say to him, "Bob, do you go to work at all?" He says, "Well, if I'm numb, and I'm lucky enough. I might go for two hours a day." And him a young man, thirty-four years old. My daughter had just put him through college, working with one paycheque. And they were just going to be on easy street, and then this happens. So see? She's got that to cope with all her life (Ellen, age 72).

Individuals also evaluate themselves when they compare their own physical capabilities with those of others who have similar disabilities. Positive assessments of oneself are made when the person being compared to has coped less successfully:

> People, not that I'm sticking out my chest, but there's people, even in this apartment, and, oh, they can't do this and they can't do that. They have people coming in and doing things for them, you know, once or twice a month. Well, so far, I do it myself. I don't have to do one room. I don't have to do all rooms in one day. I can't go on the floors. But I have a little hand mop and I think I'm pretty good. I feel proud of myself, that I'm able to do as I do (Marion, age 79).
>
> There are some people, and they complain. They complained when they were young, and they're complaining when they're older. This woman, she fell down the stairs, and she had broken her hip and that. She walks, and she says, "Marion, oh, I can't walk. It's no good." She walks the stairs, one at a time. I say, "Gee you walk great." Me, I take one step, and then put another foot up, another step and all that. I can't even do the steps. But she goes right up and yet, she says she's bad. I think in that respect, I'm worse than her, but I never say anything. I take one step to the sidewalk down, and I just don't know which foot to put down. If I didn't have the cane, I wouldn't know what foot to put down first. I'd topple over...I'm not saying she doesn't hurt, but some people, maybe they like to be babied. Me, I don't like to be babied (Marion, age 79).

Another woman acknowledged that she had slowed down considerably in her homemaking duties because of OA. However, she also noted that she outperformed her friends in terms of the number of household chores that she was able to complete. This affected how she negotiated her own personal expectations and also raised her level of satisfaction with her current role performance. In short, this type of comparison helped her to accept and to be satisfied with her own performance.

These examples illustrate that some individuals are able to re-cast unfavourable experiences in a positive light by engaging in these kinds of positive social comparisons. The person's perception of the intrusiveness of OA is tempered by her understanding of the predicaments of others. In essence, the individual evaluates herself favourably when she compares herself with others. The findings show that older persons may have many sources of comparison to draw upon. This is made possible by the prevalence of health problems in later life. Indeed, many of the women had numerous friends and acquaintances with such problems. It is also evident that in the absence of friends and significant others, acquaintances, or strangers are used as sources of comparison. Positive comparisons are also made when individuals compare themselves with their younger counterparts. These persons believe that chronic conditions are more acceptable in later life. Hence, when these persons think about the predicament of others who happen to be younger, they "count their blessings" that they were able to live most of their lives, free from OA.

Not all individuals engage in processes of positive social comparison. Others demonstrate patterns of negative social comparison. For most of these individuals, OA has produced unwanted changes in their lives and in their conceptions of themselves. Negative social comparisons only serve to emphasize these changes even more. Hence, the individual's perception of the intrusiveness of her disabilities is great. This occurs as the individual compares her own situation with those of people who are doing better. This often results in negative social comparison:

> One of my friends, she has diabetes, but she doesn't let it get her and I can't understand it. She doesn't seem to have as many problems as I do, and I always been a sensible eater. I don't eat junk food, I don't smoke, I don't drink, and yet I've got all these problems. It's just not fair. Her, she's just a borderline diabetic. But she eats junkfood, and greasy potato chips, and gravy. Things like that and there's hardly anything wrong with her. She goes to the market. She's loaded down with her family. They all have cars and she doesn't have a car and she's supposed to have bad feet. So I say, "I don't know how you do it lady. You can do all those things, because I can't do them." (Marge, age 70).

Often, positive social comparison provides little comfort and the person dwells upon negative comparisons instead:

> I always have to ask, "Why me?" But I know I'm not the only one. But then, that's no consolation, because, like I say, there's a lot of rotten people around and nothing happens to them. I know a lot of alcoholics, and they're as fit as a fiddle. So you wonder, where's the justice? I've always thought I was a good person (Marge, age 70).

Just as individuals compare themselves with individuals they outperform, individuals also compare themselves with those they perceive to be more successful. One woman expressed how badly she felt while she observed her neighbour cutting the lawn, especially since she was unable to do her own gardening. This negative comparison was compounded by the fact that the neighbour was eighty-seven years old. Hence, age also plays a role in negative social comparisons. Some individuals compare their physical capacities with those who have superior abilities. These objects of comparison are older as well:

> I compare myself to other people. What they can do at ninety-three, and I can't do nothing. If they can do it, why can't I? To tell you the truth, I didn't find people my age who are worse than me. They still go out, unless some of them just got sick and died, but not with arthritis (Emma, age 78).

> People at my age, my God, they're walking up Fennell Avenue. I can't even walk around the block. There's people here, eighty years of age, and they walk to Zeller's and back (Bernice, age 72).

These examples illustrate that both positive and negative forms of comparison are rooted in similar factors, that is, age, performance levels, and the nature of the health problems. What other kinds of comparisons are made, with respect to experiences of living with OA? The findings show that positive and negative social comparisons are also evident when individuals assess their illness histories, and their experiences of treatment. Some individuals compare their own treatments with those of others This often leads one to develop positive assessments of one's own situation:

> My sister lived in Buffalo, and she had arthritis so bad. She went to this one doctor, and they straightened her knee. Like today, you'd have this hip or

> knee, but they'd lock your knee so you couldn't move it. Next time I go down, she's got this steel brace on her knee. Well, she died. But that's what she went through with her arthritis. I mean, you don't hear of that today. We've come a long way. The hip replacements that they have now, I just have to congratulate them. I hope they don't get these hospitals to stop people from having to get them (Dorothy, age 75).

Other individuals engage in what will be called *generational social comparison.* They imagine what it must have been like living with arthritis before modern treatments were developed. This also causes the person to appreciate her own circumstances:

> Before I had the surgery, it was one year of excruciating pain. The pills that they gave me first didn't work. The next ones I took helped. But then they even started to lose their effect. At least the pain was numbed a bit. I can't imagine what it must have been like for people when they didn't have the operations, because arthritis has been around for a long, long time (Beatrice, age 69).

By the same token, the comparisons of treatment outcomes may also facilitate negative comparisons. One woman became extremely bitter as a result of her own unsuccessful hip operation:

> With the surgery, I thought I wouldn't have a limp anymore and no pain, because a lot of people have gone through it. A lot of them have told me it's the most wonderful thing in the world. So I thought, "Well why me then? Why did it have to be me?" I couldn't understand it. I was so angry. I still am (Marge, age 70).

Sometimes, because of unsuccessful of operations, individuals are forced to relinquish any hope of re-capturing past abilities and performances. These individuals come to realize that the disabled, physical self may become a permanent fixture in their lives. Part of the process of reconciling oneself to an undesirable identity entails trying to understand or explain the reason why the treatment failed. This often involves comparing one's own experiences with those of others:

> At my exercise classes, there was one lady who had a hip replacement, and came back to the pool. She also said that was a very hard adjustment and recuperation. But she went, after the operation, to a rehab centre. She said if

> she hadn't gone there, she wouldn't be able to manage now. Then I had a friend who had this knee surgery done too. After the surgery, she went into a convalescent home for six weeks and she came out fine. She had no problems. I didn't. I came from the hospital right home, because I had someone at home. Maybe that's why it didn't work out, like maybe because I wasn't getting the same rehab (Gladys, age 72).

Finally, the experiences of one woman reveal that, when significant others impose their expectations, social comparisons are inadvertently forced upon the disabled person. This may threaten the individual's own assessment of her situation:

> Well one thing that can aggravate a person is, if you were giving your case history about how you feel. Then they'll say, "Oh well so and so is much worse than you. They got more to get along with than that." I mean, you're not looking for sympathy. You're looking for understanding. It's when people treat you that way that they don't understand you (Betty, age 80).

Overall, positive and negative social comparisons illustrate how individuals evaluate themselves as superior or inferior in comparison with others. This results in either favourable or unfavourable assessments of the self. Such comparisons also influence one's perception of the meaning of living with a chronic illness.

Same Boat Mentality:

In addition to positive and negative social comparison, individuals also consider whether they are the same or different in reference to others. Some individuals identify with their own age group, and this facilitates their acceptance of the changes brought about by OA. For instance, these people draw upon their reference groups, and they compare their abilities with those of others in the same age bracket. Hence, these individuals come to terms with the declines in their personal physical capacities by referring to the experiences of others who are having similar problems. For example, several women commented that they were less inclined to socialize outside their homes, or that they felt "more mellow" and less energetic because of the OA. However, these changes in social patterns were not perceived as threatening, nor did they present significant sources of change, especially since these women recalled friends who reported having similar experiences. In essence, these individuals believed that these kinds of changes were quite common in later life.

As mentioned earlier, the prevalence of health problems in later life also means that the disabled person "certainly has a lot of company". Many women remarked that "they were in the same boat" as many others. Hence, this will be called, *the same boat mentality*. Aside from *threatening same boat comparisons* (this will be discussed later on) *the same boat mentality contributes to the belief that health declines are common in later life*. People recognize that they are not alone, when they compare their experiences with those of their friends:

> Most of my friends are in my age group, and they're slowing down too. My two girlfriends, they've never been married. One's almost blind and the other one's just gone through major surgery and she's having a problem. My other friend, she had the knee operation, and she's got the arthritis. I don't have younger people friends. We're all kind of in the same boat (Maeve, age 78).

> Well, my friends and I, we all complain about aches and pain. I think most of my friends are at the age where they have arthritis. We're all going through it. We've all had pretty good lives though (Dorothy, age 75).

The "same boat" mentality is helpful when individuals are adjusting to various physical changes. Hence, this type of comparison often serves to minimize the intrusiveness of physical limitations:

> I figure everyone else is in the same boat. You see, a lot of people, when I go out, and I say, "Gee, what is this? Cane village?" Because there are so many people with canes. I mean, that is the wonderful thing, this hip replacement and the knees...There's this man, and he said, "You know, I played golf for the longest time." He wanted to have his hip replacement done, because it was sore. And I said, "Join the club, because I just had my hip done" (Dot, age 75).

> I had to use the cane more after surgery when I started walking again. That's when I first noticed that so many people used canes. I said to my husband, "I never noticed it before." And he said, "Well, you just didn't pay attention." When I started using it, I was more aware that there was other people using it. It just meant if you need it and if it helps you, why not? (Gladys, age 72).

Sometimes, an individual will learn from the examples of others who are in similar situations. This encourages the woman to cope with her own OA in a positive manner:

> The seniors' centre does a lot for you, because there's so many happy, and you know, try to be happy people down there. So many people are in the same boat as you are. There are some of them that are kind of snobby. I don't bother to speak to them. But most of them are all happy go lucky, and try to do their best (Ellen, age 72).

People also compare their attitudes about having OA with the attitudes of others. A few women described how much they respected friends who were battling life-threatening diseases admirably. Some women tried to use these women as models. Hence, some women believed that their attitudes were quite similar to the ones modeled by their friends. By identifying themselves with these role models, they were also fostering positive, self-evaluations:

> Another friend just found a lump, and she's got cancer going through her. I think it's only a matter of time. I spoke to her on the phone, and I didn't let her know that I knew as much as I did. Her faith is getting her through it. You have to hear how positive she is about dying. Of course, I think the positive thinking, like she believes in the here-after, and to her, she's in pain but it's acceptance. She accepts so much, and I think I do too. That it's the Lord's work, and that there's better things coming... . I could say that this person is in great pain. Right now she's probably getting radiation treatment and she's so positive in her mind. I try to think like her. Like I think, we get on because we both think that way (Grace, age 75).

In some situations, the "same boat" mentality presents a threat to the individual. Identifying with another person calls into question one's own disabled identity. Often, the individual compares herself with another person, and hopes she never finds herself in the same predicament. Unfortunately, she can very easily with her object of comparison.

She is able to see reflections of herself in the other person. This leads her to make a negative evaluations of her situation, because the she does not want to be categorized as being the same boat. For many chronically disabled individuals, futures are uncertain and no one is able to predict the trajectories of diseases. Observing the declining health of others, or disabilities of others, can be quite disconcerting:

> I do in a way think about the arthritis getting worse. I know a friend of mine who was very active. She reminded me of myself. That poor soul. She's been in the hospital for months and months, and she ended up in a wheelchair. I thought, "Oh, don't tell me that could happen to me." She was a wonderful person, really active and never put on a pound, and really liked to walk, and everything. She was the last person I expected to end up that way. So that does cross my mind. I really wouldn't like that at all (Marge, age 70).
>
> Every once in a while you might see something on TV, and you think, "God is that going to happen to me?" Or somebody else in the building hears something that'll happen to them. They'll have to go to a home or something because this is the last hole in the wall. You're either going up or you're going down (June, age 69).

One woman, Betty, resented it when other people suggested that she move into a nursing home. It is not surprising then, that the experience of another woman troubled her greatly:

> It was very disturbing. Not too long ago, I heard about this lady. She was doing the best she could. And then the next thing I heard, apparently she was phoning her children, because she was lonely. She wanted some company, and uh, so they got together, and got her to the doctor, and figured she should be in the nursing home. That bothered me greatly, because when I told my son about it, he said, "You don't have anything to worry about there. Nobody's gonna." But you see, the family can do things to you and there are some families that do. Thank God my family is going along with what I want, 'cause I want to stay right here. How long, I don't know (Betty age 80).

This was an unsettling even in Betty's life. Although her children supported her in her wishes to live independently, she engaged in processes of concealment in order to maintain their support.

Interestingly, some individuals refuse to adopt the same boat mentality altogether. The individuals who exhibited this pattern, at least in this study, did not benefit from their rejection of this identification. These individuals believed that they were worse off, and that no one could possibly understand their predicaments:

> When people don't have arthritis, they can't really visualize what it is, really. One lady said, "Well everybody's got it." And I thought, "Well not everybody's got it, really" (Marge, age 70).

Finally, it must be noted that people often engage in combinations of positive, negative and "same boat" comparisons. However, the data reveal that individuals tend to focus predominantly on one type of social comparison. For example, some individuals recognize that others enjoy more desirable circumstances in terms of their physical capabilities. Nevertheless, they choose to emphasize positive comparisons. In contrast, others dwell primarily on negative ones, while others refuse to engage in negative comparisons all together. Interestingly, some individuals with quite severe disabilities continue to make positive social comparison, while others with fewer physical limitations, focus on negative ones. It is not clear why certain individuals choose to make one type of social comparison over another. The data reveals that the severity of OA does not always determine whether individuals will draw upon positive or negative comparisons. Perhaps individual personality traits and attitudes influence these decisions. This points to another interesting area for possible future research.

Overall, these types of social comparison are important in shaping the illness biographies of individuals. In particular, the processes by which the individual adjusts to changes, thereby negotiating her sense of continuity, is often influenced by the way the individual perceives her circumstances. Social comparisons play a role in determining the ways in which the person defines her own situation. The significance and the perceived intrusiveness of OA are influenced by social comparisons. Hence, positive, negative and 'same boat' comparisons may be implicated.

Positive social comparisons, and the same boat mentality often serve to buffer the impact of the perceived changes brought about by the onset of OA. While individuals acknowledge the changes in their physical capabilities, their awareness of the seriousness of these changes is mediated by social comparisons. Hence, unwanted physical limitations may be accepted by women when they compare their problems with those of others who are worse off. Women may also draw comfort from recognizing that they are not alone in their experiences. It appears that finding comfort in numbers may serve the purpose of **normalizing** one's own experience of disability. Accordingly, the perceived impact of the changes to one's performances will be evaluated within this context. Such comparisons often serve to contribute to the perception that physical declines are common in later life.

Finally, when individuals are unable to draw upon positive social comparisons, or when the same boat mentality only proves to be threatening, this may contribute to people's perceptions of negative assessments of their own experiences with OA, and unwanted changes may be perceived as such. Such comparisons do not contribute to beliefs about the "usualness" of health declines in later life. This is an interesting finding considering that Belgrave (1990) does not address the impact of negative comparisons and the processes by which age-associated beliefs do not facilitate the acceptance of disability.

WHAT OTHERS THINK MATTERS! REFLECTED APPRAISALS

The principle of reflected appraisal will be examined in this section in order to uncover the ways in which the imagined assessments of others toward the self, shape experiences of chronic illness. In particular, it will be demonstrated that reflected appraisal are sources of both continuity and change as the disabled person defines her own situation of living with OA. In addition, the implications of reflected appraisal will be examined in conjunction with the presenting self. The literature shows that chronically disabled persons often struggle with their attempts to negotiate preferred presentations of themselves. Issues of stigma, which result in efforts to normalize or conceal the chronic condition have been addressed by other authors (Conrad 1987; Corbin and Strauss 1987; Wiener 1975). However, other questions remain unanswered. Are chronically disabled, older persons exempt from such situations due to the "usualness" of health limitations in later life? How do older persons construct preferred presentations of themselves? How do older persons confront unfavourable, or threatening images of themselves when they are unable to negotiate preferred presentations? Finally, if older persons do engage in processes of concealing, under what conditions are such efforts expended? These questions will be addressed next.

Reflected Appraisal:

The process of reflected appraisal is a basic concept advanced by the symbolic interactionist conception of the self. This principle holds that an individual's picture of him/herself is shaped by the attitudes of others toward that person. Rosenberg notes that a reasonable agreement between other people's views of the person and the person's own view of him/herself is "completely indispensable for adjustment to society" (1979, 63). Indeed, one's sense of personhood emerges through the process of assuming the views of others toward the self (Rosenberg 1979, 64). Mead provides an eloquent definition of this principle:

> The individual experiences himself as such not directly, but only indirectly, from the particular standpoints of other individual members of the same

> social group, or from the generalized stand-point of the social group as a whole to which he belongs (1934, 138 in Rosenberg 1979, 64).

Hence, the person's self-concept develops as he/she, "takes the role of the other" and reacts accordingly from the viewpoint of others. This also involves "the imagination of our appearance to the other person and the imagination of his judgment of that appearance" (Cooley 1912, 152 in Rosenberg 1979, 65). Cooley's formulation of the "looking-glass self" advances the symbolic interactionist conception of the self by emphasizing the significance of the person's *perception* of the attitudes of others for the development of the self-concept.

The findings for this study reveal that reflected appraisals are important as individuals adjust to their disabilities. This concept is important because an individual's self-concept is often validated by the responses of others. By the same token, the individual may be threatened by the unfavourable responses of others. This underscores a key point: the changes in the disabled person's self-concept are often mediated by the perceptions and attitudes of others (Corbin and Strauss 1987). Hence, chronic illness presents an interesting scenario because reflected appraisals may take on new meanings.

The experiences of the women in this study reveal that reflected appraisals are either affirming, or they present a source of tension when the perceptions of others do not correspond with the individual's own view of herself. In *affirmed reflected appraisal*, the expectations of significant others complement those of the disabled individual. Role requirements, role performances, and interactions have been mutually adjusted. Moreover, the woman believes that other people are pleased with, or support, the ways in which she has adjusted to living with OA:

> My family, they're really pleased with me... . They seem to think I've coped pretty good, so I try not to worry them. They're happy to see me too, like living in a place by myself and not an institution (Grace, age 75).

In addition, the extent to which the individual perceives the chronic illness to be intrusive is also validated by others. One woman recognized that OA was limiting her activities more and more, and she recognized that her disabilities were progressing. Nevertheless, she preferred to minimize the severity of her condition. Her family helped her with this:

> We just joke about it. "Old age mum." No serious problem (Bev, age 68).

Moreover, her family is supportive and understands of her limitations:

> Well, my daughter who's at home, she's got two children at school. She'll phone, and it's, "Mum, do you want to go shopping?" And I have a granddaughter at twenty. And if she's got a day off, she'll phone and take me shopping. But they're flexible. If I feel like going, I go out and if I feel like staying home, I stay home. They're very flexible. So it's okay with them and it's okay with me (Bev, age 68).

These examples illustrate that through affirmed reflected appraisal, the individual's view of herself is supported by the reactions and attitudes of others. Such confirmation such to provide perceptions of self-consistency.

Not all individuals, however, enjoy affirmed reflected appraisals. In some cases, the attitudes of others threaten valued components of the individual's self-concept. In the case of *discrepant reflected appraisal,* the reactions of others to the disabled person are detrimental to her sense of being. The individual imagines or adopts these perspectives, and reacts to them. Some of the threatening changes that are associated with OA are reinforced by this type of appraisal. One type of discrepant reflected appraisal involves the unadjusted expectations of significant others. For example, family members are unable to accept the changes in the disabled individual. These "others" continue to cling to images of the woman as she was before the onset of the disease. The imposition of such images threatens her efforts to negotiate the changes introduced by OA. Acceptance of one's disability is made more difficult as the individual perceives the disappointments of others:

> It's hard for the family to accept that mother isn't what she used to be, able to do the things. It's hard for the family. You got to think of it that way too. It's hard for the family to understand that mother is not the way mother was when they were growing up. Mother has changed. When you say you can't do something, it's hard for them to understand that you're not making excuses. At least, I'm not making excuses. If I can't do it, I can't do it. But I will put myself out to try it. But I'm not always able... . It's that they're remembering you when you were active. They remember you as you were, and that it can't happen to you. They're accepting it in one way, and in another they're not. I feel that (Betty, age 80).

In some instances, other people view the individual as being more severely disabled than she herself does. For example, one woman was strongly opposed to the idea of leaving her home and moving into a seniors' residence. However, her daughters, as well as her doctor, strongly recommended that she consider moving. However, Cynthia was adamant that she was still capable of living independently. This was especially significant since she believed that moving into "a home" symbolized "the last stop before death". Betty's experiences also reveal how threatening these discrepant assessments can be:

> I resent people who think, because I'm disabled, that I'm ready for a nursing home. At least my family hasn't turned on me in that way. But that is one beef I have, and I'm afraid it's become contagious with me. Because I was in hospital one time. They kept bugging me about going into a nursing home and uh, I'm not ready for any nursing home. I don't intend to go as long as I can possibly fight my way out of it...I've got different things that's said, and I'm afraid I can see behind the little things that they say, like, "Well you should be needing more help." Or, "Have you thought about maybe it was getting too much for you?" I know what's coming next, and I won't. No way! So I tell them straight out, "I'm not ready for no nursing home." If I went to one, I'd send them crazy or they'd send me crazy, because I would be a very dissatisfied person (Betty, age 80).

Discrepant reflected appraisals are also evident in social exchanges:

> I have a friend on the eighth floor, and she'll come down in the afternoons or in the evenings. Well, two weeks ago I said, "I'm coming up to your place for a change." This is another thing. I said, "I'll come up to see you." Then it's, "Oh, do you think you'll be able to make it, with your feet?" I said, "I've got two feet to walk with. I can still walk." I guess they figure I can't make it. They think I can't do nothing. I can, but not as fast as what I used to, but I can still do it. It's, "Are you sure you're going to be all right?" I just say, "Well watch me!" But they just think I'm putting on. That's why I say to you, next year, I'm going to go by myself over to the mall (Bernice, age 72).

These examples illustrate how negative assessments on the part of others often present a threat to the person's own self-image. It is also interesting to note that other people's assessments are often difficult to negotiate. For instance, Bernice readily admitted that she was quite severely disabled. She had been unable to leave her apartment for most of the year. She was also disappointed that her daughters did not provide the support she had counted on, considering her worsened state. However, when others imposed their own negative assessments of Bernice's disability, she became angry and tried to draw attention away from her limitations. It appears that at least for some individuals, the impact of discrepant reflected appraisals is quite threatening. While the private and personal recognition of one's own shortcomings may be difficult enough, such recognition is made even more difficult when others attempt to impose unwanted changes. Finally, Betty's case shows that some individuals struggle to maintain preferred, independent identities, and they may resent negative appraisals. At the same time, these individuals also want others to understand and to acknowledge that certain changes in their condition have been caused by chronic illness.

In addition to affirmed and discrepant reflected appraisals, the findings also reveal what will be called *hypothetical reflected appraisals*. The individual assesses herself by imagining what a significant person from the past, usually a deceased person like a husband or late parent, would have thought of the individual in the present. Affirming and discrepant assessments are also illustrated in this type of reflected appraisal. For example, one woman had relied on her husband to oversee their banking and financial matters. She also relied on him to perform many household tasks. Her hip problems were compounded by the sudden death of her husband. After a stressful transitional period, Mabel assumed many of these responsibilities and she became quite competent at these tasks. Her assessment of herself was reinforced when she imagined what her husband would have thought of her progress:

> I often think he'd be surprised how much I'm able to do, that I'd never do before. I'd never use a telephone before. I always got him to do everything. I know that he'd be quite surprised at what I'm able to do in managing things (Mabel, age 81).

Hypothetical reflected appraisals also have the potential to extend the negative assessments of others from the past, into the present. Clearly, these appraisals are not affirming. For example, one woman had suffered through a particularly abusive marriage. Although she has been widowed for quite some time, Violet was able to imagine, hypothetically what her husband would have thought of her present situation, were he still alive. This was especially significant since OA had led Violet being confined and socially isolated. She noted that, as a result, she had become quite lonely and depressed. Her unfulfilled wife identity was quite prominent and it was important in shaping the way in which she coped with her arthritis:

> You see, really, you're in a lonesome world. If I didn't have this arthritis, I could go out and meet a friend for lunch or something. I could take the bus, and go shopping. When you're alone, you have nobody to talk to. So when you start thinking about these things that are unpleasant, you have no one to talk to about it. So therefore you're wrapped in yourself. It's sort of like somebody throws a blanket over your head and ties you up, 'cause you have no interaction with people. Instead of being able to- because of the way my marriage was, I'm not able to sit here and be happy, because I start reminiscing back to the times I was with my husband, which as you get older you start re-living your life (Violet, age 77).

The hypothetical imagination of her husband's response to her condition re-inforced this past identity:

> You sometimes wonder what happened to make him the way he was. I mean, I know now that his mother was crippled with arthritis. But she was in a wheelchair. If he was here right now, and I said, "Oh I've got terrible pain in my knees and my back." He'd say, "Oh come off it. You don't even know what pain is. Look at my mother, and the way she was." I'm having pain just the same, but he would not have any sympathy for me. Not at all (Violet, age 77).

Overall, it is evident that reflected appraisals are involved in the continual development of the self-concept. The assessments of others are important as the individual negotiates the changes in her physical self-concept. Sometimes, interactions prove to be useful sources of self-affirmation. At other times, discrepant appraisals may be quite threatening. The next section will continue the examination of reflected appraisals by illustrating the ways in which individuals cultivate preferred identities.

Reflected Appraisals and the Presenting Self:

The previous chapter showed how fragmented body moves, and mind-body discord often limit the individual's ability to master her body performances. As a result, she may become more and more aware of her impaired performances. And, discrediting presentations of the self may become an issue. Recall that the *presenting self* refers to the processes by which the self is intentionally presented to others. Often termed as "impression management", this concept addresses the ways in which the individual performs and controls personal behaviour in an attempt to present the kind of image of the self that the actor wishes to convey. Such performances vary in the extent to which the presented self fits with or diverges from the actual image that the actor has of herself (Rosenberg 1979).

Most significant, the presenting self is intricately related to reflected appraisals. That is, *individuals engage in performances in the attempts to preserve and/or affirm self-images*. The performer's self-image is validated by the responses of others to these presentations. Because the individual is able to imagine how others perceive him/her, presentations of the self will be modeled with these imagined appraisals in mind (Rosenberg, 1979, 45-49).

> Although the immediate aim may be to convince others that we are a certain type of person, this objective serves the deeper purpose of convincing ourselves. However much an individual may like to think of himself as intelligent, attractive or skilled in some way, in the long run he will actually believe he is so only if this view if substantiated by external evidence. One of the major sources of evidence is the responses of others toward us (Rosenberg 1979, 48).

The presenting self is an important concept considering the potentially disabling effects of OA, and the ever increasing likelihood of impaired performances. The individual's ability to present preferred presentations of the self may become limited. As a result, it becomes ever more difficult for her to generate the kinds of appraisals that will affirm valued components of the self-concept. Corbin and Strauss (1987) address this issue when they state that body actions, or performances are important because individuals perform not only for themselves, but for other persons, with them, and through them (257). Hence, both the interactive and evaluative components of "performance as action" are evident. These may greatly influence a person's self-concept.

Corbin and Strauss do not explore whether failed performances in later life present any unique issues. And, while the chronic illness literature has emphasized the issue of stigma, Belgrave (1990) notes that the matter of stigma may not be as problematic in later life, due to the usualness of health problems. Our study reveals a variety of ways in which discredited presentations of the self are experienced in later life.

On the one hand, the usualness of health problems in later life may minimize stigmatizing experiences as Belgrave (1990) suggests. This may be especially true for OA, since this disease is quite common in later life. However, it is also possible that the disability arising from OA may be associated with negative stereotypes of old age. Matthews (1979) contends that the old age identity presents a "spoiled identity", and oldness itself may be viewed as a stigma (57-93). Hence, do the limitations arising from OA lead to undesirable presentations of the self, and do these experiences represent a threat to the self-concept? If so, what kinds of strategies do these persons draw upon in order to deal with these situations?

In order to explore this issue, it is worthwhile to address the role of aids and devices. Our findings reveal that the use of canes, walkers, or wheelchairs may or may not be implicated in processes of reflected appraisal and presentations of the self. Some of the women in this study reported that their disability did indeed lead to undesirable presentations of the self. Sometimes, women associated these presentations with negative stereotypes of old age, and the experiences did prove to be a threat to the self:

> When I first started using the cane, it was really hard. I went to church with it first, and I didn't like it. It made me think, "Was I really at this point, that I needed a cane, just like those other old ladies?" And then I got really mad. This one woman in the congregation came up to me and said, "What's wrong with you? Why are you using a cane? I'm older than you, and I'm not needing one. You're not even seventy yet!" She just made me feel so awful about it (Marion, age 79).

Other individuals described how their reliance on walkers, canes, or wheelchairs similarly challenged their physical, self-concepts. These individuals were forced into presenting themselves in ways that were not acceptable to them. Consequently, their perceptions of the attitudes and views of others were negative. However, these persons did not necessarily relate these undesirable presentations to images of old age. Often, these persons were threatened when they associated their presentations with negative images of "cripples":

> I got my DARTS tickets, and I had them for two years before I used them. I was just so mad that I had to use something that cripples use... . I'm still, when I go out on my scooter, I look so healthy, and I think people think, "Well what the hell is she doing on that? There's nothing wrong with her." With this kind of arthritis, it's not the kind that disforms you. You can't see it, so people think it's all in your head (June, age 69).
>
> I hate the wheelchair. People do stare, and they still stare at me sometimes with the walker too. Every once in a while, I still say to my husband, "If that person looks at me again, I'm going to stick my tongue out at them." I never do. But it makes me feel better. They do stare (Lillian, age 72).
>
> It's just my way of walking. I'm really self-conscious. Oh, you go anywhere, and you got the cane. I guess I'll get over that. But if I could just walk normal. But you just feel that everybody's looking at you or something... . It's an inferiority complex, I guess. I mean, you want to look your best and look nice, eh? I'm trying to concentrate on this hippity-hoppity way of walking (Dot, age 75).

These excerpts show that for some persons, having to rely on aids and devices serves as a reminder of one's changed physical capabilities. A woman may be forced to become more aware of her changed presenting self. However, the findings also show that some individuals do not experience any difficulty whatsoever when they are forced to rely on such aids. They find that the aids are beneficial, and that they help them complete various body performances. They believe that the benefits of using the devices outweigh the risk of embarrassment or stigma. This will be called the *ends versus means mentality*. The ability to complete various activities (the ends) is seen as being more important and this justifies the use of such devices (the means):

> My daughter-in-law and I went shopping, and I said, "Oh I don't think I'm going to make out." It's just too much walking around, and your knees give out and my hips. So she said, "Well I don't think we're doing this right." So she got a wheelchair. Ever since that, every time we go shopping, she brings a wheelchair...I guess, I just thought it's the only solution. Because I'm really

> not capable of getting on those escalators, and moving fast. I felt bad for slowing her down, so it was better. It was easier for her. Anyway, now she says there's someplace to put the parcels (Violet, age 77).

> Some people are steady, and they still use the cane for protection. I do the same thing. If I go to a store and there's a buggy, the first thing I grab hold of is a buggy, because it's more steady to hold on to. I'm trying to protect myself. So I put the cane in the buggy and I push the buggy because I have more protection. That's all. But it doesn't bother me that I use the cane (Emma age 78).

These findings show that women respond to their altered presentations in a variety of ways. It is important to note however, that even those who felt threatened by these presentations learned to adjust to these changes. Generally, the ends versus means mentality was adopted, and many women came to recognize the benefits of these devices:

> I'm still, even when I go out sometimes, conscious of what other people think. But I know that, if I don't use the scooter, I ain't going no place. It don't bother me at all. Now, I take this walker. I've been taking it to the hospital, and it's beautiful. Like I went down, and the waiting room was full and the nurse says, "I'll get you a chair." But by the time she got back, I just turned around, and sat on that. She couldn't believe it. It's wonderful (June, age 69).

Individuals recognized that, if they did not utilize these aids, many of their valued activities were impossible. This encouraged many of the women to revise their personal definitions of what it meant to be dependent on wheelchairs and walkers. Rather than viewing aids as symbols of disability, they came to be viewed as ways of overcoming physical limitations. This helped some women to deal with potentially threatening appraisals. Grace described her initial distaste at having to rely on a wheelchair. Although there were moments when she continued to feel self-conscious about her disability, Grace learned to come to terms with her situation by seeing the benefits of the chair:

> Even as the arthritis worsened, I was actually seeing and enjoying the little trips I was on. With no wheelchair, I would've been nowhere. And I might've

> been different, fed up, kind of not getting out, so much pain. But the wheelchair, in my case, happened to be my lifeline (Grace, age 75).

She also made efforts to engage in what will be called *selective reflected appraisals*. Grace chose to emphasize those appraisals that were positive and affirming. The individual chooses to view her situation positively. Hence, the individual focuses on affirming interactions:

> When I first went in that chair for my husband, he was sort of pushing me. And I was, "What am I doing here? Oh dear." The thing is, the next time he took me out, he parked me into the little table, and grabbed some coffees. These other people seen me there, alone in my wheelchair and this lady was showing me the pillows she had just bought. I think they were feeling sorry for me. She left, and then a man came and said to me, "I just came out of a wheelchair." My husband was coming back with the coffee. But people were talking to me, so it didn't seem such a bad experience... . People are so wonderful, and I have looked on the part of how good people have been. I find the good in most people... . I wouldn't be thinking so much about the emotional, that I'm in a wheelchair (Grace, age 75).

While others might have tended to believe that these people were pitying them, Grace interpreted the appraisals of others positively. She chose to believe that others were being nice.

Interestingly, one woman extolled the virtues of her new walker. She valued it precisely because it helped her to maintain a preferred, "presenting self":

> I found that I had to get the canes, and that's all there was to it. Because I would walk like this, and I'd fall over. People would think I was drunk, walking along like that. Because I never walked straight. I try very hard not to get like that, and I will get like that if I don't be careful. So that's another thing, why I thought the chair would be good for me, to keep my back straight up like that....If I pull it right up to me, I can pull myself up, and walk straight like that (Maria, age 83).

As reported by Belgrave (1990), others recognized that such changes were common in later life:

> Well sometimes when I feel very weak and I'm not able to walk far, that would make me feel more hesitant. Or when you go places, you might feel

> kind of slow and pokey, but I think that all older people might feel like this. And this might not have anything to do with the arthritis. But they do feel this way because they're clutsy in what they do. For instance, when you get the change out at the cashier. Here you are fumbling in your purse because the arthritis is in the hands and you can't pick up things. So often, you just pull out a bill. You'll end up with a pile of coins. I have coins galore and I had them rolled up (Helen, age 77).

In addition, some individuals point out that the use of canes is widespread and they note that aids are not restricted to older individuals. One woman had once believed that sitting in a wheelchair meant "you're finished, you're old". She recalled the social stereotypes of aged, crippled persons that had been common when she herself was middle-aged. In negotiating the acceptance of her own wheelchair, this woman drew upon her belief that the reliance on such devices was more common than it was in the past:

> You're thinking and feeling, "Have I got to the stage where I need a cane or a chair?" Years ago, long time ago in my years, you never seen anybody out in a wheelchair. Or if you seen anybody with a cane, it was a real old person who could hardly walk and it was almost real old... . But that's not the way it is anymore. You go to a mall, and everybody, every fifteenth person, is in a wheelchair. Or you walk around, and everyone is using a cane (Grace, age 75)

Hence, the data from this study present mixed findings. Some women associated their disability and unfavourable presentations with negative images of old age. Others were threatened by their altered presentations in public settings, but they did not necessarily relate their experiences with negative images of old age. These persons were more likely to focus upon the presentation of the disability itself. Still others were not threatened by their altered presentations at all. These women adopted the means versus ends mentality and/or they accepted the same boat mentality. Hence, these findings indicate that when age-related beliefs are implicated in the presenting self, such beliefs serve both positive and negative functions, a point not made by Belgrave (1990). In all cases, the women eventually learned to adapt to their altered presentations by adopting the ends versus means mentality, by engaging in selective appraisals, or by re-defining what it meant to be dependent on aids and devices.

Given these mixed findings, processes of concealing present another interesting issue. The chronic illness literature, (which focuses predominantly on the experiences of middle-aged persons) often highlights strategies of concealment as disabled persons attempt to manage their presentations of themselves (Conrad 1987). But to what extent do issues of concealing apply to older persons? The findings reveal that processes of concealing are indeed utilized. Sometimes, individuals will make conscious efforts to *conceal* their limitations in order to present preferred identities. Some of the mother identities discussed in Chapter 3 illustrates this point:

> My daughter says I don't tell her enough. But she is immediately- you say you got something, and she is a typical nurse. I get nursed to death. So a lot of things, I don't tell her. When they're out here, they watch me. How I'm walking and it's, "You're better today mother." I just don't want to worry her because she's protective, very protective. Like she'll phone every day, and I'm, "Yes, fine, I'm okay." And then it's, "What's the matter with your voice?" "Nothing's the matter with my voice." "You're in pain tonight, aren't you?" "Well, a little bit." "Well, how much is a little bit?" She is a worrier. And unless I have to tell her something really bad, I don't (Lillian, age 72).

> I think my family is really pleased with me. So I try to do as much as I can, so they can see that I'm doing well. Then they're content to go on. Like I'll say, "Oh I'm going over to play cards tonight." And even if it ends up that I didn't go, to their knowledge, that's just like telling them, I'm fine. Don't worry about me (Grace, age 75).

In other cases, the woman's desire to present an independent mother identity is more important to her. Cynthia's experience conveys this well. Knowing that her daughters would like her to move into a seniors' residence, Cynthia often used concealment strategies in order to divert the presentation of her disabled self.

Sometimes, women are compelled to engage in adjusted presentations of themselves because they regret their past performances. For example, some regret having presented their disabled selves to others, since these interactions have led to changes in social relationships. In other cases, the individual feels that her health has improved, but that others cling to images evoked by her past presentations. If these images are difficult to dispel, the person may regret past presentations as well. This may also compel the person to engage in processes of concealment:

> People know the pain is there, which I have told them, not thinking it was going to put me in this apartment all the time. I used to be asked out for supper and everything. But now they think I can't go. I told them you'd think I had two legs cut off. "When you get better", I've heard them say...Now I won't say nothing, unless they say, "How's your ankles? Are they up?" I'll say, "No, they're down." Or if they're up, I'll say, "Oh they're up half way, but that's okay" (Bernice, age 72).

A few distinctions must also be made in order to place the issue of concealment in its proper context. It is important to note that, in some cases, individuals do not like to discuss their health problems. However, it would be inaccurate to label these preferences as processes of concealing. Sometimes, individuals simply wish to avoid thinking and talking about their disabilities. Their refusal to dwell upon their limitations do not mean that they are making efforts to conceal. Some individuals simply do not have any desire to discuss their problems:

> It's a bother, because I don't like talking about my health. Sometimes my friend phones, and she asks, "How are you managing?" And I say, "Oh fine." She says, "You sound kind of hoarse." And I say, "I've been reading again." But if she says, "What kind of a night did you spend?" I say, "Not so good." That's all I want to talk about it, and forget it. I think it just makes you feel worse, when you talk about it (Cynthia, age 84).

And as Ch. 3 demonstrated, friendships often provide the opportunity to affirm other valued aspects of the self, and the women do not wish to focus on health issues. Hence, these women choose to divert the imposition of their disabled identity, simply by minimizing the extent to which OA becomes the focus of their conversations. Hence, it would be mistake to assume these actions were evidence of concealing:

> We decided not to talk about health problems. Just when you visit, we forget all our troubles. I think it was because when my cousin was here last summer, she's had two hip operations. She takes a cane with her, and I said, "How are you feeling Helen?" She said, "I'm here to talk, but not about my health." That's when we decided to turn it down, and just talk about good times and things like that... . I think that's good, because I refuse to talk about mine too (Cynthia, age 84).

These findings also suggest that the likelihood of engaging in strategies of concealing is greatly determined by the audience in question. It is important to distinguish those situations in which the individual decides to conceal and those situations in which the presenting self is not seen as being an issue at all. Some individuals are quite comfortable about sharing their experiences with certain people. Friends are often sources of support and many individuals find that it is helpful to express their feelings. Friends sometimes have similar chronic conditions, and they can compare treatments and talk about their ailments. (However, these discussions do not become the focus of the conversations).

In addition, people who find they have the same chronic conditions often find occasions to discuss their situations. Support groups, arthritic exercise and therapy classes also provide opportunities for people to discuss their common experiences. In these situations, concealment is not an issue. This illustrates the point that a woman's presentation is influenced by her audience:

> I talk about it when I go to therapy, say whether it's physiotherapy, we talk about it, with the people that I associate with in the exercises.. Friends, we're quite open about it. What is there to hide? (Marion, age 79).

However, in reference to her adult children, this woman said:

> Some things I share with them, a few things I hold back...Well, some things you say to your children. It makes them more concerned, more alert. Always asking, "How about mother? What do you think we should do? Or shouldn't do? She's sick." Or anything like that. Well, I can cope. So why give them excess burn. They know what I have (Marion, age 79).

Hence, individuals may be comfortable sharing their experiences with certain people, but they may make efforts to minimize the impact of their limitations in other situations.

Reversed Reflected Appraisals:

The symbolic interactionist conception of reflected appraisal proved to be useful for analyzing the experiences of the women in this study. However, our findings uncovered another related principle- ***reversed** reflected appraisals*. This concept underscores a key point: individuals not only imagine and adopt the attitudes of others toward themselves, but they are also involved in constructing their own assessments of others. More significantly, people may use their assessments of others as a basis of evaluation for their own performances. Hence, a person's appraisals of others are re-directed, or transferred back to him/herself. This is especially true when the "appraiser" finds him/herself in a situation similar to that of the "appraisee". This is what is meant by *reversed reflected appraisals*.

Perhaps the clearest examples of reversed reflected appraisal are those instances in which the individual reflects upon the experiences of other disabled or ill people. The coping styles and attitudes of others are assessed. Sometimes, the presentations of others are judged unfavourably. This often causes the individual to evaluate his/her own performances. The appraiser does not wish to follow in the footsteps of his/her appraisees. As a result, the appraiser strives to manage her disability differently. For example, one woman remembered how she had responded to an old neighbour, who had complained about her health constantly. Maeve remembered what it was like having to listen to her neighbour's never-ending complaints. As a result, Maeve made efforts to conceal her own difficulties when she was with others:

> I can remember, as a young person, I had a neighbour and she was an older person. I was only in my twenties, and I guess I wasn't as understanding. I'd say, "Good morning Mrs. Smith. How are you?" And I'd listen to all her complaints. I never remember her saying, "I feel fine. It's a nice day." I Sometimes I'd see her coming around, and I'd think, "Oh, I hope she doesn't see me, 'cause I know if I ask her how she is, I'm going to have to listen to all those aches and pains." And I can remember my son telling me, "Mum, nobody wants to hear about all your aches and pains." I think that's true. "How are you?" You're fine. And I usually say, "Pretty good thanks." And I might really be hurting (Maeve, age 78).

To further clarify this concept, another example might be useful. For instance, a woman becomes dependent on a wheelchair. This presents a threat to her self-concept, and leads her to wonder what others will think of her. In addition, she then starts remembering the way in which she once viewed others who used similar kinds of aids. The woman may then start to relate these past appraisals, attitudes and assessments to herself. This illustrates the process of reversed reflected appraisal. Grace's experience conveys this process quite clearly:

> The first time I went into the chair, that was an emotional upset there. I wasn't very happy being pushed, because I'm in a wheelchair. And we used to think that, once you're in a wheelchair, that's the end of things. That meant you were finished...When I was young, everybody in a wheelchair, you just about had it...I guess, it's because of yourself. You're thinking and feeling, "Have I got to the stage where I need a cane or a chair?" Years ago, long time ago in my years, you never seen anybody out in a wheelchair. Or if you seen anybody with a cane, it was a real old person, who could hardly walk and it was almost real old (Grace, age 75).

Fortunately, Grace drew upon the ends versus means mentality. She revised her view of what it meant to rely on a wheelchair. In addition, she engaged in positive reflected appraisals in order to overcome this threatening experience.

Some individuals recall their negative assessments of others and they may wonder whether they have reached similar stages that would make them eligible to receive such appraisals themselves. The individual is challenged, and the threat of unwanted change is real:

> I never talk about my arthritis in conversation with people. To me, when I think back now, that was always a sign of old age. When I used to hear like my mother-in-law and her sisters and the older people, if they'd get together, all they talked about was the medication they were taking and their aches and pains. I thought, "Oh God, help me! Save me from this that, that should be the only thing I should be interested in talking about." And I don't. I've reached that stage. And I always said, "God help me that I don't become like one of them." It struck me odd, these people weren't well acquainted with medical terms or drugs. And then, all of a sudden, they became so wise about the names of he drugs they were taking and their friends were taking. I thought, "Oh, where did they get all this knowledge from all of a sudden in their middle and later years?" I still don't want to talk. Maybe I'm trying not to accept it by not talking about it (Gladys, age 72).

These examples show that some individuals do not wish to affirm disabled or undesirable identities in front of others. And more significantly, they do not wish to affirm them to themselves. Moreover, individuals may become aware of their own personal changes when they recall their assessments of others in the past during the process of reversed reflected appraisal. As a result, this may shape their own presentations and performances. Often, these experiences influence the way in which an individual constructs her own disabled identity:

> I never give up, because I was a visiting homemaker for thirteen years. And I saw too many of those people that gave up, and they were too young. They were sitting there, and everybody had to do things for them. They weren't capable of doing anything. They had meals-on-wheels, us homemakers to clean, they had visiting nurses. I'm not going to be like that (Ellen, age 72).

This example illustrates how the process of reversed reflected appraisal can also motivate the individual to develop certain coping skills, and a desired disabled self.

Hence, while reversed reflected appraisals may alert the individual to her changed capacities, these appraisals may also play a part in the development of the individual's own identity as she strives to maintain preferred perceptions of self-consistency.

Finally, it must be pointed out that processes of social comparison are implicated in reversed reflected appraisals. When individuals assess others, comparisons are inherent in these appraisals. For instance, one's negative appraisals of others may lead one to question whether one is also in the same situation. Others may feel threatened by this comparison and they may strive to construct their disabled selves differently. Indeed, the principle of reversed reflected appraisal is important because it shows the mental processes that are involved when individuals make comparisons.

SUMMARY

This chapter has illustrated that humans, as social beings, are closely linked to others as they define their own experiences. **It was demonstrated that the processes by which disabled persons adjust to changes, thereby negotiating their sense of continuity is often influenced by the way the individual perceives her situation. And the role of social comparison and reflected appraisal in shaping such perceptions was revealed.**

The literature provides evidence that social comparisons play a role in the development of the self-concept. Heckhausen (1990), Brandtstadter, Wentura, and Greve (1993), and Hochschild (1973) report that social comparisons are indeed utilized by older persons in order to facilitate positive evaluations of the self. In contrast, other researchers note that older persons may not have as many opportunities for such comparisons due to decreasing social networks and impaired mobility (Tobin 1991; Suls and Mullen 1983).

This study both supports and contributes to the literature. Indeed, the data provide further evidence for the role of social comparison in contributing to positive assessments of the self. And, while previous research suggests that older persons usually compare themselves to others of the same age group, this study reveals that some older persons also compare themselves to their younger counter-parts. In particular, these older persons recognize that physical limitations are more common in later life. Hence, when they compare themselves to disabled persons who happen to be younger, this reinforces personal assessments of their own situations. Contrary to the findings of Suls and Mullen (1983), this study demonstrates that older persons have many sources of comparison to draw upon. Finally, Belgrave (1990) reports that the "usualness" of health problems in later life served to minimize the perceived intrusiveness of disability. Our examination supports Belgrave's study by providing further evidence that social comparisons (in particular, the same boat mentality) facilitate the beliefs that health declines are common in later life.

However, this study provided additional information by highlighting the role of negative comparisons and threatening same boat comparisons. These comparisons demonstrate those processes whereby beliefs commonly associated with aging do not assist individuals to adjust to their physical declines, a finding not reported by Belgrave (1990). (Recall that some women compared themselves with women who were faring better, and more importantly, who were older as well. This led to negative comparisons). Hence, while experiences of chronic illness in later life may present older persons with some unique advantages, negative comparisons may be just as influential in making processes of adjustment difficult as well.

Taken together, this examination of social comparison reveals that individuals call upon the experiences of their peers as they reflect upon their own circumstances. And, this particular study reveals that the significance of one's chronic illness is often constructed in comparison to others. A person's assessment of him/herself is very much influenced by positive and negative social comparisons. As the individual compares his/her own abilities, attitudes, and performances with those of others, the various meanings of his/her own chronic illness are delineated. Hence, a woman confined to a wheelchair may not view her own situation as grave when she compares herself to friends who suffer from other diseases. Identifying oneself as being in "the same boat" as others may also serve to normalize experiences of chronic illnesses, since people tend to "take comfort in numbers". By the same token, others may reflect dreaded images of disability, and comparisons may serve as threatening reminders of one's own infirmities.

It is also evident that reflected appraisals are important in shaping the person's perception of the instrusiveness of her disability. The assessments of others are important as the individual adjusts to the changes in his/her physical self-concept. Sometimes, interactions prove to be useful sources of self-affirmation. These findings demonstrate that these affirming appraisals contribute to perceptions of self-consistency. But it was also shown that at other times, discrepant appraisals may prove to be quite threatening.

In addition, the principle of reflected appraisal was examined in conjunction with the "presenting self". This is an important concept, given the potentially disabling effects of OA, and the ever increasing likelihood of impaired performances. As Corbin and Strauss (1987) point out, the individual's ability to perform preferred presentations of the self may become limited. As a result, it may become more difficult to ensure the kinds of appraisals that will affirm components of the self-concept. This may reinforce the person's perceptions of the changes wrought by the chronic illness. Other researchers, who do not focus on experiences of chronic illness in later life, show that chronically disabled persons often struggle with their attempts to negotiate preferred presentations of themselves. Certainly, issues pertaining to stigma, which result in efforts to normalize or conceal the chronic condition have been addressed by other authors (Conrad 1987; Wiener 1975; Goffman 1963).

This study examined whether chronically disabled, older persons were exempt from these situations. In addressing this question, the role of aids and devices was examined. The findings revealed that individuals reacted differently to their changed presentations. On the one hand, some of the women were threatened by their altered presentations because they associated their performances with negative stereotypes of old age. Others were threatened by their altered presentations in public settings, but they did not necessarily relate their experiences with negative images of old age. These persons were more likely to focus on the presentation of the disability itself. Still others were not threatened by their altered presentations at all. These women adapted the ends versus means mentality, or as Belgrave (1990) reports, they accepted the belief that limitations were common in later life.

These findings contribute to our understanding of disability in later life. More specifically, the data indicate that when age-related beliefs are indeed implicated in the presenting self, such beliefs serve both positive and negative functions. That is, beliefs concerning the usualness of physical declines in later life may serve to minimize the impact of unfavourable presentations of the self thus lending to perceptions of self-consistency. Or, alternatively, negative images of old age may be re-inforced by altered presentations. Such experiences may pose as a threat the self.

Next, the issue of concealing was also examined. The literature has emphasized processes of concealing (Conrad 1987) for the management of the presenting self and this study provides support for such strategies. However, the literature often gives the impression that issues of concealing pervade the performances of chronically ill persons. This study points to the importance of uncovering those circumstances which compel individuals to conceal, and those conditions which do not warrant such efforts. And the data reveal that while individuals may appear to engage in processes of concealing, such actions do not stem from the desire to avoid threatening presentations of the self. Rather, these persons may only be engaging in efforts to affirm other valued identities.

Finally, this chapter introduced the concept of reversed reflected appraisal. This concept is significant because it presents an additional process mechanism. In particular, the process of reversed reflected appraisal is important because it demonstrates one of the ways individuals not only evaluate themselves, but how these evaluations shape courses of action in the future. Hence, it was demonstrated that reversed reflected appraisal often direct the development of the individual's own identities in ways that are consistent with the person's preferred conceptions of the self.

CHAPTER 7
THE PAST, THE PRESENT, AND THE FUTURE SELF

INTRODUCTION

Processes of continuity and change point to the importance of recognizing that humans are temporal creatures. The symbolic interactionist view of the self as an "object-in-process" portrays the self as an object that continually unfolds and develops over time. Not only is the self conceptualized as a "situated object", but the self is also viewed as a "biographical object". This means that the self is enacted not only is specific situations, but that the self can also be viewed a product of situations that accumulate over one's life-span (Hewitt 1991, 121).

In recognizing the temporal nature of the self as an "object-in-process", this chapter will examine the ways in which one's perception of continuity and change are mediated within the context of one's past, present and future when chronic illness disrupts the individual's biography. Indeed, the very concept of continuity and change necessitates the recognition that the temporal nature of the self is integral to such processes. Hence, this chapter will further our analysis of conceptions of self in later life by presenting additional processes that are implicated in patterns of continuity and change. Most important, this examination will uncover those processes that are unique to experiences of chronic illness in later life.

Some authors have addressed the role of time in mediating experiences of living with chronic illness. Charmaz (1991) describes the way in which people organize and structure time and how one's perspective of time, that is, "ideas, beliefs and views about the content, structure, and experience of time" are shaped by chronic illnesses (171).

Corbin and Strauss (1987) describe the way in which biographies are re-constructed through "ideational processes". Through such processes, persons engage in "backward and forward reviews". An individual may recall the past, assess the present, gaze into the future and interpret events in terms of the present. Often, ill persons may engage in backward reviews in order to provide meaning to current symptoms, and to explain present circumstances. Individuals may also gaze into the future and their future images of themselves may become uncertain due to their present illnesses (268-269). While these authors demonstrate that people's self-concepts are deeply embedded within time, they do not focus, in particular, on the significance of age for mediating conceptions of self in time.

The aging literature shows that older individuals display time perspectives that are different from those of their younger counter-parts. Marshall (1986) reports that people become increasingly aware of their mortality as they age, especially during their seventies (136-138). The author contends that one's "awareness of finitude" encourages processes of self-reflection, reminiscence, and life-review. Hence, this marks a shift in the person's temporal perspectives. More specifically, the person focuses pre-dominantly on the past, in light of his/her shortened future perspective (Marshall and Levy 1990, 149).

This finding points to the possibility that the temporal nature of the self in later life may contribute to patterns of continuity and change that are unique to older persons. Sherman (1991) demonstrates that processes of reminiscence and life-review are effective in helping individuals adapt to the changes commonly associated with aging. Tobin (1988) reports that the very old use the present and the past interchangeably in order to validate themselves, especially when sources of self-affirmation in the present become more scarce. Suls and Mullen (1984) propose that as sources of social comparison decline in later life, older persons may increasingly engage in "temporal comparisons". Temporal comparison is defined as "comparisons on one's present performances with one's own past performance on similar tasks to assess improvement or deterioration" (112). In contrast with the other authors, Suls and Mullen highlight the negative implications of drawing upon the past for present self-evaluations. They contend that temporal comparison may only serve to remind the older person of the declines in his/her physical and/or mental abilities (117).

This body of research is important because it establishes the role of the past in shaping the development of the self in old age. However, these authors do not examine how these temporal processes are implicated, more specifically in patterns of continuity and change with respect to chronic illness.

This chapter will both support and extend the findings presented above by addressing the following questions. How is time perceived and experienced by chronically ill, older persons? Having experienced the entire life cycle, do chronically ill, older persons engage in unique processes to maintain their self-concepts? Since older persons are more likely to confront their mortality and finitude of life, how does this shape the experience of chronic illness?

By examining the role of the self in the past, the present and the future, the following points will be made: The role of the past is indeed implicated in mediating patterns of continuity and change. It will be shown that a person's past has the potential to contribute to perceptions of change in the present self. However, it will also become evident that the inheritance of the past, combined with a shortened future perspective, present opportunities to preserve perceptions of continuity in ways which are unique to older persons. Most interestingly, this chapter will present an alternative perspective of the ways in which the past, and the future are used by individuals as they negotiate changes that are experienced in the present. While popular conceptions of old age often depict older persons to be anchored in their past lives, this chapter will reveal that perceptions of continuity are fostered when older persons are able to draw upon their personal biographies, *without perceiving themselves to be "living in the past"*. It will be shown that this is best facilitated when individuals draw upon their past unconsciously, or in ways that are taken for granted. These points will be clarified next.

THE PAST SELF

The inheritance of the past self plays a role in processes of continuity and change and its importance should not be overlooked. Throughout the previous chapters, the role of the self in the past has been presented. It was illustrated that significant others act as image bearers and memory depositories of the past self. When others hold images of the disabled person's past self, this is often beneficial, since other valued components of the individual may be affirmed by these interactions. In other instances, the opposite holds true, since the inability of others to accept and adjust to these changes constrains the disabled person's efforts to negotiate personal changes. Interactions between the disabled individual and these significant others are important then, since the assessments of others often validate, or threaten, one's own assessment of oneself.

It was also demonstrated that changes in one's physical capabilities mean that the person lives in tension between the past and the present. The desynchronized self showed that some disabled individuals may feel like they should be able to engage in past performances. In some situations, the individual desires to perform activities much like she did in the past. However, this is not often possible. Hence, the mind lags behind the reality of the changed body.

These findings also illustrated that images of the past self interact with present ones and the contrast between past and present images of the self may serve to reinforce one's perception of the changed self-concept. What are the implications of the dialogue between the past self and the present self? This section will demonstrate the role of the past for shaping conceptions of self in the present in light of OA. It will be argued that while the past often serves to remind the individual of unwanted changes, the past is equally powerful in enabling the individual to negotiate perceptions of continuity and preferred self-consistency.

Before discussing the ways in which the past can be used for the purposes of maintaining self-consistency, the ways in which the past contributes to perceptions of change will be presented. In addition to the desynchronized self, and the role that others play in acting as "memory depositories" of the disabled person's past self, the findings reveal that an *unresolved biographical self* contributes to perceptions of change. The examination of the hierarchies of identity in Ch. 4, more specifically, pattern 1.3a demonstrated the importance of the biographical self for accepting some of the changes and losses commonly associated with old age. It is not surprising then, that the accounts of some of the respondents reveal that unresolved biographies are just as important in thwarting attempts to adjust to the challenges of living with OA.

One woman admitted that she was immersed in her illness. Although Violet had been widowed for over thirty years, she described the ways in which her tragic marriage shaped her experiences of living with OA in the present. No longer able to socialize or actively participate in her church group, Violet spent most of her days confined in her son's home. Feelings of loneliness, and depression overwhelmed this woman. Having been an active person in the past, it was difficult for Violet to accept the changes in her lifestyle. Most important, Violet noted that she had become increasingly drawn into her past. Violet shared how she was more inclined to dwell on her past, in her attempts to come to terms with some of her unresolved experiences. In particular, her relationship with her abusive, alcoholic husband had become the focus of her thoughts, and she found herself re-living her past experiences.

Violet stated that she was compelled to engage in a review of her life for several reasons. First, she noted that age itself prompted her to reflect upon her life. This supports Marshall's (1986) contention that the awareness of one's finitude prompts older persons to engage in processes of life review. In addition, Violet noted that her increased isolation, and the loss of valued social interactions and activities (losses which were caused by OA) contributed to her introversion and processes of self-reflection. In particular, the changes which were caused by OA were particularly overwhelming because they were associated with her negative experiences of reflecting upon her past. Her unfulfilled wife identity was quite prominent, and it significantly shaped the way she coped with her arthritis.

> I think about the unpleasant memories more now, because before, I didn't have the time. When I was busy, going out and doing things, I didn't have to think about it. But now, I remember. And I'm more inclined to now center on my marriage. It certainly has made a lot of unhappiness for me... . You see really, you're in a lonesome world and if I didn't have this arthritis, I could go out and meet a friend for lunch or something. I could take the bus and go shopping. When you're alone, you have nobody to talk to... . Instead of being able to- because of the way my marriage was, I'm not able to sit here and be happy. Because I start reminiscing back to the times I was with my husband, which as you get older you start re-living your life (Violet, age 77).

Feelings of depression, loneliness, and hopelessness contributed to her loss of interest in many of her activities. And although Violet was diagnosed with a moderate form of OA, her perceived difficulty in managing her day-to-day affairs was great. Taken together, these experiences contributed to perceptions of great change:

> It's a whole different ball-game. My life has changed. I've changed. Everything is such an effort. And things I didn't think anything of doing before is such an effort now. You have to think, "Can I do it? And even if I can, do I want to do it?" (Violet, age 77).

Violet's account demonstrates that an unresolved biography is particularly important as individuals experience the changes wrought by chronic illness. And, the inheritance of the past is particularly significant for older persons, not only because they have longer past selves to draw upon, but even more so if the person is engaged in processes of life review.

The inheritance of the past is extremely important in shaping experiences of chronic illness in the present time for other reasons as well. Recall the "damaged mother identity". This identity demonstrates *the unaffirmed past self in the present.* This concept refers to those role transitions that fail to affirm components of the biographical self in the present. These role transitions are directly related to experiences of chronic illness and greatly shape the negotiation of the disabled self in the general self-concept. For instance, when adult children fail to meet the expectations of the disabled mother, the past mother identity is not being rewarded and affirmed in the present. An unaffirmed mother identity (as discussed in Ch. 3) is particularly distressing if the woman places a great value on this identity.

> My daughters don't even care and they don't even bother to help and to see if I'm okay. I think about what I have done for my two girls and how I helped them. What I've done for them when they had their kids small. I would run to them whenever they needed help. But there's nobody running after me. Even my grandson said, "Oh grandma. I remember when you used to come down every time my mum said I need help." And I said, "And yet Robert, what help am I getting?" (Bernice, age 72).

Bernice reported the changes she experienced since the onset of her OA two years previously. In particular, she noted that her relationship with her daughters had soured. This presented the greatest source of change.

Her feelings of resentment and her embitterment because of her experiences of living with OA were pronounced because her own past, daughter identity was not being affirmed in the present by her adult children. More specifically, Bernice had actively cared for her own disabled mother. Bernice expected that her daughters would follow in her footsteps and take on the role of caregivers, as she once had for her own mother. Bernice was deeply disappointed with her unrealized expectations:

> My daughters have no time for me. Yet when my mother was living, I was with her all the time. I was with her, and I lived with her for fifty-five years. I took care of her, heavens to betsy yes. Then my sister put her in a home and I used to go see my mum in a home everyday. The doctors told me to stop. I used to run to the home, but he said once a week was enough. I thought I would get the help too. But I'm not getting any from them. Even my friend said to me, "You done a lot for your mum, but you're not getting it in return." And I said, "I know." I expected that I would, but I'm not getting it (Bernice, age 72).

Bernice's account shows that an unaffirmed past self may contribute to negative experiences of disability. When past performances are not rewarded or affirmed in the present, this may serve to thwart efforts to adjust to the changes brought about by the onset of OA. In Bernice's case, the mother identity was central to her self-concept, and her experiences of bitterness and disappointment contributed to her perceptions of the intrusiveness of her disability.

While the past is very influential in presenting sources of change, it is also equally important for the purposes of maintaining preferred conceptions of the self. Even in the face of profound changes, some individuals are able to draw upon their past experiences so that these changes are incorporated into perceptions of continuity. Interestingly, stressful or threatening changes may even serve to affirm patterns of continuity. The women from this particular study show how certain people are able to maintain their perceptions of continuity because they engage in similar coping patterns that have been developed over the years. Individuals develop patterns in order to overcome challenges throughout their lives. Hence, the present challenges of OA are approached in ways, reminiscent of past strategies. In this way, continuity is maintained. Moreover, when individuals successfully overcome challenges in the present, this strengthens these past, coping patterns. Hence, continuity is affirmed even more so. In essence, the continuity of one's attitudes, values, and outlooks are confirmed in the present. The findings of this study provide support for continuity theory's assertions regarding "internal continuity":

> Continuity is first and foremost a subjective perception that changes are linked to and fit with individual personal history...Internal continuity is defined by the individual in relation to a remembered inner structure, such as the persistence of a psychic structure of ideas, temperament, affect, experiences, preferences, dispositions and skills...Internal continuity is a healthy capacity to see inner change as connected to the individual's past and to see the individual's past as sustaining and supporting and justifying the new self (Cohler 1982; Lieberman and Tobin, 1983, in Atchley 1989, 184-185).[1]

One woman remarked that she had developed certain attitudes over the years because of the many difficult situations she had found herself in. Her present experiences of OA only served to affirm these attitudes even more so:

> I've always been determined to get well. I've had a very hard life, or what you'd call a very hard life...I've always had to work very hard all my life. There's things that you would never have done, but I've got a lot of power in my body...You develop it through need. You develop it through having to do things for yourself...I'm still, I can still feel it in myself that I'm the same person. I'm still the same person as when I was young...It's made me stronger. I know I'm going to make it. I'm not going to let it beat me. It's not going to stop me, this arthritis. I'm not going to let it (Maria, age 83).

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[1] Atchley also identifies a second type of continuity: external continuity. "External continuity is defined in terms of a remembered structure of physical and social environments, role relationships and activities" (1989, 185). External continuity is preserved when individuals engage in familiar activities and when they interact in familiar environments with familiar persons (Atchley 1989, 185). The negotiation of change with respect to social roles, and activities, that is, role performances was already discussed in the previous chapters. Hence, internal continuity will be examined here.

Having been able to overcome difficulties in the past often preserve one's attitudes in the present. Hence, overcoming obstacles in the present are perceived as an extension of past experiences. This often contributes to one's experience of continuity:

> When I was forty-six, I had problems with my back and I went to this doctor and he said, "Well little by little, your arthritis will come back" and he told me to look out for arthritis. He was this big doctor and he said to me, "If you don't change your ways, your arthritis, your diet" because I was big then, "it's going to get you. I'll live until I'm fifty-six but you won't". But then I reached fifty-six and I thought he's wrong. I'm going to reach further, so here I am at seventy-nine, and I always had that outlook on life. I'm going to keep on reaching (Marion, age 79).

Some of the women reveal that certain values, attitudes or beliefs are extremely important in enabling them to adjust to OA. Often, religious faiths are integral to these outlooks. Hence, some of the women's religious identities significantly shaped their other identities and their ways of dealing with changes. Interestingly, religious identities provided great sources of continuity. These individuals believed that their beliefs had been tested and tried over the years. "Answered prayers" from the past provided sources of security and hope for the present. The experiences of living with OA in the present only served to affirm the continuity of these identities even more so:

> I've always believed in what I believe. It works for me. I've had so many different experiences in my life. I've had prayers answered, really answered you know that it makes you believe more when you get prayers answered...I am deeply religious and I think that helps a great deal. I take my life and I always think, "What would Jesus do in this same situation?" and I take it to heart what He said when He was on earth and I try to do what I'm supposed to do. I pray about things. I pray every night that He will show me a way, show me what to do. Let me be of use in this world. Still, even though I'm crippling up a bit, of course I'm not really crippled, not as crippled as a lot of people, but I think He still has a lot for me to do. This is why I keep pushing (Maria, age 83).

Experiences from the past are carried over into the present in order to preserve patterns of continuity. When individuals draw on approaches to life that they have developed over the years, this provides a sense of continuity in the present:

> The past is a very important part of you, your mental attitude. It's how you handle things as they come along. When you have an illness, it's how you handle that illness that makes you a better person. Being a Christian, trying to be a Christian is a very important part because you know you've got help at all times. I don't care what religion it is because there are other people who are just as sincere in their faith so your faith is important to how you cope. I was ill one time and I was told there wasn't any more help that could be given to me and I told the minister about it and the minister said, "Well, doctors aren't always right either" because I had three doctors that told me that was it. To make a long story short, I had a surgery and that problem was cleared. That problem was over but when you get those things happen to you through your life, it proved to me that you have to, I think the mind is so important to how you handle illness. I ask God to put into my mind how to cope. Very often there's things that you want to do and you cannot do it so when I get stuck that way which I have been doing for years because I've been going through this period of going down, down, down with things wrong and I ask for guidance and show me the way and I'll pray about it and suddenly there's a ray. It comes to me what to do. But I've been able to cope with things that I have surprised people that I have been able to cope (Betty, age 80).

The past is implicated in processes of continuity and change in other ways as well. Recall from the previous chapters that individuals may compare their performances with past ones. The contrast in performances between the past and present self makes one aware of personal changes. For example, many individuals reported being slowed down by OA. Tasks took longer to complete. Hence, the present self is compared to the past self and the two temporal selves are experienced simultaneously, thus accentuating one's perception of change.

The dialogue between the past and the present reveals another dimension of the self-concept- *the desired self.* Sometimes, activities that are no longer possible to engage in are relegated to the domain of the past self and the desired self becomes particularly relevant here. In addition to the extant self and the presenting self, Rosenberg (1979) identifies the desired self as the third major component of the self-concept. The desired self refers to the idealized self image, the committed self image and the moral self image. Idealized images of the self refer to an imagined picture of oneself being other than who that person really is. Idealized images are not realistic and it is unlikely the person will ever fulfill his/her idealized image. At the same time, the desired self also contains the committed image. "This self-picture is one that we take seriously, not simply one that is pleasurable to contemplate" (Rosenberg 1979, 40). Committed images may well be realized by the individual. Both the idealized and the committed image represent how the individual would prefer to see him/herself. Finally, the moral self image refers to what one feels (s)he ought, or should be. The moral self image is related to the rules or personal standards the person feels compelled to abide by (Rosenberg 1979, 40-42).

For some individuals, the **idealized** component of the desired self is implicated as they adjust to the changes of OA. Activities that are no longer possible to perform become remnants of the past self. Lost physical abilities, inactive identity components and past performances may become idealized. What was once part of the extant self, (in the past), moves into the domain of the desired self (in the present). This is an interesting finding since Rosenberg does not conceptualize the desired self within the context of time. Indeed, some individuals remember their past performances and they are amazed that they were able to engage in these activities at one point. Sometimes, past performances are missed:

> At night, I think back and I think, gee why am I like this? Why can't I do things like I used to? It's remembering what I used to do. I used to go to the Y and go swimming with the seniors, and I used to go to the Y dancing and played cards (Cynthia, age 84).

Many of these individuals realize that such performances are now a thing of the past. It is as if the loss of one's valued activities become idealized when they are no longer possible to partake in. Past performances are no longer possible and there are moments when individuals would love to be free from their disabled bodies.

> I'd do anything to be able to do them again, to do, when you do the housework even and you'd go through almost the house in a day and wash the woodwork, take down the curtains, do everything. Now if I could, well I don't take the curtains at all and if I do a room, it takes me three or four days to do it. I just don't have the strength. It just up and went (Maeve, age 78).

These excerpts reveal the inner dialogue between the past self and the present self. Individuals may experience a sense of disbelief at their present selves. The present, disabled self is at odds with the past self. More and more, there is the possibility that these identities may be shifted into the realm of the idealized self. Accordingly, the gap between the ideal and the extant self may present a source of change.

Certainly, the data from this study show that past performances are idealized by some individuals. However, these findings must be placed within the proper context. A few of the respondents did not compare their present abilities, with their past ones. That is, not all individuals engaged in temporal comparison. Moreover, some of the individuals who did engage in temporal comparisons, did not necessarily idealize their past performances. Nor did the contrast between the past and present performances necessarily present a source of great change. It became evident that there were a variety of mechanisms for mediating the perceived changes between past and present abilities. These findings are interesting, considering that Suls and Mullen (1983) propose that temporal comparisons may lead to negative evaluations of the self in later life.

The findings show that women who were distressed by the changes between their past and present abilities often suffered from sudden and drastic declines in their physical capabilities. In addition, they were unable to adjust their expectations of themselves, modify their interests, or find satisfaction in more limited activities. However, a majority of the respondents were not threatened by the perceived changes between past and present performances for a variety of reasons. Such individuals displayed the mentality of *relative disability,* (as described in Ch. 5), and they had managed to adjust their expectations, activities, and interests (as described in Ch. 5). Some of these women also experienced gradual changes in their abilities and performances, and they believed that such changes were to be expected in later life:

> Well, we know very well that as we get older, we're not going to zip around like we did when we were twenty-five, or thirty, or even forty. I don't mind slowing down, and doing things slower (Ellen, age 72).
>
> I sort of accept the aging so it isn't normal to me to want to be the way you were when you were twenty-four and there are many things, many advantages of being old, not necessarily wiser but you are able to view things from more different angles (Helen, age 77).

The findings also suggest that the boundaries between the extant and the desired self are very fine. For example, while past identity performances may depict images of the way the individual would prefer to see herself, some individuals believe that these activities remain within the domain of the extant self. This is facilitated through the *biographical self.* Individuals are thankful that, at one point, they did have the opportunity to engage in these activities. While these activities are no longer possible, and the individual may miss these performances, they remain a part of the biographical self:

> I wish I were more active, but I can't do anything about that. I'd love to be able to skip, hop and jump again. Did I really once, like I look at people when they walk along and I think, "Oh wouldn't that be wonderful to be able to walk along like that?" And then I think, **"Well, you did once upon a time. I had that day."** (Maeve, age 78)
>
> Sometimes your memory clicks back to what you used to be able to do. And I think, "Oh, gee. I used to do that, but I can't do that anymore." There's a lot

> I can't do anymore. **But then I figure, When I was able to do it, I did it, or I tried to do it.** As I say, I wasn't idle. I had a big home, and I had people living in the home when the children were small. Like borders and all that. I had to do for them, like clothes, the bedding. I used to do volunteer work of every kind that you could think of. So I'm satisfied that I did it (Marion, age 79).

These findings provide additional evidence that the past is involved when individuals attempt to accept the changes brought about by OA. Hence, older persons may have an advantage in dealing with changes, particularly if they are satisfied with their personal biographies.

Extensive past selves and a sense of fulfillment in life and past achievements often help these persons to accept personal losses in later life. For example, Betty found it very difficult having to accept help from her nurses and paid homemakers. She recalled a time when she was quite active, volunteering her own services to take care of the infirm, older members of her church congregation. In short, her present self was at odds with her preferred, past self. Since it was no longer possible to engage in identities from her past self, Betty noted that she was more inclined to discuss and share her past experiences with others in order to preserve her past identities. Interestingly, Betty stated that she had never been inclined to discuss her past deeds. She preferred to maintain her sense of modesty. Interestingly, this had changed recently:

> You help willingly and you're not doing it because you're trying to be praised because there's lots of things that my husband and I did that we didn't talk about and I don't usually talk about it. But I find now that I am more apt to say little things that I did, that I wouldn't say before, because you do things willingly. But now I find that I am more open to talk about it because then I feel a little bit better that well, I did help somebody else in the past. Now, well as they say, it's my turn. I don't particularly like being in this turn (Betty, age 80).

In this way, Betty made efforts to preserve a desired, past identity in light of threatening changes in her present, extant self. Her past identity represented how she would have liked to see herself. This image was increasingly threatened because of her disabilities. More and more, it became difficult to assert this identity within her extant self due to her present condition. Hence, in her efforts to preserve this identity in her self-concept, Betty resorted to the tactic of discussing her past self in her present interactions with others. Tobin (1991) also documents this strategy, whereby older persons will resort to sharing their past accomplishments with others in order to validate themselves.

Perhaps the most interesting finding relates to the ways in which the respondents themselves viewed the significance of the past. While the experiences of Violet and Bernice reveal that some individuals were immersed in their past, a majority of the respondents did not view themselves to be "living in the past". Some of the respondents did not engage in temporal comparisons at all, and those who did reported that these comparisons were not made regularly or that they did not dwell upon the changes in their abilities. Instead, the findings reveal that for most of the respondents, the past was significant for shaping patterns of continuity and change when they drew upon their personal biographies unconsciously and in ways that were taken for granted. This facilitated the woman's perception that she was not immersed in her past. This is an interesting point to note, considering that many of the women associated "living in the past" with undesired images of old age identities. While Betty's tactic of sharing her past accomplishments with others demonstrates a conscious engagement of one's past, most of the women did not utilize such strategies. And although this tactic was important to Betty, even she stated that she did not spend most of her time dwelling on her past accomplishments.

In order to clarify this point, the significance of the biographical self will be discussed. The excerpts presented above demonstrated that satisfaction with personal biographies often helped women to accept the losses caused by OA, and the importance of the past was noted. However, it is also important to note that individuals can draw upon their biographical selves, without actually dwelling upon their past experiences, or without devoting substantial portions of their time re-living their past. For example, April was inordinately satisfied with her "tremendously successful" life. She counted herself lucky for having been married to "the most wonderful man" for fifty "blessed years". She was also satisfied with the successful lives of her children and grandchildren. April was able to accept her disability because she drew upon the success of her biographical self. However, when asked whether she enjoyed thinking about her past memories, April firmly stated that she did believe in dwelling on the past:

> What in the hell is the use of dwelling on things that are gone? We're here. We're happy. This is the day that the Lord has made. Let us be glad in it. I just think about right now. The past is gone and I have done it all successfully. I mean, I don't mind thinking about the past, but there's too many old people who are living in the past, complaining about this thing that happened. What's the use? I like to read the paper, watch TV and know what's going on now (April, age 85).

This finding is interesting, especially since much of the literature suggests that older persons may be situated, predominantly in their pasts as they face changes in later life. This study reveals that the past is indeed important for negotiating changes. However, the past may be more useful when individuals are able to use their past, without perceiving that they are dwelling in it. Sherman (1991) reports that processes of reminiscence are extremely useful for enabling older persons to come to terms with their present circumstances. Through reminiscence, individuals may be able to find affirmation for components of the self that are threatened, or lost in the present. Interestingly, the women's comments demonstrate that, while reflecting upon one's past is useful, most of these women reported that they were firmly anchored in the present. For example, some women enjoyed reminiscing, and many of these women noted that reminiscence helped them to deal with some of the changes:

> Sometimes when I'm feeling bad because I can't go out with my knees and the arthritis, I feel bad. But I try not to dwell on it. I don't dwell on it. So, you reminisce and that's good for you. Sometimes it's good to live in the past, especially when the family comes. We talk and it's nice especially what I done with my children. "Oh mother and dad. You done this or you done that." Or something and it brings back a happy memory because I think we were a happy family (Marion, age 79).

The experiences of these women demonstrate the benefits of reminiscence, as reported in the literature (Sherman 1991; Tobin 1991). However, it is important to note that these women remarked that reminiscing did not consume their time:

> I have a friend and we like to talk about things we did when we were young and what we did through out life. As you get older, you live on memory because if nothing's happening now, especially with the arthritis, staying in alot, what have you got to talk about? I think about my church work, and then I did sales work. I was never one to just sit around. I had an active life. So I do think about what I did, **but I don't dwell on them**. I have enough trouble dwelling on day by day things... . It's not on the past all the time. Definitely no. I'm thinking about other things, what's happening in the world. I get the paper and I have difficulty reading in small print, but I still get it and see what the title is (Betty, age 80).
>
> It's nice to look back, but not all the time. If I start to look back, do you know what it does? It just makes you weepy. Like if I look too far back, you just get all uptight. You can't change things after all. There's so many old people and that's all they live for is the past. What it used to be and what it was and I can't see that. Those old ladies at the club. They burn me up to no end. They'll say, "Oh we used to wear those white gloves" and all that. Yes, I know we did, but we don't do that now. Live in the present, or just a few years back, but don't keep going back all that far (Ellen, age 72).

Interestingly, most of the women associated living in the past with images of old age, and they preferred to see themselves anchored in the present.

Overall, it appears that the importance of the past self cannot be ignored. The present self is often experienced in light of the past self, and this may foster conceptions of change. The weight of past experiences among older persons adds an interesting twist. In particular, perceptions of continuity may be facilitated as individuals cope with present changes in ways that prove to be consistent through the years, as continuity theory suggests. Fulfilled personal biographies also contribute to the maintenance of perceptions of continuity. At the same time, our findings reveal that one must be careful not to portray older persons as inordinately attached to their past, as some of the literature would suggest. While older persons may acknowledge the importance of their personal biographies, and while processes of reminiscence are useful, most of the women who participated in this study preferred to view themselves to be firmly situated in the present time. The next section will show that a great majority of the respondents chose to frame, structure, and organize their temporal selves within present, day-to-day perspectives. This present, time-oriented perspective was the most common strategy for preserving perceptions of continuity.

THE PRESENT AND THE FUTURE SELF

How are present temporal perspectives constructed by older persons? The previous section illustrated that the past self is indeed related to present experiences. The findings also show that the role of the future self is implicated in the negotiation of the present self. This is especially important, considering the unique future perspectives of older persons. How then, did the women perceive themselves in the future? How did these future perspectives shape present conceptions of the self? Sometimes, the onset and progression of OA caused some to recognize that they had moved to the next stage of their life cycle:

> I think it was because of the osteoarthritis, because of the pain, because of the hips, I think it really made me feel that I was on a downward slope. I had hit my peak a long time ago and it was sort of a gradual decline and all of a

> sudden the gradient steepened and I'm progressing into the valley of whatever a lot faster than I care to admit...You're thinking at that point, that you've probably accomplished all in your life that you're ever going to accomplish and from now on it's just falling apart one piece at a time. It's looking disintegration in the face and not liking what you're seeing. When you come right down to it and you start looking at it realistically and you stop kidding yourself, you have to tell yourself it's not going to get any better than this. It's only going to get worse and that you may only have, all things considered, if your heart's still good, you may only have ten to fifteen years of your life span left. You become much more conscious of your mortality. You know that you have crossed the Rubicon and there is no going back (Beatrice, age 69).

Evidently, the women in this study were aware that they were in the later stages of their lives. Their future perspectives were appreciably shortened and many were very aware of their mortality:

> I suppose you're looking forward, or realizing that you're eventually going to go to another home. Yet I have to say that life hasn't been that bad... . But as I say. When you get older, you get thinking more and more that well, my time's coming to an end. There's always a little bit of fear of the unknown, but then you take comfort. It's a valley we pass through and the Shepherd's with us. We don't go through it alone (Maeve, age 78).

These excerpts provides support for Marshall's conception of "the awareness of finitude" (1986).

In addition to shortened future perspectives, chronic illness often presented a future filled with uncertainty. For many women, it became difficult to plan the course of their future selves. Some individuals feared increased states of disability, and losses in personal independence. The awareness of one's mortality, combined with the uncertainty of living with OA resulted in interesting perspectives of the self. It became evident that future uncertainties were predicated on two levels: one originating from OA, the other stemming from perceptions of the finitude of time. Most important, these future perspectives shaped conceptions of the self in the present by compelling many to live "one day at a time". Hence, the strategy of living one day at a time meant that most individuals adopted a present-oriented time perspective in addressing various changes:

> I just take one day at a time. Why get yourself up in a knot? That's what happens when you look to far ahead. You gotta take one day at a time. And why look back? The past is gone so there's no sense looking back. You just have to find out what you're capable of doing when you wake up the next morning. Just make the best of each day and maybe tomorrow will be a better day (Laverne, age 79).
>
> I've tried to accustomize myself to the idea because it's been for some time that I've known that I wasn't going to get any better. Things weren't going to go my way. You just hope that for each day, pleasant things will happen and that's it. Day by day. One day at a time is all I can say. Handle each day as best you know. That's all you can do. As for dying, I'm not afraid of that (Betty, age 80).

The next excerpts show that living day by day is mediated by the awareness of one's age and mortality:

> I might live to be one-hundred or I might go in a week, and I'm not being pessimistic but with my age and some of the trouble I've got, we don't know so we just have to everyday do your best (Grace, age 75).
>
> When you get older, I mean when I was younger, sure I planned down the road but I don't now. I'm older and I mean God's been good to me. I'm seventy-eight and He didn't even promise this but seventy is the life expectancy and my dad used to say to me anything that I have from here on out is a bonus and I don't look down the road. I might hope to see something. Right now I think I'd love to see my son's home but that's Christmas 1998. He said, "Mom, we're having Christmas and I expect you to come". I think, "Oh that would be nice" but then I don't know whether I'll see it. So I would say it's almost a day to day thing (Maeve, age 78).

Because of chronological age, many older individuals are aware that they have passed through more stages in the life cycle than they can expect to in the future. Many feel that there is no real "future". They have lived through all the significant, major life stages. Planning for the future in this sense is greatly diminished and long range, future images of the self are usually confined to one or two years in the future. Even these plans are tentative. In addition, health complications and age itself may sensitize the individual to her own mortality. Therefore, living day by day becomes the sensible thing to do.

The next excerpts show that the uncertainties of living with OA fostered day-by-day time perspectives as well. For example, many of the women noted that it was very difficult to make plans since there was not guarantee that they would feel well enough to fulfill them. Hence, plans were made the "day of":

> Some days I'll make my mind that I'm going to cook. And when I get out there I can't do it. And some days I can do it. It just depends on the day how you feel...That's why we don't plan things. We never know how mother's going to feel. That's why we'll do this and that if I'm all right in the morning (Maria, age 83).

Day-by-day living also means that when plans are made, they are fairly routine. Day by day living revolves around manageable activities, activities that absolutely need to be attended to, or plans that are easily canceled and re-scheduled. This provides a sense of control and direction as the woman manages her OA, as well as relieving her of any unwanted pressure or disappointments:

> I don't plan too far ahead. My routine and my days don't even change much. You get to be a creature of habit. There aren't many things I have to do unless I choose to do them other than the usual household things. I just see how I feel that day (Gladys, age 72).

This day-by-day time perspective has been documented by other researchers as well. Charmaz (1991) demonstrates that living one day at a time is a strategy for coping with the uncertainties presented by chronic illness: "By concentrating on the present, ill people avoid or minimize thinking about further disability and death" (178). Our findings reveal that while the issues surrounding OA encouraged the women to adopt the day by day mentality, the awareness of one's mortality facilitates this process as well. This is a significant finding considering OA is not a life-threatening disease. Hence, the day by day mentality is interesting in later life because this strategy may be adopted not only for dealing with the challenges of living with OA, but also due to issues that remain unrelated to the chronic illness. Accordingly, living one day at a time may become the overarching perspective for organizing one's perception of time.

Evidently, it is beneficial to focus on the self on a day by day basis as the future self becomes more uncertain. This serves the purpose of minimizing the weight of *linear-objective time*. Linear-objective time refers to the normal way of measuring time. That is, time that is marked off in terms of the calendar year, months, weeks, and days. When the individual lives day by day, in one sense, linear-objective time is minimized and the individual lives in a preferred, *suspended present*. Rather than gazing at an uncertain future self, the individual chooses to map an image of the self on a daily basis. Phrases such as, "I'll see how I am today", or, "I'll worry about tomorrow when it comes", are common. Linear-objective time is diverted. Hence, living in the suspended present provides some sense of day to day consistency, in light of the threat of unknown sources of change.

Interestingly, the suspended present may be juxtaposed against linear-objective time as individuals strive to develop some sense of control over their future. For example, even though these women lived in the suspended present in terms of day by day living, many also made arrangements for the distant future. Wills, provisions for future care and funeral arrangements were made in advance by some individuals. It is important to note that these women did not dwell upon these plans. Rather, having structured their time to meet the realities of linear time, these women then felt at peace about living day by day in the suspended present. Evidently, living day by day served the purpose of addressing both the immediate challenges of managing OA, and other longer range forecasts which were characterized by uncertainty as well.

Finally, the data reveal that women also made efforts to maintain perceptions of self-consistency by making plans, "as if" they would be able to fulfill them. These persons recognized that it might not be possible to engage in these planned activities. Nevertheless, the woman continued to gaze into the future as if these planned performances would be enacted:

> Not too far ahead, although I paid for my lot where my trailer is and I thought, why? I'll be seventy-nine years old when I come back here. What in the world am I doing here? And then I think, well my friends are here, but that's a year ahead. Who's to say? You never know (Maeve, age 78).

In reference to the plans Maria had devised to improve her garden, she stated:

> It's most unfortunate my son doesn't know anything about flowers. He says, "I can't do the weeds for you 'cause then I'll pull the plants out" and so he does. If I ask him to do it, he pulls all my flowers out...But it's going to be better next year, because, if I'm here, well if I'm not here I won't have to worry about it will I?...If I die I won't have to worry about it, but I always plan the next year. If I'm here next year, it's going to be much different and easier. I'm going to set out everything completely different (Maria, age 83).

This proved to be a positive strategy for some individuals. Future activities and valued identities were given opportunities for affirmation, even though they might not be fulfilled. Nevertheless, these women preferred to act as if their present selves would continue to unfold into the future, thereby providing some sense of consistency.

Taken together, this section demonstrates that individuals are able to structure their time strategically in the attempts to cope with uncertain futures. Indeed, future conceptions of the self which are characterized by uncertainty, are negotiated in ways that provide preferred levels of consistency to one's experiences. The uncertainties associated with living with OA, in addition to the awareness of one's mortality compelled a majority of the women to adopt day by day time perspectives. Interestingly, this present time perspective was the most common strategy for maintaining preferred perceptions of consistency. This is an interesting finding when one considers previous research, which has emphasized the role of the past as individuals adjust to changes in later life.

VARIATIONS: WHEN THE PAST, THE PRESENT, AND THE FUTURE INTERSECT

It has been shown that the self in the past, present, and future are connected and inter-related. The first section illustrated the role of the past for shaping conceptions of the self in the present. It was then argued that day-by-day perspectives serve as an important strategy for preserving perceptions of continuity. Although day-by-day living serves as the overarching perspective for organizing one's time, the discussion of the past self, as well as the role of the future in compelling many to adopt a day by day perspective in the first place, shows that there are moments when images of the past, and the future interrupt present time perspectives. This section will describe other ways in which the temporal nature of the self reveals patterns of both continuity and change. Three patterns will be presented: first, *the unrealized future self*, second, *stretching the past self into the present and future self*, and finally, *the planned-preserved future self.*

For many older individuals, unanticipated changes in later life have the potential to produce experiences in the present that are inconsistent with the future plans, that were once hoped for in the past. For example, many individuals remembered what they had hoped their future, retired lives would be like. This is recalled in the present time, as individuals acknowledge the ways in which OA has disrupted plans that were made in the past, for their anticipated future selves. In this way, disruptions in the continuity of one's biography is assessed:

> I get very mad and frustrated. I mean some people decided when they hit sixty-five, they're going to be old. I didn't plan it that way. I planned on having a good time, and then I got knocked down. So what do I do now? I play bingo and euchre. Old people do it. That's all I'm good for (June, age 69).

> We always looked forward to when he (her husband) retired, that we could travel. Before I had any of the surgeries, we went to England twice but the arthritis must have started then because I can remember coming back after walking around and looking at all the churches, and shopping and almost

> crying with the pain in my legs. We had hopes that we'd go on a cruise. In our younger years, we never traveled because my husband worked long hours, so we always planned that someday we'd travel. When we finally got the chance to do it, the health problems kicked in and that put an end to that (Lillian, age 72),
>
> I never expected to be like this for me anyway. I expected I'd be going on trips, doing things that I enjoyed doing because I always had interests in what went on around me. I was interested in world affairs, and I was interested in reading things. I'd like to take holidays but I'm even afraid to go on a trip. I couldn't keep up with anybody. We should be able to do that at this stage of our life (Gladys, age 72).

These excerpts illustrate *the unrealized future self.* Hopes and plans for a future self, that have not been fulfilled can become a great source of disappointment. Usually, individuals adjust their expectations and interests. Some individuals also replace these lost activities with ones that are more manageable. Hence, present and future conceptions of the self are revised.

The past, present and future intersect in another way as well. Some individuals attempt to *stretch their past selves, into the present and future.* More specifically, there is a *funneling of role identities.* An increasing number of role identities become inactive, and there are fewer active identity components upon which to draw. The remaining role identities are held onto tenaciously by the individual. With the uncertainty of the future self, the individual desperately hopes that her retained, present role identities can be preserved in the future. In this way, the individual hopes to preserve remnants of her past self in the present and the future. Unfortunately, this is an ineffective strategy for preserving perceptions of continuity. Changes are viewed to be threatening and the individual is unable to incorporate these changes to maintain experiences of self-consistency.

For example, Cynthia remarked that most of her valued identities had become inactive. She had always enjoyed her volunteer work in the local hospital because it was an extension of her past, nurse identity. She had also enjoyed socializing at her church and in various seniors' clubs. With the progression of OA, she was no longer able to participate in these activities. In addition, most of her friends had passed away. She noted that gradually, things were being taken away from her. At the present time, Cynthia's greatest concerns revolved around the maintenance of her home. She had lived there for fifty-two years and had no intention of moving. Her home symbolized her valued identities from the past. She and her husband had built the house and raised their children. Cynthia noted that at the present time, all her energies were directed toward preserving her homemaking identity. This was especially crucial since this identity acted as a bridge to her past identities. Of late, the stress associated with the maintenance of the home had taken its toll on her arthritis and she readily admitted this. Nevertheless, she refused to comply with the wishes of her daughters. She would not agree to moving into a seniors' apartment. She remarked that moving into an apartment represented one step short of moving into a nursing home. Fearing the total loss of her personhood in the future, Cynthia attempted to preserve her self-concept by remaining in her home. Although she managed to stay in her home, she was also isolated since it was difficult to leave her residence to participate in social interactions. Her sense of loneliness was evident throughout the interview and these experiences only served to accentuate the unwanted changes in her life.

This example illustrates that some individuals make valiant attempts to preserve the identities they have developed over the years. Unfortunately, the efforts of some individuals to maintain their past selves by refusing to concede to changes may only result in maladapted efforts to adjust. As a result, change is unsuccessfully incorporated for the purposes of maintaining continuity.

Finally, the past, present and future selves intersect in another way as well. In the *planned, preserved future self,* the person is motivated to develop a preferred future self because of past identity performances. For example, the person may recall the times when she acted as a care giver to her late spouse, and/or parents. As a result of these stressful experiences, the person does not wish to pass this task onto her children in the future. Therefore, the person makes provisions and plans for her future self so that she will not become a burden on others in the event that she should become more disabled. For example, as a result of her own care giving experiences, one woman made great efforts to maintain her independent mother identity:

> I got sick of listening to my mother complain about it. I know that's an awful thing to say, but you do. I found it depressing trying to do things for her and nothing seemed to work but I realize now, like I didn't understand what it was like to have arthritis at the time. I guess that's why I try not to complain about it. That's why I went right away when they sent me to the surgeon. I wanted to have the operation and be independent because I wanted to be able to look after myself. I don't want to ever live with my daughters, not because I don't love them or they're not good to me and that sort of thing, but I know what a strain it is from my own experience. You do learn. Like looking after my mother and having my mother here in the house, well I wanted to take care of her and I wanted to look after her but it was a very big strain. I don't want that pressure on my girls. I think they have their life too. That's why I want to be able to look after myself and why I went through the operations because they were very painful. Knee operations are very painful (Dorothy, age 75).

This example illustrates that individuals recall their identities from the past, and they chart the development of their future selves in reference to these past experiences. In this way, some individuals attempt to plan their future selves, according to the meanings they derive from the past. This serves the purpose of maintaining perceptions of self-consistency in the present, as changes threaten to disrupt preferred identities. Hence, individuals are able to construct, and reconstruct themselves in time, in order to negotiate various changes.

SUMMARY

This chapter has demonstrated the importance of recognizing the role of time in processes of continuity and change. It became evident that the weight of the past self holds many ramifications for the self in the present and future. The past is particularly interesting in later life, since older persons have extended past selves upon which to draw. This study shows that unresolved past biographies have the potential to hinder attempts to adjust to the challenges of living with OA. The effects of OA (such as limited social interaction and the inability to participate in meaningful activities) compelled some to reflect upon their past identities. As a result, some individuals were drawn into their past experiences. This was particularly distressing if the woman had not yet come to terms with her painful memories. A few women became immersed in their past lives. Feelings of depression and loneliness engulfed them, and it became particularly difficult for these women to adjust to the challenges of living with OA. Interestingly, although none of these women suffered from severe OA, they perceived the changes in their ability to carry out day-to-day activities to be great.

The past is also involved when a person's past performances are not affirmed in the present. The *unaffirmed past self in the present* demonstrates that when the performance of central identities from the past, such as the mother identity, or the daughter-caregiver identity are not rewarded in later life, this may tarnish the person's perceptions of her experiences of living with OA. Such experiences serve to highlight the unwanted changes brought about by the chronic illness.

While past experiences may contribute to perceptions of change, the past is equally important for maintaining perceptions of continuity. When older persons are satisfied with their personal biographies, they have the unique advantage of having experienced all the major stages of the life course. The findings show that many of the respondents utilized their biographical selves to address the changes presented by OA. Individuals may draw upon the inheritance of their past in order to maintain their perceptions of continuity in other ways as well. Challenges that are experienced in the present may be approached in ways that are consistent with patterns that have been developed over the years. Hence, coping attitudes, personal beliefs and values are often reinforced. This provides opportunities to assert valued components of the self-concept, and conceptions of self-consistency as well.

Finally, the past is also implicated when individuals compare their past and present selves. Suls and Mullen (1983) propose that such comparisons may contribute to negative self-evaluations. The findings from this study present more complex results. Indeed, changes are perceived when older persons compare their present performances with those from the past. Sometimes, past identities become idealized as the activities associated with these identities are no longer possible. However, the findings also show that not all the women engaged in such temporal processes. Those who did, did not necessarily dwell upon these changes, nor did they always idealize past performances. Instead, many of the women accepted that such changes were to be expected in later life.

These findings both support and extend the literature. More specifically, Atchley's presentation of continuity theory (1989) is supported by this study. Tobin (1991) also documents the importance of the past for maintaining self-consistency in later life. However, the findings from this study (that is, the unresolved past self, and the unaffirmed past self in the present) also uncover those conditions that determine the ways the past contributes to experiences of change.

While the literature suggests that processes of reminiscence and life-reviews (Sherman 1991), and the interchangeability of the past and present (Tobin 1988) serve as preservation mechanisms, this chapter demonstrates that older persons often use their pasts in ways that are *taken for granted.* Previous research suggests that older individuals *actively* draw upon their past experiences to validate themselves in the present. This chapter, while finding support for these findings, reveals that perceptions of continuity are also facilitated when older persons draw upon their pasts, without perceiving themselves to be "living in the past". In particular, many of the women enjoyed the benefits of engaging in reminiscence. However, none of these women were immersed in their past. This point was stressed by all of these respondents, since they associated "living in the past" with negative images of old age.

Instead, a great majority of the women chose to adopt day-to-day perspectives for the purposes of dealing with OA. The examination of the future self showed how perceptions of time do change in later life, and the shortened future perspectives of older individuals were revealed. The findings showed that the awareness of one's mortality, in combination with the uncertainty of living with OA compelled many women to adopt the day by day mentality. This often served as a positive strategy for maintaining continuity.

Finally, it was illustrated that conceptions of the self in the past, present and future are subject to continual revision. It was demonstrated that some people construct the self in time in order to deal with personal changes. Some individuals recall their identities from the past, and they map images of their future selves in reference to these past experiences. Sometimes, this serves the purpose of maintaining perceptions of self-consistency in the present. At other times, efforts to preserve past identities in the present, and into the future only accentuate these changes even more.

Taken together, these findings show that as older persons experience chronic illness, a variety of mechanisms are utilized that are unique to them. The role of the biographical self, in addition to uncertain future perspectives demonstrate that the temporal perspectives of older persons must be considered.

CHAPTER 8
DISCUSSION

INTRODUCTION

The previous five chapters demonstrate the variety of results that have been uncovered by this study. Indeed, the experiences of the women who participated in this study show that one's self-concept is affected by chronic illness in many ways. Patterns of continuity and change can be conceptualized at different levels of the self-concept and the processes that are involved in mediating such patterns are not experienced uniformly. What implications can by drawn from these findings? This chapter will bring these findings together and the relevance of the data will be discussed. First, the research problems that were presented in the Introduction will be briefly reviewed. Next, a statement of the thesis will be provided and the major findings will be summarized. The contribution of this study to our understanding of chronic illness and conceptions of self in later life will be discussed as well. Finally, the implications of this study for the development of policies will be presented as well as areas of research that may be pursued in the future.

RESEARCH PROBLEMS AND FINDINGS

The Research Problem:

After reviewing the relevant literature, it became evident that several questions remained unanswered. The main question that guided this investigation was as follows:

> **How is the self-concept influenced by chronic illness in later life? Is the self-concept influenced in any significant way by the experiences of living with chronic illness in old age? In particular, are there patterns of continuity and change in the self-concept?**

This question was further refined:

> **How are social identities influenced by chronic illnesses? In what ways?**
>
> **Which processes reveal the ways in which the self-concept is negotiated, that is, changed, or unchanged?**

The next question was formulated in order to uncover the significance of chronic illness in old age and the conditions that are influential in mediating stability and/or change:

> **Which aspects of living with chronic illness are influential in challenging the self? Do older people reflect that same issues (that is, uncertainty, stigma, biographical work, dependency, social isolation, family relationships) that have previously been revealed by studies of chronic illness which do not highlight the significance of old age? Do life stage factors shape the ways in which chronic illness influences the self-concept in later life?**

Thesis Statement and Findings:

In general, the findings illustrate that OA in later life presents a source of change for the self-concept. However, some individuals are able to maintain self-consistency. Perceptions of continuity and change are influenced by several processes. The maintenance of self-continuity, or alternatively, experiences of change, depend on the kinds of processes that are used by the person, and on the extent to which these mechanisms enable him/her to adjust to the changes brought about by OA. Older individuals draw on a variety of strategies to preserve self-continuity. Some of these strategies are uniquely shaped by life-stage factors.

This statement will be presented in greater detail. The results show that experiences of living with chronic illness in later life do have the potential to influence the self-concept. However, the influence of these processes of change vary considerably. In particular, the significance of change for the self-concept is shaped by the individual's perception of the impact of chronic illness for the self. These are shaped by several factors. The impact of OA on the self is influenced by the ways in which the person's *multiple* identities are affected. And, the person's perception of continuity and change for her "overall" or global sense of self must be considered. It is important to note that the prominence or centrality of the identity components which have been affected must be considered. Finally, the type of process mechanisms that are drawn upon shape the person's perception of continuity and change.

Several types of process mechanisms are revealed. These include: shifting and non-shifting prominence hierarchies, the ability to adjust and accommodate to one's limitations and the extent to which interactions and valued identities are modified, social comparison, reflected appraisal, and the dialogue between the past, the present, and the future self. The ways in which individuals engage in these processes influence perceptions of continuity and change. (See page 43 for a schematic overview of the various types of processes that are involved in mediating continuity and change).

The research also shows the extent to which age and life stage factors are important. The data show that older people do reflect some of the same issues, (that is, uncertainty, stigma (for some people), biographical work, dependency, social isolation, and family relationships) that have previously been revealed by studies of chronic illness. However, these earlier studies do not highlight the significance of old age. However, experiences of chronic illness in later life also present unique variations. Life stage factors shape the processes by which changes are negotiated and incorporated into the general self. These include the weight of the past in comparison to a shortened future perspective, the awareness of one's mortality, the prevalence of health problems among the elderly, changed roles and obligations, shifting social networks (e.g. widowhood, fragility of friendships and opportunities for social interaction due to deaths, and impaired mobility), and changed or unchanged living arrangements.

These points will now be considered in greater detail by means of summaries of the major findings of each of the chapters. The relevance of these results for future research will also be discussed.

The Findings and Their Contribution to Knowledge:

In the review of the literature, some important gaps in the present body of research were noted. Studies pertaining to chronic illness in later life were examined and several points were raised. First, it was noted that previous studies report mixed findings. Some authors contend that conceptions of the self are changed by chronic illness (Eisenhandler 1992; Roberto and McGraw 1991; Blackwell and Levy 1987). In contrast, Brandtstadter, Wentura, and Greve (1993) report patterns of stability. Belgrave (1990) reports patterns of both continuity and change. In addition, it was found that some studies are marred by conceptual ambiguities. Operative definitions and measurement of "self" have not been utilized. Other problems were revealed. It was often difficult to distinguish the nature of change being examined. Was the researcher reporting continuity and/or change in terms of the overall/global self concept? Or was the researcher isolating certain components of the self? In addition, frameworks which are adequate for conceptualizing patterns of continuity and change were found to be lacking in the body of research as well. Next, it was argued that the studies conducted thus far do not elucidate the processes that are involved in determining the ways in which physical limitations translate into a preserved or altered self-concept. Indeed, it became evident that research dealing with issues related to old age, health, and self-concept remain under-explored. While several authors have assessed issues related to chronic illness and identity, most notably Charmaz (1983, 1987) and Corbin and Strauss (1987), it was noted that these studies have not focused on the possible influence of age.

In general terms, this study has contributed to the literature in the following ways. First, this study identified which components of the self-concept were affected by OA (at both the specific and global levels of the self-concept) and the ways in which these identities were influenced. Equally important, this study uncovered the processes involved in mediating patterns of continuity and change. These findings will be presented next.

Chapter 3 examined patterns of continuity and change within components of the extant self. It was demonstrated that identities are challenged, enhanced, inactive, lost, modified, or remain unaffected by OA. Interestingly, while other studies suggest that patterns of continuity and self-consistency are beneficial for the person (Tobin 1988; Kaufman 1986; Rosenberg 1979) this chapter demonstrated that continuity is not always desired, and that, sometimes, changes are experienced positively. In other cases, it was shown that changes are often necessary to preserve preferred perceptions of self-consistency. Hence, the women modified their role performances, role requirements, and role interactions in order to preserve their valued identities.

This chapter also provided a clear conception of the self. Specific identities, such as kinship identities, marital status identities, unpaid and paid labour identities, and identities located in other relational associations were examined. In doing so, abstract or imprecise definitions of the self-concept were avoided. As was noted earlier, previous researchers have either provided vague or inadequate conceptualizations of the self-concept (Eisenhandler 1992; Blackwell and Levy 1987) or they have not examined in detail, the ways in which roles and identities are affected by chronic illness in old age (Roberto and McGraw 1991; Belgrave 1990; Charmaz 1987).

Of particular interest are those identities that are specific to older women. Interestingly, the examination of the mother identity, the wife identity, and the homemaker identity revealed some interesting findings. Mac Rae (1990) found that the mother and homemaker identities were extremely important in preserving perceptions of continuity, but she did not assess the ways in which the inability to engage in these roles might potentially alter the woman's self-concept.

Certainly, the impact of chronic illness on family relationships have been researched by other authors. Issues related to dependency, role reversal, and power struggles between older parents and their adult children have been discussed elsewhere (Dwyer 1995; Suitor et al. 1995; Brody 1990; Brubaker et al. 1990; Cicirelli 1990; Fischer 1985). However, this chapter presented some additional findings. This chapter contributes to the literature by documenting the perspectives of the mothers themselves. The data also revealed the variety of experiences of motherhood in later life and the many ways in which this identity is modified, negotiated, and preserved. Indeed, the mother identity was not influenced uniformly among all the women. Hence, the independent mother identity, the active mother identity, the peripheral mother identity, the unaffirmed mother identity, and the empowered mother identity were introduced to denote the variety of ways in which this identity is shaped by OA.

The examination of the wife identity presented interesting results as well. Cutrona (1996) concluded that further research needs to assess the ways in which the history of the marital relationship affect levels of social support. This chapter showed that continuity and change greatly depended upon the biography of the marital relationship. For example, some women reported that their husbands had not been supportive in the past, and the continuation of these patterns was often a source of distress for these wives. Other women noted that husbands were able to provide a source of continuity by affirming other valued aspects of themselves.

Finally, the homemaker identity also revealed some interesting findings. Previous studies report that women's altered abilities to perform household duties were related to changes in the self-concept (Roberto and McGraw 1991; Belgrave 1990). The ability to maintain and manage one's own home were associated with positive self-concept scores (Roberto and McGraw 1991). But what processes of adjustment enabled the women to continue their role performances? Under what conditions do changes in the ability to engage in this role affect the self-concept? When do such changes fail to exert any influence? The findings from this study contribute to the literature by providing a broader spectrum of experiences as revealed by the respondents themselves. The data demonstrated that OA influenced homemakers in a variety of ways and that these changes or adjustments were perceived differently. Some women did not view the loss of this identity as a threat to the self and these women relinquished this role gladly. Others managed to modify their role performances and role requirements in order to preserve this identity. Finally, in keeping with previous research, others were troubled by the loss of this identity, and such experiences presented a source of unwanted change.

In addition to assessing the ways in which specific identities are affected by OA, this study also recognized that people possess multiple identities and engage in a variety of roles. Hence, Chapter 4 built upon the findings of the previous one by exploring the ways in which components of the self-concept interact. Thus, what Rosenberg has termed "the global structure of identities" (1979, 18) was examined. It was noted that OA may influence only one component of a person's self-concept, or it may influence several of them. A more global conceptualization of the self-concept was adopted in order to explore the connections between the multiple identities of each person. In doing so, the ways in which a person's various identities are related in producing an overall, or general impression of continuity and change was assessed. Accordingly, the *hierarchical* organization of the self-concept was examined in terms of shifting and non-shifting hierarchies of identity.

Interestingly, studies that deal with chronic illness and identity have not addressed these issues in detail. Charmaz (1991, 1987, 1983) and Corbin and Strauss (1987) do not focus on the processes that determine the ways in which changes in one or several components of the self-concept interact to produce perceptions of continuity and change. The research on chronic illness and aging also provides little insight. Identity theorists have noted the importance of recognizing the hierarchical structure of the self and the ways in which identities are ordered in terms of the importance or prominence attributed to them (Rosenberg 1979; Stryker 1968; and McCall and Simmons 1966). However, these studies have done little to further our understanding of the ways in which the hierarchical arrangement of identities is affected by chronic illnesses in later life.

Four patterns became evident in non-shifting hierarchies, that is, in those cases in which the ordering of identities in terms of their importance remained the same. In the first pattern, the hierarchical ordering of the person's self-concept was not affected by OA. Important identities were not challenged by OA and the person's sense of continuity was preserved.

The second pattern demonstrated that roles and their related identities were modified so that they could be preserved. Individuals made adjustments in the performance of their identities in order to preserve them. It also became evident that changes in one component were offset by the preservation of another valued component. For example, one woman was no longer to visit her friends as often as she would have liked. However, she noted that the support she received from her husband and daughters helped her to adjust to such changes. This served to buffer the full impact of the changes and contributed to patterns of overall continuity.

The third pattern showed that even when prominent identities became inactive because of the onset of OA, some women were able to maintain their perceptions of continuity because of their "biographical selves". In essence, these women were able to accept the changes in their identities because they were satisfied with their personal histories. These women felt that they fulfilled what they had hoped to accomplish in life. While important identities retained their prominence, the women viewed the changes in these identities as a natural progression in life and changes were not viewed as a loss. For example, one women was no longer able to participate in her social clubs, she was presently widowed, most of her friends had passed away, and she was unable to engage in many of her favourite activities. However, this woman accepted these changes because she felt satisfied that she was able to fulfill all her hopes when she had the chance. The importance of these inactive identities remained, but they were not viewed as a "lost" part of the self.

In contrast, the fourth pattern showed that some people were not pleased with the changes in their valued identities. The stresses associated with unwanted changes were pronounced because these identities continued to be valued by the women. Identities were not modified in order to facilitate changes, or it was not possible to do so, or modifications were viewed unfavourably. Such experiences contributed to perceptions of change in the overall self. For example, one woman was no longer able to perform her household duties and she was unable to attend her social clubs. Many of her valued activities had been curtailed by OA. These related identities continued to be valued and the woman was extremely unhappy with the adjustments she had been forced to make. In addition, she was unable to adjust her expectations or her personal interests. These factors contributed to her perception of change.

With respect to shifting hierarchies of identity, two patterns were noted. It was shown that prominent components became more important. Individuals replaced inactive identities with ones which were previously peripheral in order to maintain preferred perceptions of continuity. For example, one woman was devestated because she was no longer able to complete her household duties. This woman adjusted to this loss by decreasing the importance attributed to this identity and she found new activities to replace it.

People who displayed the second pattern lost interest in some of the identities which had been compromised by OA and these identities lost their position of importance. This often led to the perception that one's sense of self had been "lost" because of OA. This finding was similarly reported by Charmaz (1987). Such experiences contributed to perceptions of overall change.

Interestingly, the severity of the OA did not always determine the pattern displayed by the individual. For example, some of the women with the most severe forms of OA displayed patterns of continuity. In contrast, some women who had less severe forms of OA displayed those patterns that were more representative of change. Instead, as is demonstrated in Chapter 5, the ability to adjust one's personal expectations and interests, and the willingness to engage in alternative activities were more important in shaping perceptions of continuity and change.

Taken together, these findings demonstrated the role of shifting and non-shifting hierarchies in contributing to patterns of continuity and change in the global self-concept. The findings revealed that both shifting and non-shifting hierarchies are implicated in experiences of continuity and change.

Chapter 5 sharpened the focus of analysis by introducing the kinds of processes that are involved as people adjust to changes in their physical capabilities. A detailed account of the strategies for preserving continuity in terms of adjusted tasks and activities was provided. Hence, fragmented tasks, stretched/attenuated adjustments, expanded task schedules, relaxed task schedules, and prioritized tasks schedules were presented. In addition, those processes that contributed to perceptions of change were also noted, for example, when women made comparisons between past and present performances. Finally, it was shown that expectations, preferences, and interests were modified as well. These concepts were presented in the hope of uncovering sources of change (for example, lost interests, and un-met expectations) and those strategies that preserve continuity (adjusted expectations, relative disability, and modified interests).

Other researchers have also reported that the modification of activities and the adjustment of personal expectations, interests, and priorities are important if individuals are to adapt successfully to the limitations that are imposed on them by disabilities (Brandtstadter, Wentura, and Greve 1993; Corbin and Strauss 1987). Hence, the data from this chapter provided support for these findings. This chapter also investigated whether adjustment to chronic illness in later life presented any unique experiences. This study showed that older women engaged in processes of adjustment that were similar to the ones introduced by those authors who did not examine in particular, chronic illness in old age (for example, Corbin and Strauss 1987).

However, the findings also revealed that older persons did have some unique advantages. This is an important finding considering that relatively little is known about the subjective experiences of chronic illness in later life. In support of Belgrave's findings (1990), this chapter showed that when the women perceived the changes in the performance of activities to be expected in later life, perceptions of continuity were maintained. Interestingly, this study contributes to the literature by uncovering those conditions in which such age-associated expectations do **not** assist in processes of adjustment. This chapter showed that the perceived intrusiveness of OA was great when women believed their experiences of illness and disability deviated from their beliefs of what constituted "normal" processes of aging. This chapter demonstrated that a variety of strategies were involved in shaping perceptions of continuity and change, some of which were influenced by life-stage factors.

A few comments are worth making with regard to the ways in which Chapter 5 is connected with the previous ones. Recall the material presented in Chapter 3 on how identities are challenged, enhanced, modified, lost, or become inactive. Recall also how Chapter 4 presented several patterns of continuity and change within hierarchies of identities. Perceptions of continuity were negotiated, for instance, when identities were modified, and hence preserved in the hierarchy. In addition, continuity was maintained when people adjusted their personal expectations or interests. In doing so, identities which had become inactive were replaced by other identities, as in the case of shifting hierarchies.

Chapter 5 was presented as an additional building block to the study because it examined in greater detail the processes that either facilitated or failed to facilitate the adjustment to OA. These findings are linked to the previous chapters in many ways. For example, the concept of fragmented tasks, stretched activity adjustments, and expanded and relaxed task schedules provided concrete examples of the various processes whereby identities are modified or enhanced. In relation, it was shown in Chapter 4 that some women were able to maintain their hierarchies of identity and their perceptions of continuity by modifying valued identities. The concepts introduced in Chapter 5 help to clarify the processes by which identities were modified, and hence, maintained. Those cases in which women were unable to negotiate such changes were described as well. Hence, the concept of the funneling effect, or replacement with relatively unsatisfying activities was introduced. These concepts serve to clarify the various ways in which identities are challenged or lost.

Finally, the importance of adjusting personal expectations and levels of satisfaction with modified performances for the negotiation of change was discussed in Chapter 5. These processes of accommodation are related to the previous chapters in many ways. For example, Chapter 3 demonstrated that some homemakers were able to accept the changes in this identity because they had relinquished this role quite willingly. Others modified the requirements of this role. But how were these modifications accepted? Chapter 5 showed that the acceptance of these changes were often facilitated because the women had adjusted their interests or personal priorities. Some women were able to accept the changes in their performances because they had lowered their personal expectations of themselves. Others were no longer willing to place great importance on household tasks because they had changed their priorities. Hence, these women relinquished this role quite willingly. Similarly, Chapter 4 demonstrated that some women shifted their attention to identities which were previously less prominent. This allowed them to accommodate for the losses of other important identities. Indeed, adjustments in personal were usually involved in such hierarchies of identity. Thus, in combining the findings of Chapters 4 and 5, it becomes evident that the shifting and non-shifting of identities are related to one's ability to change one's interests and expectations as well.

Chapter 6 uncovered an additional set of processes whereby patterns of continuity and change are negotiated. It was demonstrated that the processes by which disabled persons adjust to changes, thereby negotiating their sense of continuity were often influenced by the way the individual perceived her situation. And the role of social comparison and reflected appraisal in shaping such perceptions was revealed.

Certainly, the literature shows that social comparisons play a role in the development of the self-concept (Brandtstadter, Wentura, and Greve 1993; Tobin 1991; Heckhausen 1990; Suls and Mullen 1983; Hochschild 1973). The findings presented in this chapter support the literature. Further support was provided to show that positive social comparisons contribute to positive assessments of the self. And while other studies suggest that older persons compare themselves to their peers (Hochschild 1973), this study demonstrated that older persons also compare themselves to their younger counterparts. When women with OA compared themselves to disabled persons who were younger, this made them assess their own lives more positively. Contrary to the findings of Suls and Mullen (1983) this study revealed that older persons had plenty of opportunities for making comparisons.

The process of social comparison showed that individuals compared their experiences with those of others. And, the intrusiveness of one's own chronic illness was often evaluated in comparison to others. Hence, some of the women who had severe forms of OA were able to make positive, subjective evaluations of their own health when they compared themselves with those worse off. Such perceptions shaped the extent to which OA was perceived as a source of change. This finding is significant considering that Belgrave (1990) reports that the "usualness" of health problems in later life served to minimize the perceived intrusiveness of disability. This chapter provided further evidence that "*same boat*" social comparisons contributed to the belief that health declines are common in later life.

However, this study provided additional information by highlighting the role of negative comparisons and threatening same boat comparisons. These comparisons demonstrate those processes whereby beliefs commonly associated with aging do not assist individuals to adjust to their physical declines, a finding not reported by Belgrave

(1990). (Recall that some women compared themselves with women who were faring better, and more importantly, who were older as well. This led to negative comparisons). Hence, while experiences of chronic illness in later life may present older persons with some unique advantages, negative comparisons may be just as influential in making processes of adjustment difficult as well.

Next, the process of reflected appraisal was examined in relation to the *presenting self.* Corbin and Strauss (1987) have pointed out that disability and handicap may threaten the person's ability to maintain preferred presentations of the self. This may have negative repercussions on the person's self-concept and the unwanted changes that result from the disability may be re-inforced. Previous studies have focused on issues relating to stigma. Hence, the processes involved in normalizing or concealing the chronic condition have been addressed (Conrad 1987; Wiener 1975; Goffman 1963).

This chapter contributed to the literature by assessing whether disabled, older persons experienced similar issues. Hence, the role of aids and devices was examined and the *ends versus means strategy* was introduced, that is, the ability to complete various activities (the ends) is seen as being more important and this justifies the use of such devices (the means). The data showed that age-related beliefs (that is, the usualness of physical declines in later life) were not always implicated in the negotiation of changed presentations of the self. However, when age-associated beliefs were involved, these beliefs contributed to both positive and negative experiences. On one hand, beliefs about the usualness of physical declines in later life served to minimize the impact of unfavourable presentations of the self, thus lending to perceptions of continuity. This supports Belgrave's findings. But chapter 7 also showed that negative images of old age were re-inforced by altered presentations of the self. These women associated their changed presentations with stereotyped images of "old" people. Stigmatizing images of old age were re-inforced by altered appearances. However, in most cases, the ends versus means strategy was adopted as a way of adjusting to aids and devices.

Finally, this chapter introduced the concept of *reversed reflected appraisal.* This concept was presented as an additional process mechanism. This concept was introduced in order to demonstrate that people use the assessments that they have made of others in the past as a basis for their evaluation for their own performances. Hence, a person's appraisals of others are re-directed back to him/herself. Thus, a women who is now dependent on a wheelchair may recall how she used to assess other people who were similarly impaired. The women then projects these past evaluations onto herself. This demonstrates the process of reversed reflected appraisal. Most important, it was argued that reversed reflected appraisal is important because it often directed the development of the individual's own identities in ways that were consistent with the person's preferred conception of herself.

Taken together, this examination of social comparison and reflected appraisal revealed the processes involved as individuals confronted the changes presented by OA. Positive social comparisons, and the same boat mentality contributed to perceptions of continuity. Negative social comparisons and threatening "same boat" comparisons contributed to perceptions of change. Finally, affirmed, selective, reversed reflected appraisal, and the ends versus means strategy helped people to maintain a sense of continuity. Discrepant reflected appraisal often re-inforced the unwanted changes brought about by the onset of OA.

A few comments are worth making with respect to the ways in which these processes are connected with the previous chapters. First, there were instances in which the women evaluated the changes in their various identities (as examined in Chapter 3) by comparing their experiences with those of others. For example, some of the mothers compared the relationships they had with their adult children with those of others. Some mothers were comforted by the services rendered by their children when they noted how other mothers were neglected by their families. In other examples, some homemakers were not threatened by their changed performances when they noted that their friends were reporting similar declines in their performances. There were also instances in which some of the women noted that their friends were in similar conditions, or in worse predicaments. This helped some women to adjust their personal expectations of themselves as well. Hence, one's perceptions of the adjustments made in the performance of tasks and activities, and the modification of interests and personal expectations (as discussed in Chapter 5) were shaped by social comparisons as well.

The discussion on reflected appraisals also demonstrate that the assessments of others are important as the individual adjusts to changes in the physical self-concept. This had the potential to affect many of the identities examined in Chapter 3. For example, the independent mother identities were often preserved through *affirmed* reflected appraisals, that is, when mothers believed that their adult children shared the belief that they were managing their lives admirably. Some independent mothers were threatened by *discrepant* appraisals. In particular, this identity was threatened in those instances in which adult children believed that their mothers would be better off in a seniors' residence where help was readily available. In short, the processes whereby identities were enhanced, challenged, became inactive, or were lost were often also shaped by reflected appraisals.

The ways in which one's perception of continuity and change were mediated within the context of one's past, present, and future were explained in Chapter 7. While other researchers have addressed the role of time in the development of the self during chronic illness (Charmaz 1991; Corbin and Strauss 1987), they do not focus on the significance of age for mediating conceptions of the self in time. This is important, given that the aging literature provides evidence of the altered time perspectives of older persons (Sherman 1991; Tobin 1988; Marshall 1986). Hence, this chapter contributes to the literature by addressing the ways in which time is perceived by chronically ill older persons, and by examining whether older persons engage in temporal processes that are unique to them in order to maintain their self-concepts. The major findings will now be summarized.

The past was indeed implicated in mediating patterns of continuity and change. It was demonstrated that the past is particularly interesting in later life, since older persons have longer past selves upon which to draw. Women who displayed *unresolved past biographies* and *unaffirmed past selves in the present* perceived the changes that were introduced by OA to be great. This is significant given that none of these women were diagnosed with severe cases of OA.

The past was equally important for maintaining perceptions of continuity. Older persons have the advantage of having experienced all the major stages of the life course. And, when older persons were satisfied with their personal biographies, many were able to accept changes in the present. Some of the women drew upon their pasts in other ways as well. Challenges that were experienced in the present were approached in ways that were consistent with patterns that were developed over the years. Hence, coping attitudes, personal beliefs, and values were often reinforced. This provided opportunities to assert valued components of the self-concept, and conceptions of continuity as well. This finding provides support for Atchley's presentation of continuity theory (1989).

Interestingly, most of the women adopted day-to-day perspectives in order to cope with the problems associated with living with OA. Charmaz (1991) also reports similar findings. However, this chapter also revealed that the women were compelled to adopt this time perspective because of their shortened future perspectives. Hence, it was argued that chronic illness in later life presents an interesting scenario because the awareness of one's mortality, in combination with the uncertainty of living with OA, encouraged many women to live day by day. This often served as a means of preserving continuity. Indeed, this chapter showed how perceptions of time do change in later life.

The examination of the past, present, and future self is related to the previous chapters in several ways. For example, the importance of the past self, in particular the biographical self was revealed in the non-shifting hierarchy of identities in Chapter 4. Women who displayed this pattern were able to maintain their perceptions of continuity because of their satisfying personal histories. In contrast, the unresolved past self shows that the disturbing experiences of important identities from the past (for example, an unfulfilled wife identity) may shape the negotiation of the self-concept in later life. The unaffirmed past self in the present shows that past commitments to identities which are not rewarded in the present (for example, the unaffirmed mother identity as introduced in Chapter 3) may contribute to difficult periods of adjustment later on. Indeed, the self can be viewed as a product of situations and relationships (which are often enacted through identities) that accumulate over one's life-span (Hewitt 1991). Hence, temporal perspectives were examined because the self-concept continually unfolds and develops over time.

Life Stage Factors: Does Age Matter?

The previous section summarized the major findings of each chapter as well as presenting their contribution to knowledge. The concepts that were uncovered were also discussed in relation to each other in order to integrate the chapters. This section will highlight those findings which addressed whether the negotiation of the self-concept presented any issues unique to experiences of chronic illness in later life. The study demonstrated that older people do reflect the same issues that have previously been revealed by studies which do not highlight the significance of old age (that is, uncertainty, stigma, biographical work, dependency, social isolation, and family relationships). **However, many of these issues were shaped by age factors.**

For example, this study explored issues related to *family relationships* in terms of those roles and obligations which specifically characterize older women. Issues pertaining to *social isolation* and *dependency* were also examined within these specific identities, for example, the mother identity and the friendship identity. Hence, the independent mother identity was presented to demonstrate the ways in which older mothers deal with their concerns of becoming dependent on their children. The friendship identity showed that social interaction and social networks may be affected differently in later life since the loss of friends through deaths, sicknesses, and impaired mobility is more common in later life. Issues pertaining to *stigma* were addressed in Chapter 6 by examining whether the usualness of declines in health in later life served to minimize stigmatizing experiences. Experiences of *uncertainty* were examined in Chapter 7 and it became evident that older women faced uncertain futures not only because of their OA, but because of the awareness of their mortality as well. Hence, the changed temporal perspectives of older persons were highlighted as well. Finally, the unresolved self, the unaffirmed past self, and the biographical self demonstrated the ways in which older persons engage in *biographical work.* These points will be discussed next.

Chapter 3 demonstrated that many of the women were involved in adjusting to changes in their role identities, social networks, and living arrangements. Changes commonly associated with later life did shape people's experiences of chronic illness. The caregiver identity, the widow identity, the retired identity, the mother identity, and the homemaker identity were shaped differently in later life than in other stages of the life course. Indeed, some of these identities were unique to older women. For instance, the independent mother identity and the vicarious mother identity are only possible when one's children have grown up. There are other examples. For example, caring for sick husbands is a common experience. Dealing with one's own chronic illness, while simultaneously caring for an ill husband, is probably more typical in later life than in the middle-aged years. The homemaker identity provided another example. Many of the women were able to relinquish their homemaker identities quite easily. After a lifetime of homemaking, many were willing to retire from these tasks.

Changes that are more typical in later life influenced processes of adjustment and one's ability to negotiate the disabled identity as well. For example, one older woman decided to change her place of residence after the death of her spouse. The change in residence altered her homemaker identity, and it also changed the woman's social network since she moved into a seniors' building. The data showed that such transitions, which are common in later life, often influenced experiences of OA.

Chapter 5 demonstrated that older persons engaged in processes of adjustment similar to the ones introduced by researchers who did not focus on age-related factors. However, the chapter showed that older persons displayed some unique processes as well. For example, many were able to adjust their expectations and interests because they believed that declines in health were common in later life. Moreover, the fact that one is released from roles and obligations in later life does shape experiences of chronic illness. For instance, relaxed task schedules and expanded task schedules were made possible because many of the women had retired, or had been released from previous responsibilities. In contrast, women who believed that their physical declines went beyond the limits of what they perceived to be normal were often unable to draw upon their age identity in order to negotiate personal changes.

Chapter 6 illustrated that the prevalence of health problems among the elderly was influential in shaping patterns of continuity and change. Often, chronically ill, older individuals were not alone and the process of positive social comparison and same boat comparisons were useful. That is, such individuals were aware that declines in one's health were quite common in later life. Some individuals utilized this belief in order to negotiate the acceptance of their own chronic conditions. Individuals also compared OA with other diseases that are common in old age. Many believed that their own chronic illnesses were minor in comparison to the problems of friends and significant others. In this way, OA was often experienced as a gradual progression in one's life and this served to preserve perceptions of continuity. However, negative social comparisons and threatening same boat comparisons were just as influential in contributing to perceptions of change. Hence, being older being older and having many sources of positive and "same boat" comparisons were not always effective in negotiating changes.

Next, issues pertaining to stigma were not affected by age factors uniformly. Some drew upon their belief that health declines were common in later life and did not feel stigmatized. In contrast, others associated their disability with negative images of old age. Hence, changes in the presenting self were not mediated by age-related beliefs in a uniform manner.

The high level of awareness of one's own mortality among older people is also significant. Many individuals commented that they were living at "the shorter end of the stick". Munnichs (1966) and Marshall (1986) refer to this as "the awareness of finitude". The experiences of some of the women in this study illustrated that the perception of the finitude of one's life span influenced treatment decisions. For example, this involved weighing the benefits of undergoing joint replacements at the later stages of one's life, and assessing the optimal age to undergo certain treatments. Individuals also drew upon the awareness of their mortalities in order to negotiate their pain, discomfort, and disabilities. These individuals remarked that they may not have to worry too much about the progression of their disease since they may die from other causes. Hence, the quality of life, in conjunction with the quantity of life remaining, became an issue. In comparison with their middle aged counterparts, conceptions of the self and plans for the future were also experienced differently.

Finally, Chapter 7 illustrated that the weight of the past self and the shortened future perspective are important. Some older individuals were able to draw upon a significant biographical past self as they engaged in biographical work. For many, deprived identity components were reconciled by the fact that the individual was able to fulfill most personal goals over the course of her life. These individuals remark that they feel fortunate for having lived the greater proportion of their lives, relatively free from health problems. However, as evidenced in a previous chapter, an unreconciled past also had negative implications as well.

Overall, the processes that are involved as people adjust to OA in later life present interesting findings. This study shows that older persons draw upon a variety of strategies. Some of these strategies are uniquely shaped by life stage factors.

POLICY IMPLICATIONS

This study explored those processes that contribute to patterns of continuity and change in the self-concept. In addition, the findings showed that the identities common among older women were influenced by OA in a variety of ways. There are several implications. The examination of the extant self showed that those identities located in family relations greatly shaped the experiences of living with OA. Much attention was devoted to the mother identity and it was apparent that the women placed a great deal of importance on those issues that were related to dependency. Most of the women were concerned about maintaining independent lifestyles and they did not want to become a burden on their adult children.

Assistance with grocery shopping, homemaking, and transportation were the most common types of services that were needed. Many of the women combined services from family members with those provided from formal service agencies. Visiting homemakers, public transportation services, and volunteer organizations that were involved in the delivery of groceries were very valuable and enabled many of the women to maintain independent lifestyles. Needless to say, these services were crucial to those who did not have the option of relying on family members. An important conclusion can be made from these observations: having the option to choose the type of assistance that is drawn upon was very important to the women in enabling them to negotiate their challenged identities. For example, having a visiting homemaker to do the vacuuming and other heavy housework was much appreciated when mothers did not want to impose on their children, especially when children were providing other valuable services. At the very least, these findings should provide further evidence of the important role that is played by the public/formal sector. If the current fiscal climate continues, more pressure will be placed upon families to provide services. This study suggests that this kind of shift in the balance of responsibility may contribute to stress, not only among caregivers, but also among disabled people. Hence, policies should continue to be directed toward developing strategies that encourage integrative and co-operative ventures between the formal and informal sectors.

Problems associated with the lack of transportation services were often mentioned by the women. Previous research has already established the crucial role played by social support networks and interaction as people adjust to illness and disability. Other studies show that social pursuits, hobbies and interests contribute to well-being in later life (Depuis and Smale 1995). When asked how OA influenced their social lives, an outstanding majority of the women stated that their participation in social activities had declined appreciably. Many of the women were negatively affected by inaccessible and inefficient public transit services for seniors. One such agency, DARTS, had restricted their services to medical visits due to recent government cut-backs. This study shows that the importance of social activities and interaction should not be overlooked when policy makers attempt to balance their budgets. Continued efforts should be made to enable disabled seniors to participate in social activities.

One solution to this problem was evidenced by the social activities provided in seniors' residences. As leaving the home became more difficult, especially during the winter, some of the women appreciated the social and recreational activities that took place right in their own buildings. Hence, this study provides support for the continuation of these valuable services. For example, the shifting hierarchy of identities demonstrated that some women were able to preserve self-continuity by engaging in new activities and by replacing lost identities with new ones. This often included new hobbies and additional social interaction. The examination of positive and same boat social comparison also showed that perceptions of continuity were often maintained as women compared themselves with their peers. This finding presents additional evidence of the importance of providing disabled seniors with opportunities for social interaction.

Next, this study demonstrated the many processes that were involved as the women adjusted to OA. Tasks, activities, interests, expectations and priorities were modified.

The experiences of some of the women showed that the unadjusted expectations of significant others made it difficult adjusting to their limitations. These findings provide further evidence that family, friends, therapists, and social workers should be sensitive and allow disabled seniors to set their own personal goals as they adjust to the limitations. This is not to deny the valuable role that supportive people can play in helping seniors to set realistic goals, while providing encouragement as the necessary adjustments are being made.

The study also showed that some people experience tragic disappointments and unsuccessful treatments. In these cases, individuals are forced to lower their expectations. This often accentuated the unwanted changes brought about by OA. Unfortunately, most of these women had not been fully informed by their doctors of the possible outcomes of these treatments. These women expected significant improvements and were bitterly disappointed when their expectations were not met. Those who had been well-informed were better prepared to deal with the outcomes of their operations. Hence, health practitioners should be reminded once again of the importance of communicating effectively with their patients.

Others were able to maintain their perceptions of continuity by dealing with changes in ways that had been developed through the years. The present challenges of OA were approached in ways, reminiscent of past strategies. This finding shows that members of the support network should be aware of the person's history of past, coping styles. Family members can play a valuable role in providing such information to therapists and social workers. In this way, the strengths of each client might be encouraged. Such accommodative strategies would be beneficial in contributing to the maintenance of continuity as well.

Finally, the role of the biographical self in maintaining perceptions of continuity was demonstrated as well. However, an unresolved past self was equally effective in contributing to difficult processes of adjustment. Women with unresolved pasts often struggled with painful memories as they engaged in personal life reviews. Such experiences often contributed to negative perceptions of the experiences of living with OA. These women were often overwhelmed by their chronic illness. This finding suggests that support groups or individual therapy would be extremely useful in helping such women to come to terms with their past experiences. Improvements in mental well-being would undoubtedly help in the processes of adjusting to the physical limitations presented by OA as well. Indeed, this study recognizes the importance of services such as friendly visitor programs for seniors and provides support for the continuation of such programs.

LIMITATIONS OF THE STUDY AND FUTURE RESEARCH

Up to this point, the contributions of this study have been presented. The limitations of previous studies were also presented in highlighting the relevance for this study as well. Nevertheless, this particular study is limited as well. First, the small size of the sample must be considered. The nature of obtaining information through the interview process, and the time limitations of this study restricted the size of the sample. The findings gathered from a larger sample would undoubtedly strengthen the generalizability of the data.

Second, this study focused upon one chronic illness only. Corbin and Strauss (1987) and Charmaz (1987) report that identity transformations were greatly shaped by the type of chronic illness in question. Needless to say, the findings of this study are not representative of chronic illnesses in general. However, much can be argued for the relevance of examining, in particular, OA. As stated in the introductory chapter, OA is the most commonly diagnosed musculoskeletal condition among older women in North America. Indeed, arthritis is often perceived to be a common condition among older people. Hence, although OA represents just one disease, this limited focus is offset by the "usualness" of arthritis in later life.

These limitations also point to areas of research that might prove to be particularly fruitful in future endeavours. First, this study utilized qualitative methods to explore the types of processes that are involved in negotiating patterns of continuity and change. Although this approach dictated a small sample, several processes were identified. In drawing upon quantitative measures, future research could examine which processes exert the most influence in shaping continuity and change. Such a quantitative approach would also make it easier to enlarge the size of the sample, (a limitation of this study that was presented above).

Next, this study only examined the experiences of **women** as they adjusted to OA. This decision was made not only because more women than men are diagnosed with OA in later life, but because the review of the literature revealed that there is a paucity of studies that have examined the ways in which identities specific to older women are affected. In the same vein, future research could assess the ways in which identities specific to older men, such as the father identity, grandfather identity, or husband identity are affected by chronic illness and disability.

This study was also limited in that the respondents were assessed at one point in their illness biography. Since the self-concept has been viewed as an "object-in-process", longitudinal studies would be fruitful. Studies which examine patterns of continuity and change as the illness trajectory develops over time would produce interesting findings. In particular, an examination of the ways in which the self develops within shifting and non-shifting hierarchies over time would shed additional information about the structural features of the self-concept.

Finally, an in-depth examination of the *history* of relationships located in family and friendship identities would provide detailed information of the ways in which identities undergo continuity and change. For example, one study shows that although people may be characterized by similar levels of social support, their satisfaction with their network may vary (Lee 1995). Hence, a woman who has never been socially active in her past may not be affected by her confinement in the same way as a women who was once accustomed to much social interaction. Indeed, the history of one's relationships, as conceptualized by "populated biographies", shape patterns of continuity and change and must be considered. Other researchers have similarly concluded that future research needs to examine the ways in which the biography of relationships shape the quantity and quality of social support at a later time (Cutrona 1996; Dwyer 1995). This approach, in combination with a longitudinal one, might uncover the ways in which continuity and change are negotiated, and the conditions which shape such patterns.

APPENDIX 1

List of Guiding Questions:

1. I'd like to understand your experiences of living with arthritis.
   a) In what ways does having arthritis influence your daily routine, if at all?
   -for example in managing your home, in terms of personal grooming, in running errands outside the home, in other responsibilities and duties, etc...

   b) Have you had to make any adjustments due to the arthritis? If so, in what ways? How do you feel about these changes?

2. I'd like to learn more about how you manage the treatment of arthritis, of coping with it.
   a) When were you first diagnosed with arthritis? (Officially by a medical practitioner).
   b) Can you recall your thoughts and feelings when you were first diagnosed? Have these changed over time? Have your thoughts and feelings about having arthritis changed? In what ways?
   c) Can you describe for me the course or progression of your arthritis?
   d) Which aspects of the disease itself have the most impact? (The pain? The uncertainty?)
   e) To what extent does treating the arthritis influence you and your daily routine?
   f) Do you think about what it will be like, living with arthritis in the future? What do you think about, worry about?

3. a) Can you tell me about any interests, hobbies, or activities of significance to you? Do you belong to any clubs, religious organizations, volunteer groups?
   b) Which ones do you value the most? In what ways are they important to you?
   c) Has your arthritis changed, in any way, your participation in any of these? In what ways? What are your thoughts about this?

4. a) Have you relied on any friends and/or family to help you manage the arthritis? If so, how important is this assistance to you?
   b) What source of help do you prefer the most? The least? Can you explain these preferences?

5. How often do you engage in social activities? For example, phone calls, visits...

6. Can you tell me about any friendships or family relationships that are important to you at the present time?

7. In general, do you think your relationships and patterns of social activity have changed at all because of the arthritis? In what ways? What are your thoughts and feelings about this?
8. If you wanted to, could you be open and honest in sharing your concerns or experiences of living with arthritis with these people? Do you feel comfortable in letting people know you have OA? Are there times when you try to conceal, or de-emphasize some of the challenges you face?

9. Do you think you are treated differently by other people, in any way, since you got arthritis? If so, what are your thoughts about this? How do you manage this?

(Questions 10 and 11 are general questions, designed to probe those issues most important to the interviewee).

10. In what areas of your life does arthritis influence you the most? The least?

11. What are you biggest concerns, or the greatest challenges of having arthritis, if at all?

12. What words would you use to describe yourself:
    a) -in terms of your occupation? For example, housekeeper, volunteer worker, church group leader.... Which is most important to you?
    -in terms of your relationships? For example, as mother, grandmother, widower, confidante, friend...
    -in terms of your habits, values, interests, personality, attitudes? Which ones are most important to you, or most relevant to how you would describe yourself?

    b) Have these always been important to you? Have these changed at all since the onset of arthritis?

    c) Has your experience of arthritis influenced in any way, your involvement as a _________, and the ways in which you would describe yourself?

13. Overall, do you think OA has changed your general feeling about yourself? In how you would describe yourself?

14. If you could change or improve anything about how you manage your life with OA, what would it be? Do you have any expectations of yourself, of how you think you should be handling OA? Are there any important people that would influence these feelings?

15. Do you think at all about the changes in what you were able to do prior to having arthritis, in comparison to what you are able to do now? What are your thoughts and feelings about this? Are there things that you wish you could do but are unable to do because of the OA? What things have remained the same?

16. What kinds of things, people, interests, activities are most important to you in helping you adjust to living with OA? In what ways have they helped? What kinds of things have made it more difficult for you?

17. Looking over your life, do you think your life is very much different today than it was before you developed OA?

18. How would you describe the pace of your week? A typical day? Do your days feel like they fly by? Do you feel like there's not enough time to do everything you want to do? Or do you feel like the day's pace is slower? Do you like the pace of things at the present time? Has it been an adjustment for you?

19. Do you ever think about the future, living with OA? How often do you think about this? Do you have any plans, any expectations of how you hope things will be like?

20. Do you ever think about why you got arthritis? Have you tried to explain it or come to terms with it?

21. Having lived a life of your own personal experiences, do you look back to explain your circumstances today?

22. Some people think arthritis is just an inevitable part of growing old. What are your thoughts about this common belief? Has it influenced your own experience or understanding of living with arthritis? Are you treated differently? What do you think about this?

23. Most people with osteoarthritis are older women. Is there anything significant or unique about having this condition at this point in your life? For example, would it have been different to have developed OA during middle-age? Do you think there is a difference in having OA now? In what ways? Has OA influenced your ideas about what it means to be getting older?

Conceptual Significance and Relevance of the Questions:

Questions 1 and 2 are designed to reveal the day-to-day issues of living with a chronic illness. Question 1 establishes the intrusiveness of OA in daily affairs. Question 2 explores the illness trajectory. How much impact did the diagnosis of the disease have? This question explores the direct impact of the disease itself, in managing the illness.

Many components of the self are expressed in the activities we engage in. We participate in these activities in order to affirm these aspects of the self. Question 3 explores the ways in which disrupted activities may challenge the self-concept, that is, the extant self. Moreover, an individual presents him/herself to others and to the self through the activities that are performed. When these actions are limited, this may challenge the self.

Questions 4 to 7 examine the significance of social interaction, that is, the role of friends and family. Issues of dependency and isolation may be implicated. The role of friends and family often shape the experiences of living with chronic illness. It is in interaction with significant others that one's self-concept is validated or judged. Relationships may be influenced by OA. Therefore, this question examines the ways in which chronic illness influences the person's relationships and the ways in which these experiences may affect the self-concept.

Questions 8 and 9 are designed to explore the ways in which chronic illness may influence the presenting self. Does the person struggle with presenting a desirable picture of the self to others? Is "impression management" an issue? Is the individual wary of being stereotyped or labeled in a certain way? Does the individual internalize the appraisals of others? In what ways? If not, why not, and how is the individual able to do this? What processes are involved in preserving the self? Questions 8 and 9 explore these issues.

Questions 10 and 11 determine which social conditions and issues are most significant to the individual. Does the individual reflect the same issues as revealed in the literature?

Questions 12 and 13 are designed to establish which components of the self have been affected by OA and the centrality of these components to the overall self. Patterns of continuity and change are explored. Moreover, the processes that are involved in shaping the developing self are highlighted by these questions.

Questions 14 and 15 are used to uncover the ways in which the desired self is implicated.

Question 16 is designed to summarize the people and events that shape the processes of adjusting to a life of chronicity. How are these conditions related to the developing self?

Question 17 explores issues of time. Does chronic illness alter the sense of time? This may be related to the self in that changes in lifestyles, that is, the flow or pace of everyday life may influence one's evaluation of the self. Do older people have different perceptions of time? If so, how does this affect experiences of living with OA and patterns of continuity and change?

Questions 18 to 21 are designed to examine whether the past is important in shaping present experiences of living with OA. Are past experiences drawn upon to affirm the self? Is the individual future oriented or deeply wedded to the past? What does this reveal about the processes that are involved in the developing self-concept?

Questions 22 and 23 explore the influence of age-related norms, and life stage transitions. These questions examine whether patterns of continuity and change are shaped in particular, by age and life stage factors.

APPENDIX 2
HEALTH ASSESSMENT QUESTIONNAIRE

We are interested in learning how your illness affects your ability to function in daily life. Please check the one response which describes your usual abilities OVER THE PAST WEEK:

	Without Any Difficulty	With Some Difficulty	With Much Difficulty	Unable To Do
DRESSING AND GROOMING				
Are you able to:				
-Dress yourself, including tying shoelaces and doing buttons.......................	_______	_______	_______	_______
-Shampoo your hair............................	_______	_______	_______	_______
ARISING				
Are you able to:				
-Stand up from an armless straight chair..	_______	_______	_______	_______
-Get in and out of bed.........................	_______	_______	_______	_______
EATING				
Are you able to:				
-Cut your meat..................................	_______	_______	_______	_______
-Lift a full cup/glass to your mouth........	_______	_______	_______	_______
-Open a new milk carton....................	_______	_______	_______	_______
WALKING				
Are you able to:				
-Walk outdoors on flat ground...........	_______	_______	_______	_______
-Climb up five steps..........................	_______	_______	_______	_______

2. Please check any AIDS or DEVICES that you usaully use for any of these activities:

____Cane ____Walker ____Built up or Special Utensils
____Crutches ____Special or Built up Chair ____Wheelchair

____Devices used for dressing (button hook, zipper pull, long-handled shoe horn etc.)

Other (Please specify) ____

3. Please chech any categories for which you usually need help FROM ANOTHER PERSON:

____Eating ____Dressing and Grooming ____Arising ____Walking

4. Please check the one response which best describes your usual activities OVER THE PAST WEEK:

	Without Any Difficulty	With Some Difficulty	With Much Difficult	Unable To Do
HYGIENE				
Are you able to:				
-Wash and dry your entire body.........	_______	_______	_______	_______
-Take a tub bath................................	_______	_______	_______	_______
-Get on and off the toilet....................	_______	_______	_______	_______
REACH				
Are you able to:				
-Reach and get down a 5 pound object (such as a bag of sugar from just above your head).......................	_______	_______	_______	_______
-Bend down and pick up clothing from the floor....................................	_______	_______	_______	_______
GRIP				
Are you able to:				
-Open car doors..............................	_______	_______	_______	_______
-Open jars which have been previously opened...	_______	_______	_______	_______
-Turn faucets on and off...................	_______	_______	_______	_______
ACTIVITIES				
Are you able to:				
-Run errands and shop....................	_______	_______	_______	_______
-Get in and out of a car...................	_______	_______	_______	_______

5. Please check any AIDS or DEVICES that you usually use for any of these activities:

____Raise Toilet Seat
____Long-Handled Appliances in Bathroom
____Bathtub Bar
____Long-Handled Appliances for Reach
____Bathtub Seat
____Jar Opener (for jars previously opened)

Other (Please Specify)____

6. Please check any categories for which you usaully need HELP FROM ANOTHER PERSON:

____Hygiene
____Reach
____Gripping and Opening Things
____Errands and Chores

Source: D. Ramey, J. Raynauld, and J. Fries. The Health Assessment Questionnaire 1992: Status and review. *Arthritis Care and Research* vol. 5, 3 (1992), 119-129.

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