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AGING, CHRONIC ILLNESS AND SELF-CONCEPT:
A STUDY OF OLDER WOMEN WITH OSTEOPOROSIS

by

Mary Seanne Wilkins

A thesis submitted in conformity with the requirements
for the degree of Doctor of Philosophy
Graduate Department of Community Health
University of Toronto

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AGING, CHRONIC ILLNESS AND SELF-CONCEPT: A STUDY OF OLDER WOMEN WITH OSTEOPOROSIS

PhD 1998

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ABSTRACT

The increasing likelihood of chronic illness with aging requires that attention be given to the social aspects of aging and chronic illness. A focus on women’s aging and health is essential because in later years women outnumber men, women have higher rates of nonfatal chronic illnesses and live longer with these conditions than men, and women have more chronic health problems than men.

The overall purpose of this dissertation is to consider the relationships between the meanings of aging and chronic illness and the self-concept of women using an interpretive sociological approach. The self is regarded as a basic concept for the understanding of the dynamic relationship between the individual and society. How individuals negotiate experiences and events in their lives depends on the content, organization and functioning of their self-concepts. The self-concept integrates individuals’ experiences across time providing continuity and meaning to these experiences.

While the meanings of either aging or chronic illness may be related to one’s self-concept, the coming together or coalescence of these two events may alter the relationships among the conceptions of aging and chronic illness and the sense of self. Using Rosenberg’s conceptualization of self-concept (1979), an in-depth interview and a self-administered questionnaire were designed and data collected from twenty-eight women with osteoporosis.

Three types of self-concepts emerged from the data: the competent self, the contradictory self and the ineffectual self. When the meanings of aging and chronic illness were examined, five themes emerged in each area. Through analysis of the self-concept processes of self-esteem and self-consistency, a reciprocal relationship was found between self-concept and the meanings of
aging and chronic illness. A comprehensive description of the three types of self-concept is presented highlighting this reciprocal relationship and including discussion of the strategies used to enhance, protect and maintain self-concept despite the changes brought on by aging and chronic illness.
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CHAPTER 1

INTRODUCTION

With the increasing proportion of elderly people in the population, with increasing longevity and with the increasing likelihood of chronic illness with aging, it is important to consider the social aspects of aging and chronic illness. Using an interpretive sociological approach, it is possible to consider the relationships between the meanings of aging and of chronic illness and the self-conceptions of older adults. The self is regarded as a basic concept for understanding the dynamic relationship between the individual and society (Breytspraak, 1984). How individuals negotiate experiences and events in their lives depends on the content, organization and functioning of their self-concepts. The self-concept integrates individuals' experiences across time providing continuity and meaning to those experiences (Markus & Herzog, 1991). Thus, the study of self-concept is essential to understanding the perspectives older people have of aging and chronic illness and how these perspectives, in turn, lead to social actions that allow them to manage their day-to-day lives. The purpose of this study is to determine what the relationships are among the meaning of aging, the meaning of chronic illness and the self-concepts of older women.

To begin, background information on the demographics of aging and chronic illness is presented to inform the reader of the importance of research in this area.

Significance of the Research

Demography

While the proportion of old people in the population increased from 5.2% in 1901 to over 10% in 1986, it is projected to be 22.7% by 2031 (Messinger & Powell, 1987; Statistics Canada, 1993). Also the life expectancy at birth has increased over time. Based on mortality conditions in 1931, a newborn male could expect to live about 60 years; a newborn female, 62 years. In 1986 this had increased to 73 for males and 79.8 for females. It is projected that by 2011, this life expectancy at birth will rise to 77.2 for men and 84.0 for women (Statistics Canada, 1993). Although some have argued that there is an upper limit on the life span (Fries, 1983), others (Manton, 1982; Schneider & Brody, 1983) have contended that there is an open life span whose ultimate boundary is yet unknown. It should also be recognized that women live longer than men, with the ratio of women to men increasing substantially at higher age levels (i.e., 65-69 years 120:100; 85+ 229:100 - McPherson, 1990). Thus, not only will there be a greater proportion of elderly people in the population in the future but they are expected to live longer than in the past and more of them will be women. However, some have argued that this increased longevity will be accompanied by poor health (Guralnik, 1991; Kaplan, 1991; Verbrugge, 1984).
"Longer Life but Worsening Health"

It is generally understood that there is an increased likelihood of chronic conditions with aging but lately considerable attention has been directed to this issue because of the potential impact an aging population may have on health and social service delivery. There are two major arguments: one argument is that there will be an increase in morbidity resulting in a crisis in health and social services as an increasing proportion of elderly people live longer but are disabled; and the other argument is that due to reductions in risk factors and improvements in health care, the onset of chronic diseases will be postponed to older ages closer to death, actually shortening the period of morbidity (Haan, Rice, Satariano & Selby, 1991). Haan et al. (1991) argued that, despite these debates which remain unresolved, efforts to understand the dynamics of changes in health, disease and disability in older people are critical now due to demographic realities. Better sanitation, improved living conditions and medical technology have decreased the likelihood of someone dying of contagious or parasitic diseases at a young age (Olshansky, Rudberg, Carnes, Cassel & Brody, 1991). This has been replaced by survival to older ages where the risk of mortality increases. Thus, "the mortality transition [has] redistributed the majority of all deaths to older ages .... the acute pain and suffering associated with death in early ages [has been] traded for the diseases of old age" (Olshansky et al., 1991, p. 195). These diseases of old age include diseases from which most people die (i.e., heart disease, stroke and cancer) and nonfatal diseases that are responsible for disability and frailty (such as arthritis, dementia, sensory impairments and osteoporosis). There are also sex differences in the prevalence of acute, fatal diseases versus chronic, degenerative diseases, with women at more risk of nonfatal chronic diseases (Manton, 1990; Verbrugge, 1989). Further, Verbrugge (1989), from her epidemiological work, concluded that women have higher rates of most nonfatal diseases; higher incidence plus longer lifetimes mean that women typically live with these conditions for more years than men; and women have more chronic health problems, on average, than men; that is, they have more comorbidity.

Whereas an increasing proportion of the future disease burden will be taken up by nonfatal, chronic, often disabling conditions, Kaplan (1991) observed that the relationship between chronic conditions and disability is not fixed: rather it can be influenced by the physical environment, social resources, economic resources, psychological states, comorbidities and medications. Relative to predictions for the future, Verbrugge (1991) concluded that secondary prevention is likely to continue as the major focus and goal of health care; thus, we should "expect to see rising morbidity and disability prevalence joined with falling mortality .... the scenario of longer life but worsening health is most likely" (p. 232). In summary, there will be a larger proportion of the population who will be old, people will live longer but with more likelihood of chronic illnesses. More of them will be women. Thus, while aging and chronic illness are important to society at the demographic and economic levels, they are also significant to the individual. It is the relationships between the
meanings of aging and chronic illness and the self-concepts of individuals that will be the focus of this dissertation.

Overview of the Dissertation

Specifically, the focus of this dissertation will be on the relationships among the meaning of aging, the meaning of chronic illness and the self-concepts of older women with osteoporosis. While there is literature on aging and self-concept and on chronic illness and self-concept, little has been written about the relationships between the meanings of aging and chronic illness and self-concept. The inclusion of women with osteoporosis in this study provides an opportunity to consider how aging and chronic illness occurring at the same time may affect self-concept. An overview of each chapter follows.

Following this introduction, in Chapter 2, there is a review of the sociological literature on self-concept generally and, more specifically, self-concept relative to aging and chronic illness in order to identify what research has been done and what gaps remain to be explored in understanding the meanings of aging and chronic illness and the self. An assessment of the literature reviewed results in a discussion of the need for research on the meanings of aging and chronic illness and the self-concept of individuals, and in particular, women with osteoporosis. The research questions are outlined and a conceptual framework described. The conceptual framework informing the research is based on the work of Rosenberg (1979) and includes both the structure and process of self-concept.

Chapter 3 describes the methods including the rationale for using qualitative methods, the procedures for identifying possible participants and for collecting data using a self-administered questionnaire and an in-depth interview. Some consideration is given to the context within which women experience aging and chronic illness. The last section of the chapter describes the analysis of the data.

Chapters 4 through 8 examine in detail the 28 women with osteoporosis who participated in the study. The sociodemographic and health profiles of the women are described in Chapter 4. The health profile details information such as, health status, pain and its management, activities of daily living (ADL) and instrumental activities of daily living (IADL). The women are categorized as being mildly, moderately or severely disabled. Chapter 5 presents the general findings about the self-concept of the women in the study using Rosenberg's structure of self-concept (extant, desired and presenting self). Three types of self-concept emerged from the analysis of the data--the competent self, the contradictory self and the ineffectual self. The meanings aging and chronic illness have for the participants are delineated in detail in Chapter 6. There are five themes or meanings which emerge in each area. Aging was considered as a natural process, as a time of wisdom and forthrightness, as a time of changing priorities and new found freedom, as a time of loneliness and uncertainty and as a time of deterioration and loss of independence. Chronic illness was described
as mundane, as inconsequential, as adaptation, as unpredictable and as overwhelming. In Chapter 7, consideration is given to the relationships between these meanings associated with aging and chronic illness and the three types of self delineated in Chapter 5. These relationships are examined using Rosenberg’s self-esteem and self-consistency motives. Consideration is given to how the women in the study enhance, protect and maintain their self-concepts in the face of aging and chronic illness. The final chapter, Chapter 8, reviews the overall findings of the study and discusses the implications of the findings for theory, research, policy and practice.

The next chapter provides a review of the literature, the need for further research and describes the conceptual framework utilized to inform the study conducted for this dissertation.
CHAPTER 2

REVIEW OF THE LITERATURE

Meaning and the Self

Meaning and the self are central to the work of social scientists, particularly those working in the interpretive perspective. This perspective is based on a view of social interaction as an interpretive process in which meanings evolve and change over the course of that interaction (Wilson, 1971). Individuals are seen as active agents who construct their social actions based on the meanings and interpretations they give to their environment; the world must be interpreted, made sense of and given meaning (Cuff & Payne, 1984). The focus of the interpretive perspective is on the individual’s perceptions of himself or herself. The "self" develops through social interaction (Mead, 1934). Although the individual’s view of self may be internal, what he or she sees and feels when thinking of himself or herself is largely the product of social life (Rosenberg, 1981); self-concept is the result of interpretations of other people’s reactions to what one says and does (Cuff & Payne, 1984). Weigert, Teitge and Teitge (1986) described the self as "the evolving, self-aware production of a series of interactional relationships that lead to the development of the sense of individuality over the life course" (p. 40).

Self-concept

While some may argue that study of the self is more properly a psychological endeavour, Rosenberg (1981) argued that the sociological relevance of the self-concept is related to the fact that social factors play a major role in its formation; it arises out of social experience and interaction; it both incorporates and is influenced by the individual’s location in the social structure; it is formed within institutional systems, such as the family, school and economy; and it is affected by cultural, social and environmental contexts. Thus, "the self-concept achieves its particular shape and form in the matrix of a given culture, social structure, and institutional setting" (Rosenberg, 1981, p. 591).

Rosenberg (1979) provided the most comprehensive descriptions of the self and these have been used as the basis for work by others (see for example, Bengtson, Reedy & Gordon, 1985; Ryff & Essex, 1991). Rosenberg (1979) defined the self-concept as "the totality of the individual's thoughts and feelings with reference to himself as an object" (Rosenberg, 1979, p. ix). The individual is able to stand outside of himself or herself and describe, evaluate and respond to himself or herself as an object. The focus is on the self as object--"the picture of the self" (Rosenberg, 1979, p.7). The self-concept

is an object of perception and reflection, including the emotional responses to that perception and reflection .... a product of 'self-objectification', requiring the individual to stand outside of himself and to react to himself as a detached object of observations .... it is a concept with breadth and depth, one with profound consequences and ramifications both for the
The self-concept is the "individual's fundamental frame of reference, the foundation on which almost all his actions are predicated" (Rosenberg, 1979, p. 59). Rosenberg further elaborated on the self-concept as including the extant self (how one sees oneself), the desired self (how one would like to see oneself) and the presenting self (how one shows oneself to others). The extant self includes i) the content of the self (including the major components of social identity, "dispositions" or qualities, and physical characteristics); ii) structure (the relationship among the above components); iii) dimensions (self-attitudes); and iv) ego-extensions (incorporation of "external" elements into the self, e.g., "my university, my company"). These four areas of the extant self will be discussed in more detail in the section on the conceptual framework. The extant self represents the cognitive dimensions of the self, indexed by nouns of personal identity and adjectives of personal characteristics (Bengtson et al., 1985).

The desired self is what one wishes to be like and is "the reference point against which the extant self is viewed and judged" (Rosenberg, 1979, p. 38). This includes the idealized (or ultimate) image; the committed image or the self picture that we take seriously; and the moral image or what we feel we must, ought, or should be. This represents the affective or evaluative dimensions of the self. The desired self is a "motive force, a spur to action" (Rosenberg, 1979, p. 44). The individual is constantly striving to shape him or herself into the idealistic self. Much of human behaviour is motivated by the wish to attain, maintain or retain the desired self (Rosenberg, 1979).

The presenting self is that self we display to others as we engage in "impression management" (Goffman, 1959)--the self that is governing, guiding and controlling actions in harmony with the type of person we wish to appear (Rosenberg, 1979). While there is a more or less consistent self that is presented to the world, the presenting self is not the same in all situations but rather is variable and situation-specific (Rosenberg, 1979). Rosenberg suggested that there were several objectives in presenting certain selves in particular situations including the realization of goals and aspirations, the establishment of self-consistency and self-esteem, and conformity to social rules and norms. Bengtson et al. (1985) suggested that this presenting self is structured largely around attempts to confirm, protect and enhance one's cognitive current self-conceptions (Rosenberg's extant self) in light of affective judgments.

While Rosenberg argued that the self-concept is largely a cognitive structure, it matters and makes a difference. People have feelings and wishes about their self-concepts and the self-concept impels or motivates the individual to action. Self-concept is also a process. Self-concept motives are related to self-preservation, the maintenance or enhancement of self. He described two self-concept motives: the self-esteem motive--the wish to think well of oneself and the self-consistency motive--the wish to protect the self-concept against change or to maintain one's self-picture. Both of these
motives have powerful behavioural and emotional consequences. They are not simply passively preferred but actively sought (Rosenberg, 1979).

Rosenberg (1979) also described four principles of self-concept formation which he utilized to understand the relevance of the interpersonal and social structural processes on the self-concept. These principles are: reflected appraisals (which are concerned with the role other people's attitudes have in shaping self-concept), social comparisons (people judge and evaluate themselves by comparing themselves to others), self-attribution (the assessment of the self based on observing one's own behaviour and its outcomes--Ryff & Essex [1991] referred to this principle as behavioural self-perceptions), and psychological centrality (the components of self-concept are organized hierarchically and interrelated in complex ways). While Rosenberg suggested that reflected appraisals and social comparisons are more social because the individual sees him or herself from the point of view of others and self-attribution and psychological centrality are more psychological, he asserted that the latter two are heavily influenced by social factors. The individual may assess him or herself by observing his or her behaviour but these assessments can only be made in terms of criteria or standards provided by the culture within which the individual lives.

Based on the work of James (1892) and Mead (1934), self-concept relates to the self as object or the "Me" rather than the self as subject or the "I" (Bengtson et al., 1985; Charon, 1992). The individual comes to see the self as a separate object in interaction with others (Charon, 1992). The self is defined and redefined in social interaction and, therefore, is a process constantly changing through interaction with others (Charon, 1992). "The individual experiences himself ... not directly, but only indirectly, from the particular standpoints of other individual members of the same social group" (Mead, 1934, p. 138).

In contrast, the "I" is the individual as subject, the actor, the "active agent--an executor, a doer" (Rosenberg, 1979, p. 6). Burkitt (1991) suggested that the "I" makes possible the inner dialogue between the responses to others and self-consciousness. The "I" is the individual as having consciousness, is the process of thinking and articulating thought (Burkitt, 1991). The "I" is the creative, impulsive and spontaneous aspect of the individual (Charon, 1992), the source of new or novel responses (Chappell & Orbach, 1986). In describing the "I" and the "Me" relative to solutions to conflict and problems, Burkitt (1991) suggested that,

the more conservative values are linked to the past and to the past self, or the 'me', while the need for change and adaptation is expressed through the 'I', which is the self of present activity moving toward a planned future. Both the past and the future are reconstructed in the present, according to the problems and conflicts which must be solved, and this draws attention to certain aspects of the past and certain possibilities for the future. (p. 44)

This also suggests a temporal aspect of the self. Chappell and Orbach (1986) proposed that, in order to understand the self as a process, it is important to appreciate Mead's notion of the temporal order. For Mead, the locus of reality was the present. The present includes events as they emerge.
The past is remembered and reconstructed from the perspective of the present. The future is anticipated as alternative possibilities (Chappell & Orbach, 1986).

Although Rosenberg presents a very comprehensive description of self-concept, brief consideration will be given to other researchers' conceptualizations of self to ascertain if there are important concepts that are missing and should be added to Rosenberg’s ideas. For example, Charon (1992) and Gecas and Mortimer (1987) considered self-concept under two dimensions: identity and self-evaluation or self-judgment.

**Self-evaluation.** Self-evaluation is the evaluative aspect of self. Within this aspect of self-concept, Gecas and Mortimer included self-esteem (positive or negative regard in which one holds oneself), self-efficacy (the sense of mastery, causality and control in affecting one's environment) and authenticity (a fundamental sense of self, one's sense of reality). All three of these self-evaluations are important because they have motivational, as well as evaluative, significance (Gecas & Mortimer, 1987). This self-evaluation aspect of self-concept is subsumed under Rosenberg’s desired self.

**Identity.** While Rosenberg (1979) described social identity as part of the extant self, Charon (1992) and Stryker (1981), using Burke's (1980) work, described identities as meanings a person attributes to the self as an object in a social situation or social role; identities are relational, social, placed in a context of interaction and are a source of motivation. Identities are social locations. The question of “Who am I?” leads individuals to identify themselves in groups or in social categories. Weigert et al. (1986) explained identity as a "typified" or socially expressed dimension of the self; an individual has one self that becomes typified through a variety of identities including 'personal' identity and 'social' identity. "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 et al., 1986, p. 40). In contrast, Marshall (1980) considered identity to be the overarching concept with an identity being comprised of many selves.

Gecas and Mortimer (1987), while describing identity generally as who or what one is and the various meanings attached to oneself by self and others, further elaborated on important types of identity: role-identity, character identity and existential identity. **Role-identities** refer to the structural features of group membership, such as, social roles (parent, spouse); social categories (gender, age, race); and memberships (labour unions, club memberships). These anchor the individual to various social institutions and social networks. **Character identity** refers to qualities which the individual and others attribute to self, expressed in terms of beliefs, values and character traits, for example, honest, industrious, brave and resourceful. This category would include negotiated identities which individuals are likely to strive to protect in their self presentations and impression management strategies as described by Goffman (1959). "Identity-as-character emphasises the kind of person one is, whereas identity-as-role specifies what one is" (Gecas & Mortimer, 1987, p. 266). Role and
character identity are included in Rosenberg's extant self.

**Existential identity** refers to the individual's sense of uniqueness and continuity, the biographical self and is similar to Goffman's (1963) concepts of "personal identity" and "ego identity". This brings in the temporal/historical dimension as subjectively experienced and is a mental construct which keeps changing over the life course. These changes are not simply the result of new experiences that the person undergoes in life but "more importantly they are the result of continuing reconstruction of the past, as well as the anticipated future, from the perspective of the present. Each new present gives the individual a new perspective on the past and future" (Gecas & Mortimer, 1987, p. 267). Rosenberg (1979) argued that self-concept is not existential identity. Rather, he considered the existential self as the world of being, of immediate experience, concerned with what is, not what has been or will be (i.e., with being, not becoming) and thus, was more limiting than his ideas of self-concept.

**Self-concept Formation**

Relative to self-concept formation, Gecas and Mortimer (1987), as did Rosenberg, stressed the importance of reflected appraisal (the appraisals and perceptions of others, particularly significant others, in the environment); social comparisons (processes by which individuals assess their own abilities and virtues by comparing them with those of others); and self-attributions (tendency to make inferences about ourselves from direct observation of our behaviour). Therefore, "we come to know who and what we are from the responses from others, from the inferences we make from observing our own behaviour and from the reference groups we use in our social comparisons" (Gecas & Mortimer, 1987, p. 271). Rosenberg (1979) included an additional principle relative to self-concept formation: psychological centrality. He argued that self-concept is not a collection but an *organization* of components that are organized hierarchically and interrelated in complex ways. Certain dispositions--intelligence, morality, honesty--are more or less central to our concerns as are social identity elements, such as white, mother, teacher.

**Change and Stability in Self-concept**

Sociological theory views development of the self as continuing long after adolescence and over the life course (Strauss, 1959). Change is perceived as the natural state of the self-concept through continual self-examination and alteration (Gecas & Mortimer, 1987; Goffman, 1959). The self is always changing or "becoming", however gradually, slowly or subtly (Chappell & Orbach, 1986; Mead, 1932). Strauss (1959) described transformations of identity as "turning points": "points in development when an individual has to take stock, to re-evaluate, revise, resee, and rejudge .... stock-taking goes on within the single individual [but] it is obviously both a socialized and a socialization process" (p. 100). For example, in later life, widowhood is a turning point for many women requiring an adjustment from living with a husband to living alone independently (Martin Matthews, 1987). Changes may also be due to variations in the environment, for example, changes
in interpersonal relations and social structural circumstances may alter the self-concept. Changes in self-concept increase under conditions of conflict, confrontation and discrepancy (Gecas & Mortimer, 1987; Mead, 1934).

While change may be considered natural, there is a certain stability inherent in the self-concept (Chappell & Orbach, 1986; Gecas & Mortimer, 1987; Mead, 1934). This may arise from external or internal stability (Gecas & Mortimer, 1987) which is similar to Rosenberg’s self-esteem and self-consistency motives. External stability is dependent on the constancy of the social environment within which the individual exists, (i.e., the stability of reference groups, significant others and contexts within which selves undertake reflected appraisal, social comparison and self-attribution). Internal stability is due to the motivation of the individual to maintain the self-concept, enabling one to more effectively take action in the world; otherwise, "without a clear conception of who and what one is, action becomes confused, uncertain or even paralysed" (Gecas & Mortimer, 1987, p. 272). This motivation to maintain a positive view of the self is realized "through selectivity and reconstruction of one’s social reality" (Gecas and Mortimer, 1987, p. 273). Stability is essential to the maintenance of existential identity or the sense of sameness, uniqueness and temporal continuity even if the stability has no basis in fact (Gecas & Mortimer, 1987). Strauss (1959) stressed the importance of a sense of personal continuity:

Each person’s account of his life ... is a symbolic ordering of events. The sense that you make of your own life rests upon what concepts, what interpretations, you bring to bear upon the multitudinous and disorderly crowd of past events. If your interpretations are convincing to yourself, if you trust your terminology, then there is some kind of continuous meaning assigned to your life-as-a-whole. Different motives may be seen to have driven you at different periods, but the overriding purpose of your life may yet seem to retain a certain unity and coherence. (p. 145)

Meaning

The self-concept and meaning are interrelated: "experiences of self must be transformed into socially available meanings for personal experience to be ‘real-ized’; that is, both made real and simultaneously made known as such" (Weigert et al., 1986, p. 42-43). Acts and objects have meaning only because they can be described using words or language. Language, defined in interaction, is used to describe to others and ourselves what we observe, think and imagine (Charon, 1992). The self-concept provides organization for one’s life experiences, giving a sense of coherence and continuity across time. Also it provides the personal meaning that allows individuals to make sense of their diverse life experiences (Markus & Herzog, 1991).

Lofland and Lofland (1984) described meanings as the most fundamental and ubiquitous aspect of the human social setting. Meanings are the linguistic categories making up the participants’ view of reality and defining their own and others’ actions. Meanings describe behaviour but also define, justify, and interpret behaviour as well. The Loflands presented alternative words used by
social analysts to refer to meanings depending on the breadth or range of situations being described: culture, norms, understandings, social reality, definitions of the situation, typifications, ideology, beliefs, world view, perspective or stereotypes.

Relative to meaning, Meltzer, Petras and Reynolds (1975) outlined the basic premises of interactionism based on the work of Blumer (1969): human beings act towards things on the basis of the meanings that things have for them; these meanings are a product of social interaction; and these meanings are modified and handled through an interpretive process that is used by each individual in dealing with the things that he or she encounters. Human beings transform "things" into meaningful "objects" or realities in the process of interaction with other human beings (Meltzer et al., 1975; Weigert et al., 1986). Meanings are transmitted through symbols—gestures, language and appearances (Weigert et al., 1986), which are defined in interaction and are meaningful for the user; thus, "the person who uses symbols does so for the purpose of giving off meaning that he or she believes will make sense to the other" (Charon, 1992, p. 43). Meaning informs social action, arises out of social interaction and must be established before goal-directed behaviour can occur (McCall & Wittner, 1990; Reinharz, 1987; Weigert et al., 1986). In order for individuals to take social action, Burkitt (1991) suggested that one must understand Mead's ideas about intelligence which is "the ability to solve the problems of present behaviour in terms of its possible future consequences as implicated on the basis of past experience - the ability ... to solve the problems of present behaviour in the light of, or by reference to, both the past and the future; it involves both memory and insight" (Mead, 1934, p. 100).

As well as taking individual action, people are also actively involved in creating society. They "shape joint lines of action into emergent collective action and generate shared meanings that provide the ... empirical structures of social life" (Weigert et al., 1986, p. 36). However, social life does not emerge without conflict and negotiation—while certain ideas become institutionalized and stable, these then become the bases for further change (Burkitt, 1991). The social process "solidifies into stable interactions and meanings here, only to liquefy into conflict and uncertainty there" (Burkitt, 1991, p. 45). Despite exposure to a common society, the individual develops a unique self as a result of the distinct combination of intersecting circumstances in relation to a specific past and future (Chappell & Orbach, 1986).

**Summary**

Thus, studies of the self require an interpretive perspective that considers the self-concept and how it changes and remains stable over time, how events impact on the individual's self and meanings about life while considering the larger social context. Rosenberg's (1979) concepts of the self (including both structure and process) appear to be the most comprehensive for viewing this complex area and thus, will inform my further work in this area.

The next two sections review the literature on studies of the self relative to aging and
chronic illness.

**Aging and the Self**

While many researchers have conducted work in the area of aging and the self, a selected review follows. Researchers whose work was most insightful for my study are reported below.

**The Self as Process in Older People**

Breytspraak (1984) presented an excellent analysis of knowledge of the self and aging. The usual emphasis in social gerontology has been on adaptation, adjustment and life satisfaction; the dominant image of the aging individual is one who is left to react to changes and degradations in social roles with a resultant threat to selfhood. While the individual's reaction may be influenced by factors such as gender, ethnicity and socioeconomic status, the emphasis is on reacting, responding, adjusting and accommodating. In contrast, having reviewed various approaches, Breytspraak maintained that the symbolic interactionist and phenomenological perspectives were useful in the study of aging in that they assume that people are always developing, acting, constructing and negotiating selfhood no matter what their age. The self is a process. The person is a participant in constructing meanings about his or her self in a social world that shifts as one moves through time and space. Although the processes of self-conceptualization work at any stage in the life course, "the need to make sense of one's finitude, the match between one's aspirations and achievements, role changes and physical losses, and the mixed images of old age pervading our society ensures that these processes are used at this [later] stage of life" (Breytspraak, 1984, p. 118). Finding solutions to problematic issues is realized through creative efforts. In her discussion of finitude, Breytspraak makes extensive use of the work of Marshall (1980).

Marshall (1980), in his study of aging and dying, suggested that the heightened awareness of one’s finitude stimulates increased self-reflection and reminiscence. Using the metaphor of writing one's autobiography, he described how older adults writing the last chapters of their life stories tried to "legitimate and find meaning in past events and acts" (Marshall & Levy, 1990, p. 249). "They want their story to be a 'good' one, not necessarily a story of success, happiness, fame, and the like, but a story that 'makes sense', that is meaningful" (Marshall, 1980, p. 108). This active process, which he called the legitimation of biography, is a strategy through which an older person attempts to make sense of his or her life in the past and present, to make sense of the self. He argued that reflection occurs throughout life and is the way the self is created.

In order to understand the self, Breytspraak (1984) suggested that it is necessary to consider the cognitive and affective aspects of the self (also see Breytspraak & George, 1982). To date, in gerontology more attention has been given to the affective aspects but Breytspraak argued that we need to understand more about the processes associated with self-concept and "how people come to characterize themselves in certain ways and then live with and alter those characterizations."
People seem to have a remarkable capacity for protecting and enhancing themselves ... but our knowledge is really rather limited about how the process works" (p. 120). To more fully understand aging, we must focus on the selfhood of the aging person; "for it is there that we can observe and experience the dynamic interplay of many individual and social forces" (Breytspraak, 1984, p. 20).

**The Ageless Self**

Kaufman (1986) studied the relationships among old age, personal reflection and identity and explored the issue of continuity and meaning in old age. She found that, although sociocultural demands for change were inevitable in later life and did present dilemmas, people, in describing the meaning of their lives, were able to create continuity of the self. This process enabled them to cope with demands for change and, thus, was a critical resource for remaining healthy. She also observed that when older people talked about who they were and how their lives had been

*they [did] not speak of being old as meaningful in itself; that is, they [did] not relate aging or chronological age as a category of meaning or experience. To the contrary, when old people talk about themselves, they express a sense of self that is ageless-an identity that maintains continuity despite the physical and social changes that come with age.* (Kaufman, 1986, p. 7)

Kaufman recommended that analysis of life-story material allows researchers to be aware of the operating frameworks of elderly people themselves. Rather than focus on "morale" and "life satisfaction" as key elements of behaviour, "construction and interpretation of experience as one grows older are found to be critical elements that give form and meaning to one's actions" (Kaufman, 1986, p. 162-163). Old people continue to participate in society and interpret participation in the social world. They cope with losses, create new meanings and build viable selves. "Creating identity is a lifelong process" (Kaufman, 1986, p. 168). Kaufman concluded that individuals "integrated a wide range of experiences - unique situations, structural forces, values, cultural pathways, knowledge of an entire life span - to construct a current and viable identity" (Kaufman, 1986, p. 187-188).

Matthews (1979), in her study of the social worlds of old women, found uncertainty to be the most salient feature of "being old". She argued that the lack of a rite of passage into "old" age and the shortage of norms and expectations about "old" led to ambiguous social situations for old people. Matthews also found that oldness was a stigma, although a weak one. These factors combined to make self-identity and self-presentation problematic. Although these old women shared society's stereotypical view of old people, oldness was not a pivotal self-identity for these old women. In most situations they rejected the label of old for themselves but used it to describe others who were age peers. In order to protect their self-identity within the seniors' centre in her study, the old women used two strategies, confrontation and role distance. The staff of the centre actively promoted a definition of these old people as "post adults or "nonadults" who by virtue of their age no longer had the physical and social resources required to confront the problems they had
and therefore, needed the "help" of the professional staff. Confrontation of the postadult status used to characterize them was employed by criticizing the centre and its staff. They distanced themselves by not accepting the postadult definition of needing help; rather "old people who came to the Center came to do for others or to do with others, not to be done unto" (Matthews, 1979, p. 161).

Matthews concluded that, in comparing the strategies used by old people to maintain self-identities, the similarity among them is that they all lead to increased social isolation. "The powerlessness stemming from roles with no content and lack of economic resources, and the possession of a discrediting attribute, combine to make self-presentation problematic" (Matthews, 1979, p. 168).

The Meaning of Aging

In a study of the meaning of aging, Keller and associates (1989) found that respondents' overall impressions of aging were very positive although the changes they associated with aging were almost uniformly negative. When asked about the meaning of aging, five categories were mentioned: aging as a natural and gradual process without remarkable features; aging as a period of life evaluation, philosophical reflection, or increased wisdom and maturity; aging as a period of increased freedom, new interests, and fewer demands; aging as associated with physical health difficulties or concerns about health; and aging as a period of losses, both interpersonal and job related.

The most important signs of aging noticed in themselves and in others were categorized as social, physical, emotional and cognitive changes. Five categories of coping activities were reported by the participants: compensation, stress management, maintenance, involvement with others and alteration in meaning. Respondents reported high levels of satisfaction and effectiveness with respect to these coping strategies. Those who believed that they were coping successfully saw aging as a positive period in their lives despite the presence of significant numbers of negative changes in themselves and in those close to them.

Keller et al. (1989) also found that classifying self as "old" was not a permanent state: some respondents reported episodic awareness of aging--at times they felt old but at other times they did not. Those describing a constant awareness of aging associated it with a social event such as retirement or eligibility for social security. The researchers concluded that the lived experience of aging is quite vivid and people can describe their perceptions. Rather than reporting passive acceptance of change, people used a wide range of active, problem-focused strategies in response to what were perceived as normal age-related changes.

Ryff (1986) proposed using a life events approach in order to consider "the inner meanings and goals of the person [that] are interwoven with the constraints and opportunities of the external environment" (Ryff, 1986, p. 68). She reported on studies completed by herself and her colleagues of people's personal experiences of change as they age. Most of the studies included men and women and various combinations of three age groups (young adults, middle and older aged adults).
Participants completed personality inventories including questions related to psychological well-being (i.e., self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth). They were asked to examine changes by rating themselves in the present, by recalling what they were like in the past and by anticipating what they would be like in the future. Comparisons among these outcomes provided a measure of subjective change.

In a subsequent study with Essex (Ryff & Essex, 1991), she used the psychological well-being scale as well as questions developed based on Rosenberg’s theory of self-concept. Specifically they used his concepts of reflected appraisals, social comparisons, self-attributions, and psychological centrality in a study of older women making a transition from their independent homes to apartments or retirement communities. The goal of their research was to assess the value of a life-events approach to psychological well-being as an alternative to the usual consideration of sociodemographic or personality variables. They concluded that Rosenberg’s framework was valuable in clarifying the role of various cognitive activities (reflected appraisals, social comparisons, self-attributions, and psychological centrality) in life-events processes and that social comparisons and reflected appraisals had the greatest predictive impact on well-being outcomes.

As a result of her research, Ryff has warned that it was not enough to look only at the inner meanings and goals of the individual but that these must be considered within the constraints and opportunities of the external environment, the larger sociocultural conditions. She advocated the combination of psychological and sociological perspectives to fully understand how individuals manage life events.

**Change and Stability in Self-concept in Later Life**

By using the concepts of role transitions and life events, George (1980) developed a model of social adjustment in order to understand the major adaptive challenges or role transitions of later life. By examining adjustment and identity in the role transitions of retirement, widowhood and residential relocation, she was able to identify the consequences of social stress on the individual. Social status factors, personal resources and coping skills were considered in order to understand individuals' responses to stressful situations. As a result of her research, George (1980) argued that, while old age is often viewed by gerontologists as a period of decline when role transitions generate a sense of loss and disruption threatening personal well-being, most older people exhibit adequate levels of adjustment. They successfully negotiate environmental demands and retain essential informal attachments to social structures. They report relatively high levels of life satisfaction and maintained viable personal identities. Most role transitions did not appear to lead to negative outcomes.

George (1990) reviewed current thinking on how social structure and social processes impact on the attitudes and behaviours of older people. In her analysis of the research on the aging self, she argued that, while there is consensus that the self is multidimensional, the degree to which
the self changes or remains stable with age continues to be unclear. She cited the work of Bengtson et al. (1985) which reviewed 62 studies of stability and change in various dimensions of self-perceptions. That research concluded that while most self-concept dimensions remained stable over time (e.g., temperament especially well-being, security/adjustment, sociability/amiability and competence/assertion/achievement), there were some self-concept dimensions that changed over time (e.g., autonomy, self-competence, self-confidence, excitability and humanitarian concerns) but that fewer changes seemed to be developmentally generated than were triggered by changes in social situations. Bengtson et al. noted that most of these studies were cross-sectional and, thus, their conclusions about age changes remained tentative. In contrast, in a five year longitudinal study of four age groups ranging from late adolescence to early old age, Fiske (1980) described high rates of change in the salience hierarchies of four self-concept dimensions in all age groups. Thus, George (1990) concluded that a strong case can be made for both stability and change in self-perceptions in later life (see also Markus & Herzog, 1991). In summarizing her review, she determined that "the self" represented "an arena in which both social and individual factors operate" (George, 1990, p. 198). The self, while developing in social contexts, remains responsive to social context. Changes to social structures may occur, posing challenges to the integrity of the self. However, most older adults "rise to the challenge and retain a sense of self that is comfortable and positive" (George, 1990, p. 199).

Summary

In summary, the interpretive perspective allows consideration of the self as both a structure and a process, as multidimensional. Elderly people continue to protect and enhance their selves over time in response to problematic situations (Breytspraak, 1984; Marshall, 1980; Matthews, 1979). They negotiate environmental demands while retaining social attachment. Both continuity and change in self emerge in response to changing social situations (George, 1980, 1990; Kaufman, 1986). The interpretation of experiences as one ages gives meaning to one's actions. While recognizing the need for more research in the area of self-concept and identity, most researchers have also argued that an increased understanding of the experience and meaning of aging must incorporate the situational context within which old people conduct their everyday lives.

This overview of aging and the self suggests that a gap exists. Research on aging and the self has not included participants who, as well as aging, were chronically ill. As people live longer there is an increased likelihood of non-fatal diseases such as, osteoporosis, which may result in disability. Thus, it is important to consider the possible effects of chronic illness on self-concept. I will now consider the literature on chronic illness and the self to ascertain whether there are ideas and concepts which will add valuable information to my study.
Chronic Illness and the Self

A brief review of work on chronic illness and the self is reported below. While the writings of these researchers do not reflect all of the work on chronic illness and the self, the summary includes work that is pertinent to this thesis.

Chronic Illness and Biography

The impact of chronic illness on biography has been examined by several researchers. Included in this review are the writings of Bury (1982), Corbin and Strauss (1988) and Williams (1984). Biography is used to refer to a "life course: life stretching over a number of years and life evolving around a continual stream of experiences that result in a unique—if socially constituted-identity" (Corbin & Strauss, 1988, p. 50).

Chronic illness as biographical disruption. In his study of young and middle aged adults with rheumatoid arthritis, Bury (1982) described chronic illness as biographical disruption "where the structures of everyday life and the forms of knowledge which underpin them are disrupted" (p. 169). He argued that chronic illness involves recognizing the worlds of pain, suffering and possibly death which ordinarily are seen "as distant possibilities or the plight of others" (p. 169). Also, if dependency results, chronic illness disrupts the normal rules of reciprocity and mutual support between the individuals and their social networks. Expectations and plans for the future must be re-examined. He linked three aspects of disruption to the unfolding of chronic illness: first, there is the disruption of taken-for-granted assumptions and behaviours involving attention to bodily states not usually brought into one's awareness and decisions about seeking help; second is the more profound disruptions in the explanatory systems (see also Kleinman, 1988) usually used by people, resulting in a need to re-think biography and, thus, involving self-concept; the third aspect is the response to disruption involving the mobilization of resources, such as cognitive and material resources, in this altered situation.

Germane to the disruptions in biography is the uncertainty in the experience of illness, particularly chronic illness—uncertainty about the impact and course of the disease and of appropriate behaviour considering its effects. While medical intervention may provide an opportunity to consider the disease as separate from the self, Bury argued that a strict separation of disease and self is precarious; the experience of those in his study emphasized "the uneasy balance which is struck between seeing the condition as an outside force and yet feeling its invasion of all aspects of life" (Bury, 1982, p. 173). People with a chronic illness may, on one hand, want a definite diagnosis but, on the other hand, realize that medical knowledge and intervention may be of limited benefit. This latter realization leads individuals back to their own knowledge and biographical experience in search for a more comprehensive explanation. Attempts are made to impose meaning on the events of chronic illness. These involve examination of familial and biographical experiences. However, Bury did not find that his study participants were generally disillusioned with medicine; rather they held
high expectations of medicine. "Medical conceptions of chronic organic disease and its causation .... provide[d] an objective fixed point on a terrain of uncertainty" (p. 179). Bury concluded that, as well as facing changes in self-concept and meaning related to disability, disruptions in biography are also disruptions in social relationships and the ability to mobilize material resources. While medical and lay knowledge about disease and illness are important, the changed behaviour due to chronic illness is determined by many other factors, such as, disruption of reciprocity, problems of legitimating changed behaviours, effects of stigma, the ability to mobilize resources and the impact of wider social structures including the experience of illness within specific cultural and family contexts.

Relative to aging, Matthews (1979) reported similar findings of uncertainty, lack of expectations about "old", ambiguous social situations, weak stigma and increased social isolation. This may suggest that being old and having a chronic illness may have a cumulative effect leading to increased biographical disruption.

**Narrative reconstruction in chronic illness.** Williams (1984) was interested in how people with rheumatoid arthritis explained the origins of the illness and made sense of the fragmentation of their lives produced by chronic illness. He suggested that people use narrative re-construction. An individual is "a social and historical agent with a biographical identity" (Williams, 1984, p. 177). If `biographical disruption' (Bury, 1982) occurs, then an individual's account of the origin of his or her illness in terms of presumed causes can be seen as an attempt to establish points of reference between body, self, and society and to reconstruct a sense of order from the fragmentation produced by chronic illness. Thus, narrative reconstruction is "an attempt to reconstitute and repair ruptures between body, self, and world by linking-up and interpreting different aspects of biography in order to realign present and past and self with society" (p. 197). He concluded that the individual's narrative has to be reconstructed in order to understand the illness in terms of past social experiences and to reaffirm that life has a course and the self has a purpose or "telos"; this reconstruction of the past gives meaning or purpose to the present.

**Biographical work in chronic illness.** Corbin and Strauss (1988) discussed the biographical work in managing chronic illness. Biographical work was defined as "the work involved in defining and maintaining an identity" (Corbin & Strauss, p. 10). While the life course may be interrupted and changed profoundly because of chronic illness, illness constitutes only one part of the self and thus, its management must be considered within the context of one's whole life.

Three dimensions of biography which in combination affect biographical continuity and meaning were described: biographical time or the concepts that past experiences influence who one is in the present and that the past and present influence who one is in the future (Mead, 1934); conceptions of self change over the life course but also differ in different situations and social relationships altering actions based on interpretations of events and situations; and the body is the medium through which concepts of the self are formed. Engagement in activities and tasks results in
the formation of the self. One constantly evaluates performance which results in a changing and evolving conception of self.

Taking into consideration these dimensions of biography, biographical processes are central to taking action to retain or regain some degree of control over a life altered by chronic illness (Corbin & Strauss, 1988). Four biographical processes were differentiated: these include contextualizing the illness into one’s biography, making it part of one’s ongoing life; coming to terms with the illness including the limitations it imposes and the possibility of death; reconstituting identity or restructuring new concepts of the self in light of the illness and the changes it brings; and biographical recasting or giving new directions to one’s biography through crystallization (realization of what body failure means to one’s biography) and having some control over trajectory. These latter two biographical processes are similar to the biographical disruption described by Bury (1982).

Central to all of these biographical processes are the ideational processes of backward and forward reviews which involve recapturing the past, examining the present, and projecting the future.

Corbin and Strauss concluded that there is a need for more research studies focusing on the biographical processes, especially with people suffering from specific illnesses. Such research would promote a better understanding of the mutual influences of illness on identity and vice versa.

**Chronic Illness as Disability and Disadvantage**

In his study of young and middle-aged adults severely disabled by rheumatoid arthritis, Locker (1983) argued that disabled people are disadvantaged because chronic illness and its limitations result in a loss of personal, material and social resources. The resources people with disabilities can summon and the problem-solving strategies they utilize are factors which intervene between impairment, disability and disadvantage. He identified problems of everyday living, including sleeping, personal care, cleaning, shopping and mobility in the community. Relative to these, he described the loss of identity of some women in his sample who, having adopted the role of wife and mother and expected to care for others, found that chronic illness and physical disability turned their situation upside down, making them recipients rather than providers of care and leaving them with a deep sense of loss. Additionally, he considered problems related to work and income. Unemployment may rob people with rheumatoid arthritis of their sense of achievement and self.

Relative to problems with social relationships and family life, Locker described how one characteristic of the person is taken to characterize the person as a whole. This results in the person ceasing to be a person or a person with a disability and becoming a disabled person, identified solely by his or her medical problem and its limitations. "Disability becomes the pivot around which interaction with others revolves" (Locker, 1983, p. 139). In contrast, neither Kaufman (1986) nor Matthews (1979) found old to be a pivotal self-identity for the elderly people in their samples. Another assumption was that of general incompetency in which the difficulties that the person with a disability has with some aspects of everyday life are generalized to all activities. For example,
those with physical disabilities may be assumed to have mental disabilities as well.

The meaning of rheumatoid arthritis was not the same for all participants in Locker's study even if they were limited in similar ways. Rather the management of problems was dependent on available resources (e.g., money, knowledge, aids and equipment, and adapted environments), which varied among participants. His data established a complex picture of hardship and unhappiness unrelated to social class. He concluded that the basic needs of physical access to the community, improved mobility, adequate income, work or meaningful activity and independent living with help of a protected environment, if necessary, offered in a "manner which does not create dependency and a devalued status" (p. 198), will enhance the lives of those with chronic disabilities.

The Self in Chronic Illness

According to Conrad (1987), the most conceptually developed analysis of chronic illness and self is found in the work of Charmaz (1973, 1980, 1983, 1987, 1989, 1991). Charmaz (1983) argued that people who are chronically ill experience "a crumbling away of their former self-images without simultaneous development of equally valued new ones. The experiences and meanings upon which these ill people had built former positive self-images are no longer available to them" (p. 168). Thus, over time loss of former self-images results in a diminished self-concept. She stated that the experience of illness is a social psychological process within which the inner dialogue between the "I" and the "Me" changes as well as do definitions of experience. The person who is ill draws on past social experiences, cultural meanings and knowledge "to engage in a mental dialogue about the meanings of present physical and social existence, specifically, the emergent indications of identity elicited by illness" (Charmaz, 1983, p. 170). Subsequently loss of self can result from: 1) living a narrow, restricted life in which choices are limited, uncertainty and fear predominate and loss of control results; 2) existing in social isolation as a result of a restricted life which may mean lack of participation in work, leisure and social relationships; 3) experiencing discredited definitions of the self arising out of unmet expectations that the ill person may have of himself or herself and those that arise out of interaction with others and; 4) becoming a burden, which involves becoming more dependent, thus, losing power over their situations and the quality of their lives. She concluded that the chronically ill people who participated in her research disclosed a self-concern about the person they saw themselves becoming and about lost valued self-images. They saw themselves and their lives as fragile. This created further dilemmas: they examined encounters with others for hints of discrediting and negative reflections of self; they grew increasingly dependent on others for self-definition and value at a time when relationships were more strained; they were less capable of maintaining relationships because they were engrossed in their illness; and in a society that emphasized doing, those who could not perform conventional tasks and social obligations lost the means to sustain a meaningful life.

Her research led her to suggest that, in the lives of people who are chronically ill, there are
preferred identities which "symbolize assumptions, hopes, desires and plans for a future now unrealized .... preferred identities represent identity goals" (Charmaz, 1987, p. 284). An identity hierarchy can be discerned as people who are chronically ill choose different preferred identities over time reflecting difficulty in achieving aspirations and objectives. She described four identity levels: the supernormal self, the restored self, the contingent personal self and the salvaged self. The supernormal self is an identity demanding extraordinary achievement in conventional worlds. The restored self is a reconstruction of previous identities before illness. The contingent personal self represents a hypothetically possible, though uncertain, identity, because of further illness. The salvaged self retains a past identity based on a valued activity or attribute while becoming physically dependent (Charmaz, 1987).

In her recent book, Charmaz (1991) suggested that the meanings of illness and self shift and change as illness progresses or recedes into the past. People encounter illness differently depending on their definitions of the experience. Some view it as interruption. In this view, the illness is temporary, of short duration and with a predictable outcome. Such individuals expect to get better soon and have little or no concept of chronic illness or disability. Others perceive illness as intrusion demanding continued attention, allotted time and forced accommodation. Illness becomes a part of life in which symptoms and treatments are expected and planned around. While struggling for control over illness, these people feel a threat to control of self and situation and uncertainty. Still others react by immersion in illness: illness orders life, they must reconstruct their lives based upon illness, the requirements of illness come first and define their pursuits.

Charmaz (1991) proposed that the effects of chronic illness on the self range from loss to transcendence with most people falling in between the extremes. While chronic illness may mean physical, mental, social, psychological and economic losses, these losses may or may not result in the loss of self.

Loss of self means being involuntarily dispossessed of former attributes and sentiments that comprise one's self-concept, as well as the actions and experiences upon which they are based. It also means losing self-definitions with which one had most identified. With loss of self, earlier boundaries of the self-concept shrink and become permeable. The self grows vulnerable to demeaning images reflected by others. The attrition of former attributes and sentiments results in changed feelings about self. Resignation follows. Hence, loss of self results in passivity. (Charmaz, 1991, p. 257)

In contrast, transcendence of self means that "the self is more than its body and much more than an illness .... [it] implies self-acceptance .... reevaluation and renewal. Achieving transcendence requires making choices and taking action" (Charmaz, 1991, p. 258). While both loss and transcendence originate from the experience of illness and its meanings, they are not static states and may be experienced at different points in an individual's illness.

Both loss and transcendence are grounded in time--in what Charmaz referred to as good days.
and bad days. Time must be examined when considering the self. Chronic illness requires people to restructure time (i.e., frame, organize and use time), thus altering perspectives about time (i.e., their ideas, beliefs and views about the content, structure and experience of time). "Temporal incongruence develops when time perspectives are incompatible and inconsistent with time structures" (Charmaz, 1991, p. 171). Relative to self, "an irretrievable past, an unsettling present, and an irrevocably changed future alter an individual’s views of self. These altered views reflect shifts in the relatively stable foundation of the self-concept; the structure of it changes" (p. 229).

Unlike most research on self-concept and chronic illness, Charmaz (1991) included some older people in her studies. While not discussing the elderly people in her sample at any length, she implied that their responses to chronic illness may be different than younger people because of their age and life stage. For example, "aged men and women often assumed that they would lead narrowed, even restricted, lives .... they believed that reasonable people should expect to feel worse as they age .... [they] defined the 'appropriateness' of illness in relation to the life course" (p. 61) and "Living one day at a time reveals emotions embedded in the experience of illness. Many ill people, especially older people, express greater fear of dependence, debility, and abandonment than of death (also see Marshall, 1980). Living one day at a time helps to reduce their fear that the future will be worse than the present" (Charmaz, 1991, p. 180).

After almost 20 years of research on the impact of chronic illness on people’s lives, Charmaz concluded that the loss of self leads to loss of control, autonomy and self-respect. In contrast, for those who gain autonomy and control, "their stories of illness may shift from chronicles of loss to tales of transcendence .... ill people may ... reconstruct their timemakers and turning points into chronologies of a changed, more aware self .... [they] struggle to prevent illness from inundating their self-concepts" (Charmaz, 1991, p. 260).

Meaning and Chronic Illness

Bury (1988) has suggested that the focus in the sociological literature on the management of chronic illness (Corbin & Strauss, 1988), on narrative reconstruction (Williams, 1984), on trajectories and adaptation (Strauss & Glaser, 1975) and the management of uncertainty (Davis, 1963), while certainly correct, implies that coping and the search for stable meanings about chronic illness are relatively straightforward. Rather Bury argued that greater attention should be given to meanings. He proposed that there are two aspects of meaning: the consequences of illness and the significance of illness. The most often discussed meaning refers to consequences of chronic illness for the individual--money problems, job problems, problems of personal care and practical daily living. The meaning of disability is related to how the individual copes with or adapts to a chronic illness. Chronic illness is characterized by its disabling (activity restriction) and handicapping (social disadvantage) consequences. This conceptualization of the consequences of chronic illness focuses on the practical problems and policy issues (Bury, 1988).
In addition to the social problems created by chronic illness, Bury suggested that there is a second level of meaning—the significance or connotations that the conditions carry. The central issue is what medical conditions and disabilities signify within particular cultures. Conditions vary in their significance relative to disability, disfigurement and future outlook. The ideas held by a culture about particular illnesses are available to those afflicted and provide a context within which the individual experiences his or her illness. Stigma and discrimination are derived from this significance rather than from the disability itself.

**Summary**

In summary, chronic illness is generally perceived as a major disruption in the life of the individual requiring biographical work. While chronic illness may mean physical, social, psychological and economic losses, these losses may or may not result in loss of self (Locker, 1983; Charmaz, 1991). Biographical processes have been identified that allow the individual to retain or regain control over life (Corbin & Strauss, 1989). These processes require the reconstructing of the past and anticipating future in terms of the present situation (Bury, 1982; Williams, 1984).

This review of chronic illness and the self suggests that most of the research has included young and middle-aged adults rather than older adults. When older people are included in studies, the researchers have not focused attention on this group separately in their writings. Also the focus of many of these studies has been on diseases acquired earlier in life, such as rheumatoid arthritis, rather than diseases with a later life onset. This difference in the timing of the onset may affect the impact chronic illness has on self-concept.

The next section will consider the literature on self-concept relative to both aging and chronic illness.

**Aging, Chronic Illness and the Self**

As has been discussed above, research on the self has been primarily confined to the separate analyses of aging or chronic illness. Exceptions include Belgrave (1990), Kaufert and Kaufert (1984) and Verbrugge (1984, 1990, 1991).

**The Long Term Impact of Disability on People with Poliomyelitis**

Kaufert and Kaufert (1984) studied the long term impact of disability on people with poliomyelitis. These individuals talked about the impact of polio on their lives in terms of an 'expected' life pattern, that is, how their life would have proceeded if polio had not occurred. As they aged, their actual life trajectory was described in terms of how it fit with what they had been able to achieve. The uncertainties of aging were also of concern relative to their ability to maintain the social aspects of their lives unchanged. This was felt most by those who were dependent on others for support and help—they were concerned about the impact of aging, not on themselves but on those providing care and the effect it would have on their lives.
Assessing Disability in Elderly People

Verbrugge (1984, 1990, 1991) studied elderly people with adult-onset, chronic disabling conditions, such as arthritis, high blood pressure and heart disease. She defined disability as "how chronic conditions affect people's ability to act in typical and personally desired ways in their society. The essential notion ... is how much difficulty people have doing valued activities .... [which] can be obligatory, committed, or discretionary" (Verbrugge, 1991, p. 225). Obligatory activities include personal and household care, committed activities include paid employment and child care, and discretionary activities include hobbies and social activities. She argued that currently data collected on functional disability measure only personal care (activities of daily living) and household management (instrumental activities of daily living). These are obligatory or strongly normative activities and difficulty doing these activities suggests serious health problems (Verbrugge, 1990). Most statistical studies on disability are limited to these two activity domains. She suggested the need for a more varied approach to research in order to understand more about real-life disability experiences and about the progression of disability over time.

Although Verbrugge and the Kauferts addressed the issues of aging and chronic illness, they have not done so from the perspective of the self, aging and chronic illness. The work of Belgrave (1990) considered the experience of chronic illness among elderly women and thus, is similar to my research interests. Her work will be considered now.

The Experience of Chronic Illness among Elderly Women

Belgrave (1985, 1990), in a qualitative study of 29 elderly women, explored the subjective experience of chronic illness using a conceptual framework of chronic illness as stigma. While her focus was on the experience of chronic illness and stigmatization as part of that experience, she also considered how chronic illness was experienced relative to self-concept. All participants had either arthritis or diabetes but many had multiple health problems. The mean age of her sample was 74.

Relative to the experience of chronic illness, Belgrave identified three levels of abstraction. At the most concrete level, the experience of specific diseases varied by the characteristics of their presentation; for example, the pain of arthritis was experienced quite differently from hypertension which was virtually symptomless. A second level was related to the effects of chronic illness on activities and lifestyles; these effects include on-going daily problems, relinquished activities and feelings of stigmatization. At the highest level of abstraction was the relevance of chronic illness to self-concept and more global ways of living with illness.

Because disability is less extraordinary for elderly people than those who are young or middle-aged, Belgrave found stigma to be inadequate in explaining the chronic illness experience for these women. Rather they understood their illnesses as concrete health problems, past events, treatment regimens, or abstract medical conditions, depending on the illnesses they had. Relative to self-concept, they described themselves as: a) basically healthy and having a problem with which
they had to deal to pursue their activities, b) ill and doing the best they could given their health problems, or c) overwhelmed by illness. Concrete physical problems were more important than treatment regimens in leading to a definition of oneself as limited. Ailments seen as past events or abstract medical conditions and not part of everyday life were inconsequential to these women's self-concepts. "The ability to continue valued activities or to define their loss as appropriate enabled [these] women to maintain their self-concepts as healthy in the face of chronic illness" (Belgrave, 1990, p. 497). Only two women in Belgrave's sample were overwhelmed by illness. While one was severely disabled and able to manage only a few activities, the other woman was not so limited and had outside interests but perceived her illness and other problems as more than she could handle. Belgrave concluded that the relevance of illness for self-concept was determined by the perceptions of these women of the extent to which the body and its care dominated their everyday lives.

Belgrave suggested that her findings should be considered in light of the context within which these women experienced chronic illness. Because chronic illness is so prevalent among elderly people, having such ailments does not set them apart. These conditions are experienced in common with age peers, thus, providing opportunities for support and diminishing the stigmatizing effects of chronic illness. Age has freed them from some roles and responsibilities, changing time and energy resources available to manage chronic illness. Also she proposed that gender and cohort may have had an effect on her findings. This particular cohort of women may have regarded passivity and acceptance as favourable feminine traits.

In conclusion, Belgrave argued for an alternative conceptual framework to that of the stigma of social deviance. She suggested a framework within which the experience of specific chronic ailments on everyday life and self-concept is variable. She argued that this would allow us to understand the experience of chronic illness by considering the possibilities of illness as mundane and its relevance as variable.

Summary

While the work of the Kauferts and Verbrugge is related to aging and chronic illness, it did not attend to the issues of aging and chronic illness and their impact on self-concept. Belgrave's research does consider the self-concept of elderly women with chronic illnesses of arthritis and diabetes. Although this research is similar to my own interests, there are questions that arise about her research and her conclusions that are unanswered by her article. These will be discussed in the next section.

The Need for Research on the Relationships between the Meanings of Aging and Chronic Illness and the Self-concept

This review of the literature indicates that little research has been done specifically on the relationships between the meanings of aging and chronic illness and the self-concept. As suggested
above, while including self-concept, Belgrave's (1985, 1990) focus was on the stigma of chronic illness on the lives of elderly women. Accordingly, I would suggest that there is a gap in the literature concerning the relationships between the meaning of chronic illness and self-concept in later life. The remainder of this section provides an analysis of the literature reviewed, forming the basis for the theoretical framework for this study.

Rosenberg's (1979) concept of the self (as structure and process) affords a global framework within which to consider self-concept while allowing consideration of the cognitive and affective aspects of the self (Breytspraak, 1984; Breytspraak & George, 1982). These ideas about self-concept are based on the assumptions that self-concept is consciously available to the individual and that it can be described through self-reporting methods (Breytspraak & George, 1982). Within this framework, the interpretive perspective in sociology enables one to consider the individual as an active participant constructing meanings about his or her self in the social world over time (Breytspraak, 1984). This perspective allows one to consider how the self-concept changes or remains stable over time and how events impact on the individual's self and meanings about life, while considering the larger social context.

Generally the literature on aging and the self presents a very positive image of older people's ability to actively develop, construct and negotiate selfhood. Continuity exists despite physical and social change. In the face of loss, people are able to create new meanings and build viable selves.

In contrast, the literature on chronic illness and the self is less positive. The focus of this research has been on those in their young or middle years. The individual is presented as suffering the loss of personal, material and social resources--and ultimately the loss of self. Although transcendence is also discussed, most of the literature focuses on disruption and loss. The narrowed life, increased social isolation, discrediting definitions of self and increasing dependence often lead to a need to change but preferred identities may or may not be realized over time. Illness is perceived by some people who are chronically ill as merely interrupting or intruding on their lives while others become immersed in illness. Changes must be made through biographical work such as contextualizing illness, coming to terms with illness, reconstructing identity or recasting biography. However, despite the interruption and profound changes brought about by chronic illness, the meaning of illness and self shifts and changes over the course of the illness (Charmaz, 1991) and illness constitutes only one part of the self; thus, one must consider the broader context of the lives of people who are chronically ill (Corbin & Strauss, 1988).

In the limited literature on aging and chronic illness, only Belgrave (1985, 1990) has dealt with the effects of chronic illness on self-concept. Her focus on stigma is a good beginning to this complex area but additional work is needed to further describe the consequences of chronic illness on self-concept in older people. She concluded that an alternative framework to stigma may be more appropriate. She argued that the effect of the experience of chronic illness on everyday life and self-
concept is variable depending on specific illnesses. In light of the literature on self-concept and change and stability over time, this alternative framework seems more appropriate.

Belgrave (1990) suggested that the ability of the women in her study to maintain their self-concepts as healthy in the face of chronic illness may be related to general perceptions about chronic illness being part of life for elderly people or "mundane" rather than extraordinary as chronic illness is for younger people. She also argued that the reactions of the women in her study to chronic illnesses may be related to the willingness of that particular cohort of women to "accept" chronic illness passively or to the increasing time and energy available to manage chronic illness because of decreasing obligations, roles and responsibilities.

However, I would argue that, while chronic illness may be more normative in later years, it is too simplistic and premature to suggest that chronic illness is mundane for older adults and that they maintain their self-concepts as healthy in the face of chronic illness. Rather I would suggest that the effects of chronic illness on self-concept will vary over time relative to the manifestations of the chronic illness--the onset, type, stage and course of the particular disease. If the onset is relatively sudden and acute, causing pain and discomfort, the self-concept of the older person may be negatively affected. This represents an extraordinary event as does chronic illness for a younger person rather than a mundane occurrence. In this situation the individual may display similar reactions to those discussed in the literature on chronic illness. Alternatively, if the onset is more gradual and painless, representing a mundane incident, self-concept may not be affected. The slow progression of the chronic illness may lead to a realization over time of the implications of the illness on everyday life. Charmaz (1991) described the extremes of loss and transcendence of the self among those with chronic illness, suggesting that most people fall somewhere in between the two extremes and that the extent of loss or transcendence varies over time and over the course of the disease.

Also, Belgrave (1990) does not describe her sample in detail. This creates some problems in fully understanding her conclusions. How long had they had arthritis or diabetes? Was the onset acute or more gradual? What type of arthritis or diabetes did they have? Belgrave has created some confusion by her choice of arthritis and diabetes as chronic illnesses of study. It is possible that the onset of either of these chronic illnesses was in midlife rather than later life--as would be the case with rheumatoid arthritis or insulin-dependent diabetes. If so, then the chronic illnesses of her sample may have been fairly stable or the women may have adjusted to and been accepting of their illnesses. Alternatively, these women may have had osteoarthritis or non-insulin-dependent diabetes with a more gradual, less acute or severe onset leading them to accept their ailments as part of "getting old". A closer look at Belgrave's (1985) sample revealed that of the 22 women with arthritis, the average length of time they had been diagnosed with arthritis was 24 years with the range being less than one year to more than 60 years. She did not differentiate between rheumatoid
and osteoarthritis. While some (6) had been diagnosed in their mid-30s or earlier, for most (13) their arthritis was diagnosed in their 50s. Those with diabetes (n = 7) had been diagnosed for an average of 16 years with a range of eight to 24 years. Most had learned about their diabetes in their 50s and 60s. I would suggest that the average length of time with the disease (24 years for arthritis and 16 years for diabetes) would strongly influence their perceptions of their chronic illnesses. They had had a number of years in which to incorporate chronic illness into their everyday lives. The day-to-day management may have been fairly predictable, leading to a perception of their chronic illness as mundane. Therefore, it seems that before we accept that chronic illness is a mundane event in the everyday lives of older people, we must understand more about how older people deal with chronic illness relative to the clinical aspects of the chronic illness. For example, a recent acute onset of a chronic illness associated with pain and decreased mobility may result in a change in self-concept, whereas a gradual onset resulting in minimal disruption of everyday life may not affect self-concept. These issues need to be explored in more detail relative to the meanings of chronic illness in later life.

Belgrave’s participants did not generally perceive stigma as a major problem, although it was experienced or feared by some. This varied with the visibility of the chronic illness, history of medical crises and length of time with chronic illness. Belgrave concluded that chronic conditions are experienced in common with age peers, providing opportunity for support rather than stigmatization. However, given the findings of Charmaz (1983) related to chronic illness, I would argue that, depending on the severity of the disability resulting from the chronic illness, there is potential for elderly people to be forced to lead narrow, restricted lives with limited choices and uncertainty and fear predominating, isolated from their peers and unable to perform activities necessary to maintain a preferred lifestyle, and becoming more dependent resulting in a loss of power over their situations and the quality of their lives. For example, decreased mobility and fear of falling may limit their ability to interact and seek support in social situations. Similarly, depending on the chronic illness, stigma may be felt. With Belgrave’s sample, there may have been few physical deformities, no major medical crises or recently acquired illnesses leading to stigmatization.

In summary, I use Belgrave’s conclusion that the key determinant of the relevance of illness for self-concept is “the perception of the extent to which the body and its care dominate everyday-life” (Belgrave, 1990, p. 496; also see Corbin & Strauss, 1988) as a starting point as well as her argument that the effect of experience of chronic illness on everyday life and self-concept is variable depending on specific illnesses. However, I focus on self-concept as my primary concern relative to chronic illness. Further to Belgrave’s work, I would suggest that the specific manifestations of chronic illness and their effects on "valued activities" (Verbrugge, 1991) in the everyday lives of elderly people will vary over time and therefore, have varying consequences on their self-concepts. By concentrating on one chronic illness and using theoretical sampling to include individuals at
different stages of the illness and whose onset and/or outcome vary in severity and timing, I consider the meaning of chronic illness and its relationship to the self-concept of older people.

The general research question is: "What are the relationships between the meanings of aging and chronic illness and the self-concept of older people?" The next section considers the research population utilized for addressing this question.

**Research Population**

It seems appropriate to consider studying how chronic illness affects women's self-concept in their later years because: 1) in later years women outnumber men, 2) women have higher rates of nonfatal chronic diseases plus longer lives living with these conditions than men, and 3) women have more chronic health problems or comorbidities than men (Verbrugge, 1989). Gee and Kimball (1987), in describing how they chose to include certain illnesses in their limited review of conditions affecting women, considered those conditions that affect women more than men, those that affect large numbers of women and those that create major physical and psychological problems in the lives of women. They included osteoporosis along with depression, Alzheimer’s disease and breast cancer. Osteoporosis was also mentioned by Olshansky et al. (1991) as a nonfatal disease of old age resulting in disability and frailty along with arthritis, dementia and sensory impairments. Because of the prevalence of osteoporosis among older women, I examine the relationships between the meanings of aging and chronic illness and self-concept among women with osteoporosis.¹ The following section describes, in more detail, the specifics of osteoporosis.

**Women with Osteoporosis**

Osteoporosis has now been recognized as a major public health problem facing

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¹ Others (Coney, 1994; MacPherson, 1988) argued that menopause, a natural process in mid-life, has become medicalized, that is, described as estrogen deficiency syndrome requiring intervention from physicians as well as the prescription of hormone replacement therapy. Osteoporosis is included as part of the menopause syndrome. Originally considered a problem of bones, osteoporosis is now considered a problem of women. Coney argued that this is largely the result of marketing by pharmaceutical companies to promote their estrogen products as aids to retard bone loss. Regardless of scholarly debate as to whether osteoporosis as part of the menopause syndrome has been unduly medicalized, women who are diagnosed with osteoporosis experience it as a chronic illness. It is defined as a chronic illness by those working in the health care system and thus, in the social context within which these women live. A chronic illness is one which persists over time, often involving some functional disability or the prospect of future disability and creating anxiety and concern about the future; this definition applies without question to osteoporosis. While acknowledging the critiques noted above, for the purposes of this thesis, I have considered osteoporosis to be a chronic illness. Osteoporosis is particularly appropriate to this research since its onset generally coincides with aging, thus, providing an opportunity to consider self-concept as aging and chronic illness coalesce.
postmenopausal women and aging individuals of both sexes (Riggs & Melton, 1995). Riggs and Melton (1995) have warned that osteoporosis is a worldwide problem which will reach epidemic proportions in the future if preventive steps are not taken. They have argued that the increase in incidence is related to the continued aging of the population in developed countries and the increases in the population of underdeveloped countries in the latter half of this century. There are estimates that fractures of the hip could triple in the United States by the year 2040.

While estimates of the incidence and prevalence of osteoporosis vary and are presented in different ways, the numbers suggest that it is a major problem for women. For example, some (Murray, 1991; Roberto, 1988) have suggested that one in four women over the age of 50 will be affected; others have stated that one third of postmenopausal white women have osteoporosis or the lifetime risk of any fracture among white women from age 50 onward approaches 75% (Andersson et al., 1997); still others reported that one in two women over the age of 70 are affected by osteoporosis (Nordin, 1983 cited in Roberto, 1989). Despite the various ways the information is presented, one can conclude that osteoporosis is a major chronic illness in women. While it has been suggested that osteoporosis is one of the most common chronic illness, along with diabetes and hypertension (Andersson et al., 1997; Murray, 1991) and can result in loss of life, its major impact is a chronic reduction in physical performance, psychosocial adaptation and quality of life (Cook et al., 1993; Gee & Kimball, 1987; Murray, 1991).

Osteoporosis has been defined as a "disease characterized by low bone mass and microarchitectural deterioration of bone tissue, leading to enhanced bone fragility and consequent increase in fracture risk" (Consensus development conference, 1991 cited in Kanis, Melton, Christiansen, Johnston, & Khaltaev, 1994, p. 1137). This definition suggests that people with osteoporosis may be asymptomatic and that fractures are the complication of underlying disease of the bone (Delmas, 1997). Delmas (1997) has suggested that the advantage of this definition is the early identification of osteoporosis before the occurrence of fractures and more effective intervention resulting in a decrease in the burden of osteoporosis. The fractures associated with osteoporosis are those of the vertebrae, distal radius (Colles' fracture) and hip (Chrischilles, Butler, Davis & Wallace, 1991; Gold, Smith, Bales, Lyles, Westlund & Drezner, 1991; Smith, 1992). The most common causes of osteoporosis are increasing age in both men and women and menopause in women (Riggs & Melton, 1995; Smith, 1992). Although osteoporosis is not a new disease, Smith (1992) suggested that widespread interest has increased recently, in part, because of the very rapid increase in the incidence of fractures in the aging population. In the United States the cost of care for people with osteoporosis was estimated to be over 10 billion dollars per year in 1990 (Gold et al., 1991; National Osteoporosis Foundation, 1991). It has been estimated that fractures of the hip, spine and forearm will result in 2 million person-years of functional impairment among post menopausal white women in the US during the next 10 years, along with $45.2 billion in direct
medical costs (Melton, 1997). Fractures of the hip are important in terms of mortality, morbidity and escalating health costs. It is estimated that 15% of women suffering from hip fracture die shortly after their injury (Notelevitz & Ware, 1982) and that up to 20% die within a year (Melton, 1997). Half of those who were ambulatory before their hip fractures are unable to walk without assistance subsequently and 20-25% require long-term care (Melton, 1997; Riggs & Melton, 1995). Morbidity from vertebral fractures is also considered important due to progressive loss of height, postural changes, kyphosis, and persistent pain that interferes with activities of daily living. Those with more severe disease may also have altered self-esteem, body image and mood (Melton, 1997; Riggs & Melton, 1995).

Over the past decade, advances have been made in the diagnosis and treatment of osteoporosis. Osteoporosis may result either from inadequate skeletal development or from excessive bone loss. Each of these is the result of complex genetic (e.g., skeletal size) and environmental (e.g., calcium intake, exercise) influences (Andersson et al., 1997; Melton, 1997). Most researchers in this area argue that the medical treatment of osteoporosis must start with prevention to maximize peak bone mass through proper nutrition, appropriate intake of calcium and vitamin D, maintenance of physiologic menstrual cycles and a program of weight-bearing and strengthening exercises (see for example, Lane, 1997). Excessive bone loss is treated with antiresorptive agents such as, hormone replacement therapy, calcitonin and bisphosphonates. Of this group, estrogen has been the most widely studied. It has been found to be a cost-effective treatment for postmenopausal osteoporosis preventing bone loss and fractures (Lane, 1997). Hormone replacement therapy continues to be problematic for some women (Gee & Kimball, 1987) because of the increased susceptibility to the development of cancer, particularly uterine and breast cancers (Ettinger, 1987; Gee & Kimball, 1987; Kane, 1997; Persson, Adami & Bergkvist, 1990).

While advances have been made in the treatment of osteoporosis, attention to the psychosocial aspects has been minimal given the prevalence and incidence of osteoporosis and the associated disability that may result from fractures, particularly fractures of the hip and spine (see for example, Markus, Feldman, & Kelsy, 1996). Some exceptions include the work of Ettinger et al. (1988), Roberto (1988, 1989), Gold et al. (1991), Hallal (1991), Cook et al. (1993) and Gold (1996). More recently, research on the quality of life measures has been reported (Lips et al., 1997; Osteoporosis Quality of Life Study Group, 1997). Some of this work will be discussed below.

Kirkpatrick (1987) stated that "osteoporosis has been described as a silent, crippling, unheeded killer and has gained attention as a phenomenon of aging and the aged in the 1980s" (p.4). She noted that despite advances in understanding bone disorders, osteoporosis remains "a multifactorial and complex health problem" (p. 4). Women with osteoporosis may be concerned with physical limitations such as pain, spinal curvature, fear of fractures and limited stamina (Kirkpatrick & Bailey, 1987). For example, vertebral fractures may be painless and gradual in progress or acute
and accompanied by severe pain (Lindsay & Cosman, 1990). Also there may be psychological problems associated with osteoporosis, such as depression, hopelessness and uncertainty about the future (Gold et al., 1989; Melton, 1997; Riggs & Melton, 1995).

Cook and associates (1993) were interested in quality of life issues for women with vertebral fractures due to osteoporosis. Their study population included 100 women who had at least one vertebral fracture and a clinical diagnosis of chronic back pain due to osteoporosis-induced fractures. The questionnaire included questions about symptoms, physical limitations, activities of daily living, emotional function and leisure activities. Lower levels of quality of life were related to pain, particularly when standing, and to difficulty lifting and carrying objects. Fear of falling and fear of additional fractures were serious problems identified in this group of women. They concluded from their study that the number and severity of fractures, the magnitude of pain and the impairment of quality of life were unrelated to the severity of symptoms. Pain from osteoporosis had a profound effect on the lives of the women relative to function in their homes and emotional dysfunction associated with disability. Quality of life was not adequately reflected by the usual clinical measures used by clinicians such as duration of illness, radiographic evaluation of disease severity, bone density studies or global inquiries about the degree of pain. Rather information regarding areas of dysfunction had to be elicited with specific questions. Although their study was quantitative in nature, they did spend some time in interviews with women with osteoporosis. This work led to the development and testing of the Osteoporosis Quality of Life Questionnaire (OQLQ) for postmenopausal women with chronic back pain due to osteoporosis (Osteoporosis Quality of Life Study Group, 1997). The OQLQ includes 30 questions distributed across five domains: symptoms, physical function, activities of daily living, emotional function and leisure. The testing was conducted with women from Canada and the US. Similarly, a quality of life questionnaire has also been developed by the European Foundation for Osteoporosis (Lips et al., 1997). This questionnaire was developed for people with established vertebral osteoporosis and intended for use in clinical trials. It includes questions and visual analogue scales in the domains of pain, activities of daily living, jobs around the house, mobility, leisure and social activities, general health perception and mood.

Gold and associates (1991) assessed 103 women and men involved in a Duke University program for osteoporosis to determine their health locus of control orientation. The purpose of the research was to identify patient characteristics that would provide physicians with insight into appropriate management styles for older people with osteoporosis. Health locus of control was not found to be of utility in facilitating management of older adults with osteoporosis.

The study by Hallal (1991) was undertaken to determine what combination of variables was the best predictor of life satisfaction in women with postmenopausal osteoporosis of the spine and vertebral fractures. In her sample of 93 women, life satisfaction was best predicted by the following combination of variables: income level, frequency of back pain, perceived internal control over health
and perceived social support.

Roberto (1988, 1989), focusing on 115 community dwelling women with osteoporosis, examined stress and adjustment patterns. Of the four studies reviewed in this section, only the study by Roberto included in-depth interviews exploring the physical, psychological and social aspects of living with osteoporosis. The findings included the role of family and the service community in providing support (1988) and the conditions leading to feelings of stress and coping strategies used to adapt to osteoporosis (1989). Since this study is similar to my own interests I will describe Roberto's findings in more detail.

Older women in her sample reported their major problems to be pain and inability to do housework. Pain limited social and recreational activities and restricted physical movements, often leading to dependency and isolation. Most women viewed their families as supportive, receiving both affective support and instrumental assistance. While married women depended most on their husbands, others relied mostly on children with siblings providing limited instrumental assistance. The actual number of services used by the women was low.

While 46% of Roberto's sample had not experienced an overt fracture, 86% reported suffering acute or chronic pain as a result of osteoporosis. Physical changes, such as loss of height, rounding of the shoulders and a protruding abdomen were reported. Common complaints associated with these changes were pain, discomfort and concern about their appearance. When asked about stress, these women expressed greater amounts of stress after diagnosis than before. The most common coping mechanisms were taking pain relievers, lying down and resting, and using a heating pad or taking a hot bath. These women also reported making adjustments in their daily routines with the most frequently reported adjustments being giving up housework, using a supportive device such as a cane or walker and limiting social and recreational activities. Those making adjustments in their lives were older, more likely to have experienced a fracture, more likely to be experiencing pain and to have perceived a greater amount of stress in their current lives than those not making adjustments. Thus, Roberto (1989) concluded that the number of specific adjustments made seemed to be related to the state of the disease.

In addition to considering the subjective aspects of chronic illness, it is also important to understand the context within which women experience osteoporosis. Osteoporosis is considered part of the menopause syndrome (MacPherson, 1985). In youth-oriented cultures such as North America, menopause is a symbolic milestone on the way to old age (Beyene, 1989; MacPherson, 1985, 1988); thus, "osteoporosis and menopause are embedded in a social and cultural context that devalues women older than 45 years" (MacPherson, 1985, p. 13). Feminists have argued that a disease definition of menopause has served the interests of both the medical profession and the pharmaceutical industry (Beyene, 1989; MacPherson, 1985). MacPherson (1988) traced the history of the medicalization of menopause to the 1960s. Menopause was defined as a deficiency disease
requiring estrogen replacement therapy. Subsequently the definition expanded from a deficiency disease to a syndrome that added osteoporosis to the "symptoms" of hot flashes, night sweating, vaginal dryness and other psychological and physiological conditions. MacPherson argued that the entire climacteric period has been medicalized primarily by gynecologists who claim that "the period of life between 35 and 65 is potentially dangerous for women and harbours other threats, such as sexual dysfunction, in addition to menopause and osteoporosis" (p. 186).

In addition to a continuing review of the technical literature, Strauss and Corbin (1990) suggested the review of the non-technical literature (for example, Horner, 1989 and Sheehy, 1992) to assist in understanding the information available to women with osteoporosis. Over the past few years there have been articles about menopause and osteoporosis in popular magazines such as Toronto Life (Barsky, 1992); Newsweek (Beck et al., 1992); Maclean's (Elash, 1995); Reader's Digest (Paillard, 1995) and Canadian Living (Ward, 1995). Also, I contacted the Osteoporosis Society of Canada for written information that they produce for the public to ascertain their vision of osteoporosis, its management and treatment. Brochures are available from local pharmacies (for example, Shoppers Drug Mart's Living with aging: Women and osteoporosis) and health facilities (Advice from the Baycrest [Centre for Geriatric Care] experts on ... Osteoporosis). A review of these provided the current popular ideas to which these women have easy access and which might inform the meaning they derive from living with osteoporosis. Thus, review of these written materials were utilized to sensitize me to social contextual issues that might influence how these women lived their everyday lives with osteoporosis.

This overview of osteoporosis indicated that there was a need to learn more about the lives of women with osteoporosis. The specific research questions addressed are considered in the next section.

**Research Questions**

The overall research question is: "What are the relationships among the meaning of aging, the meaning of chronic illness and the self-concepts of older women?" The specific research questions are:

1. What are the self-concepts of older women with osteoporosis?
2. What meanings or perspectives do older women with osteoporosis have on aging and chronic illness?
3. How are the meanings or conceptions of aging and/or chronic illness related to self-concept?
4. How do the manifestations of osteoporosis (e.g. the nature and severity of symptoms) relate to self-concept?
5. What strategies do older women with osteoporosis use to maintain their self-concepts in the face of aging and chronic illness?
Conceptual Framework

The major focus of this research is to determine how the meanings of aging and osteoporosis are related to the self-concepts of older women. The meanings of aging and chronic illness for the women in this study as well as the strategies they use to enhance, protect and maintain their self-concepts are considered.

In the literature, ideas about the self have been conceptualized in many different ways. Although different terminology is used, the basic premise is that self-concept relates to the individual's thoughts and feelings about himself or herself as an object and that self-concept provides the individual with the foundation on which almost all actions are determined and have meaning (Rosenberg, 1979). Rosenberg (1979) provided sound and useful descriptions of the self and his conceptualization of self-concept provides the theoretical basis for this research. This conceptualization will be discussed in more detail.

While Demo (1992) suggested that Rosenberg's work on self-concept is exemplary sociological research on the self and provides an excellent description of the structure of self-reflection, he also submitted that it is a static view of the self that is fixed at one point in time. Thus, Demo considered Rosenberg's model as part of the structuralist view of self-concept which is relatively stable and generalizable from one situation to the next. Demo argued that it is also necessary to consider the self-concept as a process—"self-concept is simultaneously a complex structure and a process, ... it is stable, but ... it is also dynamic" (p. 304). Despite his critique of Rosenberg, he acknowledged that components of reflected appraisals, social comparisons and self-perceptions suggest that self-concept changes, fluctuates, stabilizes, reverts to earlier levels and changes again. While lives are constantly changing, as roles and situations are changing, there is still little known about the "emergent, dynamic, changing qualities of human self-images" (Demo, 1992, p. 306). But Demo's critique does not acknowledge Rosenberg's self-concept motives which serve as incentives for action nor does Demo recognize Rosenberg's principles of self-concept formation (reflected appraisals, social comparisons, self-attributions and psychological centrality) which provide a framework within which to view the self-concept as more dynamic and changing over time.

In contrast, Ryff and Essex (1991), using Rosenberg's self-concept theory as a theoretical framework to guide their research on how particular life events affect psychological well-being, argued that Rosenberg's perspective is comprehensive. It integrates many domains of theory (i.e., social comparison, symbolic interactionism, identity and self-perception theories) and views people as adaptive, as possessing the capacity to make sense of their life experiences in ways that minimize negative consequences for the self. Using Rosenberg's principles of self-concept formation, they developed a new measure which they used in combination with the previous scale of psychological well-being developed by Ryff (1989). They then assessed how older women adjusted as they moved from their independent homes to apartments or retirement communities.
Rosenberg’s self-concept motives and principles of self-concept formation add the process perspective to the conceptual framework guiding this study and will be considered in Chapter 7 relative to the strategies the women use to enhance, protect and maintain their self-concepts despite aging and chronic illness.

**Structure of Self-concept**

The **extant self** or how one sees one's self includes four aspects as noted earlier: the content, structure, dimensions and ego-extensions of the self (see Figure 1-1). The **content** of the self-concept includes: the major components of social identity or the groups and statuses to which one belongs (i.e., age, ethnicity, family status, gender, membership groups, personal identity, religion, etc.); dispositions or qualities such as, abilities, attitudes, habits, preferences, traits, and values; and physical characteristics.

The **structure** of the self-concept describes the relationships among the components of social identity, dispositions and physical characteristics. These components are of unequal centrality to the individual's concerns and are hierarchically organized. Self-concept is based not only on the assessment of qualities but on an assessment of what is important to the individual or what counts. Self-concept can be viewed globally or by components (Rosenberg, 1979).

The **dimensions** of self-concept are related to one's attitudes or feelings toward one's self as an object. These self-attitudes may differ in content (what does one see when one looks at oneself), direction (is one's opinion of oneself favourable or unfavourable), intensity (how favourable or unfavourable are these feelings), saliency, consistency, stability, clarity, accuracy, verifiability, et cetera (Rosenberg, 1979). The self is important, it is always with us and enters into every situation. It is reflexive, that is, the individual is both subject and object. The self is viewed from the individual's unique point of view in terms of her biography and in harmony with her own interests and concerns. There are aspects of self-confidence or anticipated mastery—the belief that one can overcome challenges or obstacles to make things happen in accordance with one's inner wishes. Self-esteem includes positive and negative evaluations of the self—self-acceptance, self-respect, and feelings of self-worth (Rosenberg, 1979).

**Ego-extensions** integrate external elements into the self such as, "my university" or "my company", and are associated with feelings of pride or shame. Some of these external elements become very central particularly those which are the outcome of our efforts (e.g., the artist's painting, the author's book) and one may feel personally affected by what happens to these objects.

The **desired self** reflects what one wishes to be like and is the reference point against which the extant self is viewed and evaluated. Rosenberg's three images for inclusion in the desired self

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2 Since women are the focus of this thesis, I will use female pronouns and possessives throughout.
Figure 1-1

CONCEPTUAL FRAMEWORK: STRUCTURE OF THE SELF-CONCEPT

- content:
  - social identity
  - dispositions, physical characteristics

- extant self

- structure

- dimensions

- ego-extensions

- idealized self

- committed self

- moral image

- fulfilment of ends

- self-consistency, self-esteem

- conformity to norms

Reference: Rosenberg, 1979
discussed earlier are: the *idealized image* (or the ultimate image that individuals strive for--striving that may take on a pathological quality); the *committed image* (or the self-picture that one takes seriously and judges achievements by and is usually within one's reach); and the *moral image* (what one feels one must, ought or should be). See Figure 1-1. The moral image is further described as having three aspects: conscience associated with norms of morality (i.e., one should not lie, steal, etc.); role demands (which are a set of prescriptions associated with expected behaviour of status incumbents); and personal and idiosyncratic self-demands (e.g., one should only need eight hours of sleep a night or should always be cheerful and good-humoured) (Rosenberg, 1979).

Most importantly, the desired self is a motivational force that urges the extant self to take action to become like the desired self. This striving is reflected in the following quote:

He *works* [italics added] to become a 'better person', *strives* to realize his ambitions, *struggles* to censor his unacceptable impulses, *selectively directs* his efforts in the immediate situation or in the long run to converting the self he wishes to observe or to maintaining a desired self against the forces that threaten to blemish it .... much of human behaviour is *motivated by the wish to attain, to maintain or to retain a desired self.* (Rosenberg, 1979, p. 45).

The *presenting self* governs, guides and controls our actions so that we act in accordance with the type of person we wish to appear; the presenting self is the product of intention. How we attempt to behave is within our control as we view ourselves as objects, make decisions about ourselves as objects and act upon those decisions in speech and action (Rosenberg, 1979). Rosenberg suggested that there are several objectives in presenting certain selves. These are the fulfilment of personal goals or ends, the need to establish and protect oneself through self-consistency and self-esteem, and the conformity to social rules and norms (see Figure 1-1). The presenting self may be strongly influenced by social and historical factors. One of the major aims or ends is social approval. People select presenting selves that are functional, comfortable and congenial and in keeping with their extant selves. Although the presenting self does show more variability and is more situation-determined than the extant or desired self, it is not "chameleon-like". "At the core, and frequently cross-situationally, there is a more or less consistent self that we elect to present to the world" (Rosenberg, 1979, p.46).

**Self-concept as Process**

Along with this cognitive structure of the self-concept, Rosenberg also highlighted the self-concept as being a motivational system--certain aspects or components are desired and thus, serve as incentives for action. He described the *self-concept motives* as the *self-esteem motive*--the wish to think favourably about oneself and the *self-consistency motive*--the wish to protect and maintain the self-concept against change. He concluded that both motives have powerful emotional and behavioural consequences. They are not passively preferred but rather actively sought.

Self-esteem is a positive or negative orientation to an object. High self-esteem denotes
feelings of self-respect and self-worth while low self-esteem indicates that one lacks respect for oneself and considers oneself inadequate, unworthy, and wanting as a person. Rosenberg identified some of the defense mechanisms emphasized by Freud and often used to protect and enhance self-esteem.³

Self-consistency is the motive "to act in accordance with the self-concept and maintain it intact in the face of potentially challenging evidence" (Rosenberg, 1979, p. 57). Rosenberg argued that the power and persistence of self-consistency motive may be "remarkable". People develop self-concepts early in life and continue to hold to these views long after the actual self has changed. The importance of the self-consistency motive is two-fold: the individual must have a picture of himself in order to see and hear, and, in turn, think and act. As an actor one must act on some implicit assumption of what kind of a person one is and how other people see that individual (Rosenberg, 1979).

Rosenberg also discussed four principles involved in self-concept formation--reflected appraisals, social comparisons, self attribution and psychological centrality. Reflected appraisals (appraisals or perceptions of others influence how one views oneself and shape self-concept) include direct reflections or how particular others view us; perceived selves or how we believe others view us; and the generalized other or the attitudes of the community are internalized and serve as a perspective for viewing the self. This latter point emphasizes that self-concept arises out of social experience, particularly social interaction. Social comparisons encompass the processes by which individuals judge and evaluate themselves by comparing themselves to others (referent individuals, reference groups or social categories). These comparisons lead to positive, neutral or negative self-ratings. There are two types of social comparison: in the first situation individuals see themselves in comparative terms--are they superior or inferior to others in terms of some criterion of excellence or virtue. This requires a judgement of both the others and the self. The second type is normative and refers to deviance or conformity. The issue is not whether one is better or worse but whether one is the same or different than others. Self-attribution, also referred to as "behavioural self-perceptions" by Ryff and Essex (1991), is the assessment of one's abilities and competence based on observation of one's behaviour and its outcomes. Psychological centrality relates to the hierarchical organization of components of the self-concept. For example, some dispositions such as, intelligence, morality, honesty, and social identities (parent, religion, ethnicity) may be more or less central to our

³ Examples of defense mechanisms are: rationalization (finding a socially acceptable explanation for one's behaviour), compensation (overcoming a weakness in one area by extraordinary achievement in another), projection (attributing to others undesirable characteristics of the self), displacement (people humiliated by powerful others assert their superiority over others), reaction formation (emphasizing characteristics which are the reverse of undesirable characteristics of the actual self), and repression (thrusting into the unconscious impulses that would offend self-esteem).
concerns. Rosenberg argued that self-values are heavily influenced by the value system of the particular society and by the system of social rewards and punishments which drive certain qualities to the centre of concern and relegate others to the periphery.

Also important to the consideration of the process of self-concept in this study is the meaning of aging and of chronic illness. As discussed earlier in this chapter, Bury (1988) argued that there are two aspects of meaning that should be considered related to chronic illness: the consequences of illness and the significance of illness. The consequences of illness include the effects, problems and costs of chronic illness—the activity restriction (disability) and social disadvantage (handicap) inherent in chronic illness, such as personal care problems and employment and financial problems. The significance of chronic illness is related to the connotations and imagery that different conditions carry within a particular society. "Individuals and communities have expectations about disabling illnesses available to them from the immediate cultural environment, and these provide a context for the thoughts and anxieties as to what the condition will mean" (p. 92). He gave as an example the common belief that arthritis is a disease of elderly people. This may create a feeling of premature aging and the loss of stages of an individual's biography. Stigma and discrimination are derived not so much from the disability but from the significance accorded the condition by others. Bury (1988) concluded that these aspects of meaning are important in understanding the strategies people employ in managing their chronic illnesses. Placed in terms of the conceptual framework of self-concept, meaning may have a profound effect on how individuals regard themselves (extant self) and how they think others see them (presenting self).

Other ideas from the literature on the sociology of chronic illness which adds to the active process of self-concept is the concept of coping. Pearlin and Schooler (1978) defined coping as “the actions that people take on their own behalf as they attempt to avoid or lessen the impact of life problems” (Pearlin, 1989, p. 250). Coping serves “to change the situation from which the stressors arise, to manage the meaning of the situation in a manner that reduces its threat, or to keep the symptoms of stress within reasonable bounds” (Pearlin, 1989, p. 250; italics in the original). Bury (1991) argued that there needs to be a distinction made between the cognitive processes and the behavioural strategies used in adapting to chronic illness. He referred to the cognitive processes as coping and the behavioural actions as strategies. Coping refers to the cognitive processes whereby the individual learns how to tolerate or put up with the effects of illness while maintaining a feeling of personal worth and sense of coherence in the face of disruption. It involves maintaining a sense of value and meaning in life despite symptoms of chronic illness and their effects. Strategy directs attention to the actions people take, or what people do in the face of illness or the actions taken to mobilize resources and maximize favourable outcomes. From the individual's point-of-view, strategic management of chronic illness involves: skilful manipulation of social settings and appearances to reduce the impact of illness on interaction, attempts to mobilize resources to advantage, setting of
realistic goals to maintain everyday life, and documenting successful actions in order to maintain hope and a sense of the future (Bury, 1991).

These concepts advanced by Rosenberg (1979), Pearlin and Schooler (1978), and Bury (1991) were used to guide and frame the in-depth interviews that were conducted for this research.

The next chapter describes the methodology.
CHAPTER 3

METHODS

Twenty-eight women, aged 54 to 80 with a clinical diagnosis of osteoporosis, participated in this study. The design of this study is qualitative utilizing in-depth interviews. In addition to an in-depth interview, each participant also completed a self-administered questionnaire. The purpose of this questionnaire was to facilitate the gathering of demographic and financial information as well as information about general levels of functioning so that attention during the in-depth interview could be given to discussion of self-concept. This chapter outlines the rationale for the qualitative nature of this study and the methods used.

Rationale for Qualitative Research

The review of the literature on self-concept, aging and chronic illness and the resultant research questions indicates an explicit methodological direction. Self-concept and meaning can be discovered through qualitative methods. An interpretive perspective which combines phenomenological and symbolic interactionist approaches affords a position conducive to seeing the social world from the point of view of the actor. This perspective also allows for careful consideration of the contextual forces that affect the lives of the women in the study.

The research questions can be answered by understanding the lived experience\(^4\) of women with osteoporosis—how they experience osteoporosis in their everyday lives and the perspectives they have of aging and chronic illness and how these are related to their self-concepts. The lived experience of the women in the study is considered within the particular context of that experience for them. Qualitative, interpretive sociology requires a method that allows the uncovering of how individuals give meaning to their life experiences. This method relies on verbal or written expressions of meaning given by those being studied (Denzin, 1989).

A review of the literature on the measurement of self-concept suggested that self-concept can be studied directly. Breytspraak and George (1982) argued that the measurement of self-concept is based on the assumptions that self-concept is consciously available to the individual and that it can be measured by using self-reporting methods. Also relative to the assessment of self-concept, Bengtson et al. (1985) suggested that change or stability in self-concept across the lifespan can be

\(^4\) Denzin (1991) described lived experiences as “those life events which radically alter and shape the meanings persons give to themselves and their life projects” in contrast to examining the “more mundane, taken-for-granted properties and features of everyday life”. Greene (1994) discussed the phenomenological meaningfulness of lived experience as “people’s interpretations and sense making of their experiences in a given context” (p. 536).
studied by comparing the desired self and the extant self.

Participants

Initially a sample was drawn from a medical clinic with the cooperation of Dr. Tim Murray, Director of the Metabolic Bone Clinic at St. Michael’s Hospital, Toronto, Ontario, Canada. This clinic includes women with a clinical diagnosis of osteoporosis. While Conrad (1987, 1990) argued that, in sampling relative to chronic illness, we should not rely solely on clinically derived samples of "patients", in the case of osteoporosis a diagnosis of osteoporosis is often not made until after a fracture (Smith, 1992); thus, most, if not all, women with a diagnosis of osteoporosis will have some medical affiliation. Also for the purposes of this research it is important that the women know that they have osteoporosis.

At the proposal stage I had hoped that access to this group of women would allow for theoretical sampling (Glaser & Strauss, 1967) of women with various presenting symptoms (for example, traumatic onset versus gradual onset; spinal fractures versus wrist fractures; visible deformities versus no visible deformities) and at various stages of the disease process (early versus later stages). This was not possible because there was no current computerized database available upon which to select such a sample. Also Dr. Murray requested that I begin my study with a systematic sample of women attending the clinic.

A list of 60 possible participants was generated by selecting every fourth name from the Metabolic Bone Clinic lists covering a four-month period from February to May of 1993. The Clinic Coordinator reviewed the list and deleted the names of six women who were depressed (2), who were participating in other studies (2) or who did not speak English (2). She contacted 38 women to obtain a list of 30 possible participants (seven did not wish to participate and one had moved from the Toronto area). I henceforth refer to the "clinic sample" to differentiate it from respondents obtained from different sources, as described later in this section. However, the sample is obviously not systematic in a population-based sense; rather, it is a systematic sample of one clinical population.

Because of the qualitative nature of the study a sample of 30 was considered adequate. Sudman (1983) has argued that samples of 20 to 50 respondents are appropriate for the exploratory research required to develop hypotheses and procedures for measuring them. Others have asserted that in-depth interviews are necessary to acquire the depth and detail needed to interpret feelings and perceptions of participants (Lofland & Lofland, 1984; Patton, 1990). Patton (1990) has further argued that there are no rules for sample size in qualitative inquiry. Rather, "sample size depends on what you want to know, the purpose of the inquiry, what’s at stake, what will be useful, what will have credibility .... the validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical
capabilities of the researcher than with sample size" (p. 184-185). Lincoln and Guba (1985) have recommended sampling be terminated when no new information is forthcoming from new sampled units; thus, the final sample number was kept open so that further sampling could be done if necessary around considerations such as manifestations of osteoporosis, life events, et cetera. Morse (1994) argued that the sample is determined according to the needs of the study and not according to external criteria. Participants are representative of the same experience or knowledge not the general population.

Between September of 1993 and September of 1994, I contacted the 30 women identified through the clinic sampling to ascertain their interest in participating in the study. Once a woman agreed to participate, a covering letter and a self-administered questionnaire (see Appendix 1) were mailed to her. Of the 30 questionnaires mailed, 24 were returned. Of the 24 women who returned the questionnaires, 20 were interviewed between October, 1993 and September, 1994. Two women refused to be interviewed, one due to illness, the other due to her commitments to the care of her aged mother and her own medical problems. The third woman had recently learned that she did not have osteoporosis and thus, was not eligible to participate in the study while the fourth woman was not able to be contacted by telephone.

Because of the qualitative nature of this study, data were transcribed and analyzed on an ongoing basis, concurrent with interviewing. Midway through the interviewing, I became aware that the women interviewed to date were not very disabled by osteoporosis. During the interviews some of these women had told me that their stories of life with osteoporosis were not very interesting because they really didn’t have any significant limitations. They suggested that I speak to other women they knew who were more disabled than themselves. Their descriptions included women with mobility problems requiring the use of canes and walkers; women who had to alter or give up their employment; women who had suffered from mental health problems, such as depression; and women who were attending support or self-help groups. Also there were women in the clinic sample who were more disabled than the women I was interviewing—in my telephone conversations some had told me that they did not know if they would be well enough to participate in an interview which might last up to two hours. But when I reassured them that we could complete the interview in two sessions rather than one, they agreed to participate and I sent them the questionnaire. As noted earlier, two of them completed the questionnaire and returned it to me but refused to participate in the interview when I called to set a time for the interview. Six women did not return the questionnaires. Those women who had returned the questionnaire and were being interviewed discussed their discomfort with answering the questionnaire with me. They had found themselves becoming confused by the scoring system and the wording of some of the questions. They also expressed their discomfort with the psychological focus of some of the questions. Thus, willingness to participate might have been affected by the health status and/or the comfort level with answering
the questionnaire. Accordingly, I considered my options.

In my proposal I had allowed for the need to use purposive sampling depending on the participants from the original sample by suggesting that further sampling, determined by particular theoretically relevant concepts arising out of the initial interviewing, might be required around considerations such as manifestations of osteoporosis, life events (Ryff, 1986; George, 1990), functionality, shifts in status and role or social integration (Frank & Vanderburgh, 1986). Therefore, as well as continuing to interview those women identified from the clinic sample, an additional 11 were identified as possible participants--four by the Coordinator of the Metabolic Bone Clinic and seven through Women Against Osteoporosis (WAO). WAO is a voluntary organization formed by a group of women receiving care for osteoporosis in Toronto. The purpose of the organization includes fund raising for research, increasing public awareness about osteoporosis and offering support for others with osteoporosis (source: pamphlet, Osteoporosis, prepared by WAO, undated). I spoke to the Vice President of WAO who coordinates the support group program and subsequently attended a support group meeting in Toronto. I discussed my research with the group and invited participation. Contact with the Vice President and the support group resulted in an additional seven women being identified as potential participants. While two of these women refused to participate because of poor health, the other five were interviewed. Of the four women identified by the Coordinator of the Metabolic Bone Clinic, three were interviewed and one had moved from the greater Metropolitan Toronto area. This brought the number of women interviewed to 28.

Relative to the self-administered questionnaire, I changed this procedure after the initial questionnaires were mailed. With the last eight participants I took the questionnaires with me to the interviews rather than mailing them. I left them to be completed and returned to me. Two questionnaires were not returned--one woman was very disabled by her osteoporosis and chronic obstructive lung disease and spent most of her day lying in bed while the other woman was in the midst of taking on new responsibilities with her job which left her little free time.

The next section will consider the particular data collection strategies necessary to address the research questions posed in Chapter 2.

Data Collection

The methods of data collection (i.e., the self-administered questionnaire and in-depth interview) are discussed in more detail below.

Self-administered Questionnaire

Charmaz (1991) suggested that in order to understand the complexities of chronic illness it may be necessary to interview participants in research for more than one session. Rather than schedule two interviews for each participant, a questionnaire (Appendix 1) was to be completed by
each woman. The purpose of this questionnaire was to address specific questions related to general health status including other medical conditions and symptoms, general functional status including activities of daily living (ADL) and instrumental activities of daily living (IADL) as well as demographic and financial information. Therefore, these questions which might require extensive responses and be time-consuming were not asked during the interview to allow more time for the open-ended questions. There were also questions related to self-concept, self-esteem and psychological well-being (environmental mastery, purpose in life and self-acceptance). The questionnaire was utilized to create a profile of each participant including general health and functional status and some aspects of self-concept. These data were utilized to complement and confirm the information collected in the in-depth interviews. Responses to the questions in the questionnaire were reviewed to establish consistency of individual responses between the fixed answer questions of the questionnaire and the open-ended questions of the interview.

In-depth Interview

In-depth interviews were conducted using an interview guide (Appendix 2) focusing on self-concept, the experience of aging and the experience of chronic illness. The questions were developed utilizing the concepts gained from the literature review. The interview included guiding questions to elicit the individual’s perceptions of self living with osteoporosis against the backdrop of aging and chronic illness. The interviews provided an opportunity to examine how these women

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5 These questions were drawn and adapted from questionnaires developed by the Centre for Studies of Aging at the University of Toronto (Second Mile Club Home Support Services Client Attitudinal Survey, November, 1992; Health Care Issues for Older Canadians in Florida, undated; in collaboration with The Centre on Aging, University of Manitoba, Study of the Needs of Elderly People in Bermuda, Fall, 1990); from provincial government surveys (Ontario Health Survey, Premier’s Council on Health Strategy, Ontario Ministry of Health, undated); and federal government surveys (General Social Survey, Statistics Canada, 1985; Survey of Ageing and Independence, Statistics Canada, 1991).

6 E.P. Mason’s (1954) self-concept questionnaire cited and included by Breytspraak and George (1982). Mason defined self-concept as including both cognitive and affective components.


8 Ryff (1989) and Ryff and Essex (1991). Only three of six scales were used. The scales of environmental mastery, purpose in life and self-acceptance were included. The scales of autonomy, personal growth and positive relations with others were not included. In retrospect (as discussed in Chapter 8), given the similarities in the data from the in-depth interviews and Ryff’s scale, it may have been useful to have included the complete scale to enhance the study by providing another source of data to support the qualitative findings.

thought and how personal and cultural values shaped their understandings about chronic illness (Fetterman, 1989).

Specific questions focused on those structural aspects of self-concept described by Rosenberg (1979)--the extant self or how one sees oneself, the desired self or how one would like to see oneself, and the presenting self or how one shows oneself to others. Questions included "How would you describe yourself as a person?", "If you could live your life over again what would you do differently?", and "How would others describe you?". The process aspects of self-concept including the self-concept motives of self-esteem and self-consistency which enhance and maintain the self-concept. Questions included "What are your strong points?", "What are your weaknesses?", "How have you changed or stayed the same over your life?". Information about self-concept formation, including reflected appraisals, social comparisons, self-attributions and psychological centrality, was elicited with questions such as "How would others describe you now? and in the past?", "Generally how do you think you have made out in your life? compared to what you hoped when you started out?", "How would you compare the person you were x years ago (before the diagnosis of osteoporosis) with the person you are now?", "What have you learned about yourself over the past x years?", "What are your concerns for the future?", "What things have you done to manage your osteoporosis?".

The experience of aging was explored through questions that focused on the meaning of aging for the individual. Meaning was considered from two perspectives (Bury, 1988). The first is related to consequences (i.e., the problems, repercussions and costs to the individual). Consequences were discussed in response to questions such as "What is the hardest thing about growing old?". The second view of meaning is the significance of what being old denotes in a particular culture. The significance of being old was captured in questions such as "How do you feel about growing old?".

The chronic illness experience was traced by asking the women to recount how their osteoporosis was diagnosed, feelings about that process, treatments recommended and used, how they had adapted their everyday lives to accommodate osteoporosis and what had changed in what they did and how they did it since the diagnosis. The ways they coped with chronic illness and the strategies they used to maintain their self-concepts were explored. There were also questions related to their biography, for example, "Thinking back over your life, what past experiences or events have influenced how you manage your day-to-day life with osteoporosis?".

The next section will elaborate on the procedures used for the study.

Procedures

There were two sets of procedures used: one for those participants identified from the clinic sample and the other for those participants identified by purposive sampling. These will be discussed
separately.

**Clinic sample**

Once the original systematic list was developed, the Clinic Coordinator contacted potential participants either by telephone or in person briefly explaining the research project, asking if they were interested in participating in the project and if so, whether their names, addresses and telephone numbers could be made available to the researcher (see Appendix 3 for the information sheet that was used by the Clinic Coordinator to describe the study). If a potential participant wanted more information about the study before deciding to participate, the Clinic Coordinator gave the individual the researcher's telephone number, thus, allowing the individual to contact me without disclosing her address and telephone number. The Clinic Coordinator verbally assured the potential participants that the decision to participate was voluntary, that the research was not being done by the Clinic staff, that Dr. Murray and/or their Clinic physician would not know whether they participated or not and that non-participation would not affect their medical care.

Upon receipt of the addresses and telephone numbers, I telephoned each potential participant to explain the purpose of the study and the two methods to be used to collect data (the self-administered questionnaire, in-depth interview). The women were again asked if they wished to participate and assured that the Clinic staff would not know if they participated or not and that non-participation would not affect their care. With their agreement to participate, a package was mailed to each participant. The package included a letter on Department of Behavioural Science letterhead outlining the purpose of the research, a questionnaire, consent statement (see Appendix 1) and stamped self-addressed envelope for the return of the questionnaire to me.

Upon receipt of the completed questionnaire, I contacted each participant by telephone to arrange the in-depth interview at a time and place convenient for the participant that allowed for confidentiality of the interview response.

At the time of the interview, after an explanation of the overall purpose of the research including risks and benefits as outlined in the information sheet (Appendix 2), each participant was asked to sign a consent form (Appendix 2). This consent emphasized the voluntary nature of participation and the opportunity for refusal to answer any questions and withdrawal at any stage of the project without jeopardizing further medical care. Confidentiality was ensured. With the permission of the participants, the interviews were audiotaped. Copies of the consent and information sheet were left with the participant. The interviews lasted 1-1/2 to 3 hours. Provision was made within the interview guide to ask if the participant wished to complete the second half of the interview at a later date. All of the participants completed the interview in one session. Also, at the end of the interview each participant was asked if the researcher could contact her at a later date for clarification of information or another interview and if they wished to receive a summary of the findings upon completion of the project. All agreed to be contacted again and all wished to
receive a summary of the findings.

**Purposive Sample**

My initial contact with these participants was the same as with the clinic sample group. After I contacted the women to set a time for the in-depth interview, the procedure changed for this group in that the self-administered questionnaires were not sent out prior to the in-depth interviews. Instead the questionnaire package (Appendix 1) was given to the participant at the beginning of the interview. The women were asked to return the questionnaires to me in the stamped, self-addressed envelopes provided. Otherwise the procedures for the interview were the same as for the clinic sample group.

While the data gathered were at the micro level, I hoped to influence my analysis through an awareness of the broader social context that may affect how the women in the study thought about their everyday lives. Some of the potential methods for increasing sensitivity included the ongoing review of both the technical literature as well as the non-technical literature as discussed in Chapter 2. As the research progressed, these methods were utilized to gain additional information related to the social context within which women with osteoporosis live.

The next section will describe how the data were analyzed.

**Data Analysis**

The collecting, coding and analyzing of the data occurred concurrently. Upon receipt, the completed questionnaires were read to get an overall sense of the level of health and function of each participant. If responses were unclear or further questions arose from the responses to the questionnaire, these were noted for inclusion in the in-depth interview or for a follow-up telephone call.

Following each in-depth interview, I recorded my reactions to the interview noting atmosphere, tone, openness and any other impressions. The interviews were then transcribed into The Ethnograph (Seidel, 1988). During transcription, thoughts and ideas about the data were recorded in a journal. Before formal coding began, each interview transcript was read through to consider the story line or overview--the essence of the woman's story. Once this was done, coding began.

Initial codes were developed using ideas from the literature review and used in the construction of the interview guide (see Appendix 4). For example, under the general area of self-concept which was the first section in the interview guide, initial coding included extant self, desired self and presenting self. These codes were then broken down into sub-codes. For example, extant self included the content and structure of social identity, personal qualities, physical characteristics; dimensions (strengths and weaknesses) and ego-extensions (the meaning of life).

Initially, after completing the interviews, I transcribed the interview tapes myself. However,
because of the time required, after 11 interview tapes, the remaining tapes were transcribed by two paid transcribers requiring that I only edit the tapes. The transcribing and editing procedures familiarized me with the contents of the transcripts and reinforced each woman’s story for me. While certain questions in the interview were directed toward particular concepts (for example, How would you describe yourself as a person? was included to evoke comments from the participant about the extant self), analysis included all codes throughout the interview transcript rather than just the particular question asked to elicit the particular concept. Despite the argument of Breytspraak and George (1982) that self-concept is consciously available to individuals and that it can be described through self-reporting methods, not all of the women in this study found it easy to answer questions that required this amount of self-knowledge or self-disclosure. But even for these women as the interview progressed, most of them gave information about their extant self. Thus, the entire interview transcript informed my analysis of extant self.

Preliminary coding was done on the first few (7) transcribed interviews. During this phase the coding scheme was revised as new ideas or concepts emerged from the data. For example, under the code, extant self, the structure of the extant self was further differentiated to include aspects of family and work. These transcripts were then re-coded and the subsequent interviews coded. The coding scheme continued to be revised and changes made to previously coded interviews to reflect these coding changes.

The transcribed interviews were then entered into The Ethnograph Version 3.0 (Seidel et al., 1988). Selections of particular coding words were then conducted to begin to analyze these interviews for specific concepts important in answering the four research questions.

Relative to research question 1 (What are the self-concepts of older women with osteoporosis?), selections were completed for extant self, desired self and presenting self and summary tables created (see Appendix 6). After extensive consideration of each woman’s self-concept, three types of self-concepts emerged: the competent self, the contradictory self, and the ineffectual self. These will be discussed in detail in Chapter 5. In the case of research question 2 (What meanings or perspectives do older women with osteoporosis have on aging and chronic illness?), the meaning of aging and the meaning of chronic illness were reviewed for each participant (see Appendix 7) and the meanings considered across all of the participants. There were five themes that emerged in each area. These will be discussed in detail in Chapter 6. Utilizing the meanings of aging and chronic illness, I then considered question 3 (How are the meanings or conceptions of aging and of chronic illness related to self-concept?) using the analysis of self-esteem and self-consistency across the three types of self-concept. To answer research question 4 (How do the manifestations of osteoporosis [e.g., the nature and severity of symptoms] relate to self-concept?), each participant was classified relative to mild, moderate and severe disability by considering the participants’ descriptions of their chronic illnesses through the selections of codes for initial
disruption, disruption, symptoms and course of chronic illness. These were then compared to self-concept relative to aging and chronic illness. The fifth research question (What strategies do these women use to maintain their self-concepts in the face of aging and chronic illness?) was assessed through selection of the codes: coping and strategies for each participant. These codes were then used as in the discussion of self-esteem and self-consistency.

Thus, the analysis and interpretation resulted in the identification of patterns and themes that emerged from the data. These themes suggested adding or revising questions for subsequent interviews. For example, early on I interviewed a woman who described how her early life (including her family being uprooted from their home and country, a period of internment in a refugee camp and her subsequent immigration to Canada) had influenced how she perceived subsequent events or things that happened to her as important or worthy of concern or not. In re-reading the transcript of my interview with her I realized that I did not have a clear overview of the chronology of these important events in her life. Subsequently, following the work of Gubrium (1993) with nursing home residents, I began each interview with a comment "Before we begin talking about your osteoporosis, I wondered if you could tell me a little about your life story. Tell me about your life in about 15 or 20 minutes or so, if you can. Begin wherever you wish and include whatever you wish.". For some of the women in the study this created a dilemma as to where to begin. I would often say "Well, some people have started by telling me that they were born in Orillia or on a farm--wherever you wish to begin". But most of the women easily gave a concise overview including a chronology of important events and milestones in their lives. This also provided a context within which I began to understand how they perceived themselves over time.

The responses to the questionnaires were also utilized during the analysis as direct responses to particular questions but also to check out "hunches" that I had while reading the interview transcripts. For example, in reading one woman's interview transcript I was aware that there was something unspoken going on. While she did not discuss feeling depressed or lonely, there was an overall sense of disquiet through out the interview. I then reviewed her questionnaire and found that she had reported feeling depressed and lonely over the past few months.

The constant comparative method described by Glaser and Strauss (1967) was used to review and revise categories. Analysis and interpretation continued until order was brought to the data.

The next chapter describes the characteristics of the participants in this study. The social, demographic, and health profile of the participants will be described. The health profile results in the categorization of each woman as mildly, moderately or severely disabled. Chapter 5 considers the self-concepts of the women in detail outlining three different types of self-concept. Chapter 6 examines the meanings of aging and chronic illness across all the participants. Chapter 7 considers the relationships between the meanings of aging and chronic illness and the self-concepts of the
participants.
CHAPTER 4

SOCIODEMOGRAPHIC AND HEALTH PROFILE OF PARTICIPANTS

This chapter will present the general characteristics of the women in this study and how osteoporosis as a chronic illness disabled them.

Characteristics of the Participants

The 28 participants in this study were community-dwelling women with a known diagnosis of osteoporosis. Some had other chronic illnesses as well, such as, arthritis, cancer and digestive problems (e.g., diverticulosis, irritable bowel syndrome, hiatus hernia). The sociodemographic profile of the women will be described first, followed by the health profile.

Sociodemographic Profile

The women were between the ages of 54 and 80 years with most in their 60s (their mean age is 65.3; median age is 64.5; standard deviation of 6.38). See Table 4-1. All lived in the greater metropolitan area of Toronto, Ontario, Canada and most (27) received care for their osteoporosis at St. Michael's Hospital Metabolic Bone Clinic. While 10 of the participants were married and lived with their spouses, 14 lived alone and the remaining four lived with other family members. Those who were married or widowed generally lived in their own homes while those who were single, divorced or separated lived in rented accommodation. Most of those who were not working rely on government pensions rather than job-related pensions. Many had held jobs that did not provide good pension plans. Half of the participants described their financial situation as "having difficulty making ends meet" or "having just enough to get along" while the other half described their financial situation as "comfortable". The participants were generally well educated with most having completed high school and 17 having some post-secondary education, such as secretarial or nursing diplomas. Most worked outside the home for varying periods of their lives, although at the time of the interviews only six of the 28 are in the paid labour force.

Health Profile

Relative to health status (see Table 4-2), when asked to compare their health to others their age on a four point scale with 1 being excellent and 4 being poor, most described their health as good (or 2). When asked about their satisfaction with their health, most answered somewhat satisfied or somewhat dissatisfied rather than very satisfied or very dissatisfied. When asked to describe the effect of pain or discomfort experienced on their activities, more reported that pain or discomfort prevented a few or some activities while fewer reported that they were pain free or not prevented from doing any activities because of pain. Pain and discomfort limited activities at home and in leisure time pursuits. Among those who worked, only two reported that their pain and
Table 4-1: Sociodemographic Profile of Participants (n = 28)

<table>
<thead>
<tr>
<th>Age Range</th>
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<tbody>
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<td>54-59</td>
<td>5</td>
</tr>
<tr>
<td>60-64</td>
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<td>65-69</td>
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<td>70-74</td>
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<tr>
<td>75-79</td>
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<td>80 and over</td>
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<tr>
<td>single</td>
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<tr>
<td>married</td>
<td>10</td>
</tr>
<tr>
<td>widowed</td>
<td>6</td>
</tr>
<tr>
<td>divorced/separated</td>
<td>8</td>
</tr>
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<table>
<thead>
<tr>
<th>Accommodation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>own</td>
<td>18</td>
</tr>
<tr>
<td>rent</td>
<td>9</td>
</tr>
<tr>
<td>lived in someone else's house</td>
<td>1</td>
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</table>

<table>
<thead>
<tr>
<th>Living Arrangements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>live with spouse</td>
<td>10</td>
</tr>
<tr>
<td>live alone</td>
<td>14</td>
</tr>
<tr>
<td>live with other family members</td>
<td>4</td>
</tr>
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<table>
<thead>
<tr>
<th>Ancestry</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
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<tr>
<td>French</td>
<td>2</td>
</tr>
<tr>
<td>Irish</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
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<table>
<thead>
<tr>
<th>Income</th>
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<tr>
<td>less than $9,999</td>
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</tr>
<tr>
<td>$10,000 to 19,999</td>
<td>5</td>
</tr>
<tr>
<td>$20,000 to 39,999</td>
<td>8</td>
</tr>
<tr>
<td>$40,000 to 59,999</td>
<td>4</td>
</tr>
<tr>
<td>$60,000 to 99,999</td>
<td>2</td>
</tr>
<tr>
<td>$100,000 or more</td>
<td>1</td>
</tr>
<tr>
<td>no data</td>
<td>7</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Financial Situation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>having difficulty making ends meet</td>
<td>6</td>
</tr>
<tr>
<td>have just enough to get along</td>
<td>13</td>
</tr>
<tr>
<td>comfortable</td>
<td>7</td>
</tr>
<tr>
<td>no data</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>some high school</td>
<td>6</td>
</tr>
<tr>
<td>completed high school</td>
<td>5</td>
</tr>
<tr>
<td>special diplomas, certificates</td>
<td>8</td>
</tr>
<tr>
<td>some university</td>
<td>2</td>
</tr>
<tr>
<td>graduated university</td>
<td>7</td>
</tr>
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<table>
<thead>
<tr>
<th>Major Occupation in Life</th>
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</tr>
</thead>
<tbody>
<tr>
<td>paid employment</td>
<td>24</td>
</tr>
<tr>
<td>homemaker</td>
<td>4</td>
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<table>
<thead>
<tr>
<th>Current Employment</th>
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</tr>
</thead>
<tbody>
<tr>
<td>employed part-time</td>
<td>5</td>
</tr>
<tr>
<td>employed full-time</td>
<td>1</td>
</tr>
<tr>
<td>not employed</td>
<td>22</td>
</tr>
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Table 4-2: Health Profile of Participants  (n = 28)

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<tr>
<th>Health status</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>excellent</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>good</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>fair or poor</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>no data</td>
<td>2</td>
</tr>
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<table>
<thead>
<tr>
<th>Satisfaction with health</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>very satisfied</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>somewhat satisfied</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>somewhat dissatisfied</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>very dissatisfied</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>no data</td>
<td></td>
<td>2</td>
</tr>
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<table>
<thead>
<tr>
<th>Pain or discomfort</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>free of pain/discomfort</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>or pain/discomfort does</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not prevent any activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pain/discomfort prevents a few or some activities</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>pain/discomfort prevents most activities</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>no data</td>
<td></td>
<td>3</td>
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<table>
<thead>
<tr>
<th>Manage pain</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>very or fairly well</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>not very well</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>no data</td>
<td></td>
<td>5</td>
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<table>
<thead>
<tr>
<th>ADL</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>can do most activities</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>with no/some difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>needs assistance or</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>unable to do particular activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no data</td>
<td></td>
<td>2</td>
</tr>
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<table>
<thead>
<tr>
<th>IADL</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>can do most activities</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>with no/some difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>needs assistance or</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>unable to do particular activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no data</td>
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<td>2</td>
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<table>
<thead>
<tr>
<th>Mental health</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>not unhappy &amp; depressed</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>over time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>unhappy &amp; depressed</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>over time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sometimes lonely/remote</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>or depressed/unhappy</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td>2</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Satisfaction with life</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>very or somewhat satisfied</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>somewhat or very</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>dissatisfied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no data</td>
<td></td>
<td>2</td>
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<table>
<thead>
<tr>
<th>Describes self as</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>very or somewhat happy</td>
<td></td>
<td>22</td>
</tr>
<tr>
<td>somewhat or very</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>unhappy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no data</td>
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<td>2</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Contact with friends</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>very or somewhat satisfied</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>somewhat or very</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>dissatisfied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no data</td>
<td></td>
<td>2</td>
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<table>
<thead>
<tr>
<th>Contact with family</th>
<th></th>
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<tbody>
<tr>
<td>very or somewhat satisfied</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>somewhat or very</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>dissatisfied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>no data</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

NOTE: ADL = activities of daily living; IADL = instrumental activities of daily living
discomfort limited activities at work. Most reported that they managed their pain or discomfort well.

When asked about ADL and IADL, more women reported that they could do most activities with either no difficulty or with some difficulty than said they needed assistance or were unable to do particular activities.

When considering their mental health, most (21/26) reported that in the past six months they had not been unhappy and depressed more than usual for two weeks or more, but just over half of those completing the questionnaire (14/26) indicated that in the past few weeks, they sometimes felt very lonely or remote from other people or depressed and very unhappy. Most were very or somewhat satisfied with their lives as a whole and described themselves as very or somewhat happy. Most were satisfied with the kind and frequency of contact with friends and family.

The next section will describe the manifestations of osteoporosis and how these affected or disabled the women in the study.

Prior to beginning the study, my assumption was that the manifestations of osteoporosis (i.e., type, onset and course, as well as the nature and severity of symptoms) would be related in some way to self-concept. I will describe the manifestations of osteoporosis and how these disabled the participants. The relationship between manifestations and self-concept will be discussed later in Chapter 7.

**Type or Cause of Osteoporosis**

In my proposal, I had specified that I would seek women with post-menopausal osteoporosis to participate in the study. However, upon review of the available medical information on the women attending the Metabolic Bone Clinic, it became clear that the differentiation of the types or causes of osteoporosis was not available. Therefore, I selected possible participants using age only (55 years and older) rather than type or cause of osteoporosis. Fifty-five years of age was chosen because the literature suggested that by age 55, most women are post-menopausal.

During the interviews with the participants, I asked them what they thought caused their osteoporosis. Some identified the cause as menopause but many identified other factors such as, body build, family history, advancing age, drugs (e.g., steroids), excessive smoking or alcohol consumption and poor diet. These are the risk factors identified in the literature (see for example Compston, 1992).

**Onset of Osteoporosis**

The onset of osteoporosis was described by the participants in different ways. For some the onset was very sudden while for others there had been no easily defined “event” that had signaled the beginning of their osteoporosis. Those whose onset of osteoporosis was very sudden usually reported a defined "event" such as, picking something up from the floor or rolling over in bed, which they described as causing acute back pain. For most, this resulted in bed rest--five or six weeks of lying in bed in acute pain. When x-rays were taken, their doctors found evidence of spinal fractures
and osteoporosis. The participants were usually then referred to the Metabolic Bone Clinic. For others, the diagnosis of osteoporosis had been made during a routine medical examination or after minor fractures over a number of years.

**Course, Nature and Severity of Osteoporosis**

After considering the participants' descriptions of the course, nature and severity of their osteoporosis, three categories of disability\textsuperscript{10} emerged from the data. The categories are mild disability, moderate disability and severe disability. I have used the term "disability" rather than osteoporosis because, in some situations where a participant had more than one chronic illness, it was not always clear to her which of her chronic illnesses was disabling. In fact, in some cases it was probably the combination of chronic illnesses that created the disability. The criteria for inclusion in each category include the physical health or symptoms of osteoporosis (such as, fractures, loss of height, pain and deformities) and functional health or activity level including problems with mobility, ADL, IADL, and leisure activities. Each category will be described in more detail below.

Analyzing how each woman described her experiences with chronic illness, I was able to assign each woman to one of the three categories. While for the most part, particular levels of physical health usually resulted in similar levels of functional health (because of the physical requirements of functional activities), there was one woman (P101), in particular, who was difficult to place in one category or another. Although she was able to walk without a mobility aid, she had given up many light activities as well as heavy chores due to pain. She had been diagnosed with both rheumatoid arthritis as well as osteoporosis. She was not able to afford to buy any pain medication (which might have enabled her to do light chores) due to financial problems. Although she walked independently, I classified her as severely disabled due to her limitations in ADL and IADL.

The assignment to categories follows. NOTE: identification numbers are used\textsuperscript{11}; a plus sign (+) indicates that the participant has at least one other chronic illness in addition to osteoporosis.

\textsuperscript{10} Disability is usually defined as any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being (World Health Organization, 1980). But Verbrugge (1991) provides a more comprehensive definition: "disability refers to how chronic conditions affect people's ability to act in typical and personally desired ways in their society. The essential notion ... is how much difficulty people have doing valued activities .... [which] can be obligatory, committed, or discretionary" (p. 225). Obligatory activities include personal and household care, committed activities include paid employment and child care, and discretionary activities include hobbies and social activities.

\textsuperscript{11} P103 indicates Participant 103. The numbering is related to my original list of 30 systematically selected women (i.e., the numbers in the range of P101 to P130 are from the original sample). Those participants with numbers in the 200 range are the women who were added with the change in sampling procedures outlined in the Methods chapter.
See Appendix 5 for the specific information.

Mild disability (n = 10): P103, P112+, P116, P119+, P121, P122+, P123, P126, P128+, P129
Moderate disability (n = 9): P107+, P108, P109, P111+, P114+, P115+, P118, P120+, P206+
Severe disability (n = 9): P101+, P127+, P201, P202+, P203+, P208, P209+, P210+, P213+

Mild disability. Mild disability was characterized by women who described either no symptoms or minor symptoms (see Table 4-3). Some had had fractures but these were reported as minor. They attributed no pain to their osteoporosis. They had no obvious deformities and they continued to participate in their usual activities. One woman said, "I don't have any [diseases] other than this mild form of osteoporosis". When she had asked the doctor "'If you rated me, what degree of osteoporosis do I have?' ... he said, 'Well, really mild'". She continued, "I've never had any spontaneous fractures. I don't have any pain that could be attributed to [osteoporosis], I don't have any pain" (P122, age 66). Another woman said, "I'm not really finding [osteoporosis] any inconvenience because I don't have any crushed vertebrae. Therefore I'm not bent over or I don't have any pain anywhere with it .... I guess because I don't have any physical symptoms I forget that I have osteoporosis". In response to a question about whether her osteoporosis affected her day-to-day life, she responded, "No. I'm doing the same things but [the osteoporosis is] in the back of my mind when I'm doing some of these things" (P103, age 58). Another woman stated, "I don't feel any different. I don't feel like I've got anything wrong .... I pick the grandchildren up and do my [house]work and everything like I normally would do" (P129, age 64).

<table>
<thead>
<tr>
<th></th>
<th>mild disability (n = 10)</th>
<th>moderate disability (n = 9)</th>
<th>severe disability (n = 9)</th>
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<tbody>
<tr>
<td><strong>Physical health</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• fractures</td>
<td>none/minor</td>
<td>minor</td>
<td>moderate/severe</td>
</tr>
<tr>
<td>• loss of height</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>• pain</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>• back deformity</td>
<td>no</td>
<td>yes-mild</td>
<td>yes</td>
</tr>
<tr>
<td><strong>Functional health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of activity</td>
<td>usual</td>
<td>some restrictions</td>
<td>restricted</td>
</tr>
<tr>
<td>problems with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• mobility</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>• ADL</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>• IADL</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>• leisure</td>
<td>no</td>
<td>some</td>
<td>yes</td>
</tr>
</tbody>
</table>

NOTE: ADL = activities of daily living; IADL = instrumental activities of daily living
**Moderate disability.** The women categorized as having moderate disability (see Table 4-2) had lost some height due to osteoporosis and had some back deformity. They complained of pain. They were able to do ADL activities but were unable to do IADL activities such as, heavy housework, house maintenance or yardwork. They had given up some valued leisure activities. One woman related her experience at the Metabolic Bone Clinic. "I didn't like [the doctor] the first time because I [asked] 'How do I compare with most women my age?' and he said 'Worse'--one word, 'worse'. And that just threw me". She continued, "I was 5 foot 8 [inches] and I am 5 foot 4 [inches] now and almost, not quite 5'4" .... my legs are still as long so my body is disproportioned .... I am rounded". When describing household chores, she said, "When I vacuum I'll do [the living room] which is not much. But I only do this room at that one time and then I lie down" (P107, age 78). Another woman stated,

I can't get down and [wash] the floors and I can't lift the vacuum. Everything seems too heavy .... I've got a little ... carpet sweeper which I push over [the carpet] ... but I tried to get down to washing [the kitchen floor] but ohhh, my knees, I just about cried, the pain is something terrible. (P111, age 74)

Another woman described the changes she had made in her life because of osteoporosis. In addition to having given up gardening and heavy housework, she also found it difficult to sew and bake. Travelling by car was also problematic.

I found this past summer bending over in the garden is not as easy as it was .... I've cut back a little bit on sewing .... my husband vacuums .... probably the worst thing I do that causes my back pain is if I stand and bake .... If we're going on a trip, I don't sit for too long. An hour of sitting is, I'm very uncomfortable after sitting for an hour [in the car]. (P118, age 71)

**Severe disability.** Women categorized as having severe disability were those who, in addition to being unable to do heavy household chores, also had difficulty with light chores, making meals and getting in and out of bed or a chair. They used canes, walkers or scooters. They complained of pain which limited some activities. They had given up leisure activities. One woman said,

It's very difficult for someone who really likes to get down into the tub, otherwise you just have to sponge bath in the chair with the shower [head]. Because you just can't get up out of the tub ... sometimes it's just hard to get out of the chair. (P127, age 58)

She described her reluctance to use a scooter.

I've had a few falls and that's scary which is why I've started using the walker a lot more now and the scooter. I had a mental thing about [the scooter]--to try and not to use it unless I really, really needed it, but now I don't have that pride any more, I'd rather have that than a fall and fracture something. (P127, age 58)

Another woman described herself as a burden to her husband. Not only was she unable to do household chores but she was often unable to go out socially or travel.

I'm a burden to [my husband] in certain respects now because we can't do the things we
had hoped [in our retirement] .... at least my family wasn’t depending on me and without [my husband] I couldn’t cope .... I can’t reach for things, I can’t bend, I can’t do this and do that. (P208, age 70)

She further described herself as hostile and angry. She wondered, "I had advantages for which I am very grateful but at the same time I’m damn well mad that’s it’s me. Why wasn’t it somebody else? Nobody I know, I wouldn’t wish it on a dog but, but .." (P208, age 70).

In summary, the women in this study were distributed across the three levels of disability when consideration was given to physical and functional health. This distribution will allow comparison of self-concept by disability level in Chapter 7.

The next chapter describes findings related to the research question: What are the self-concepts of older women with osteoporosis?
CHAPTER 5

SELF-CONCEPT

As discussed in Chapter 2, self-concept has been defined by Rosenberg (1979) as "the totality of the individual's thoughts and feelings with reference to himself as an object" (p.ix). It is the picture one has of oneself, that is, one's self-ideas and general guiding self-views (Rosenberg, 1979). Self-concept is believed to be consciously available to the individual and can be measured using self-reporting methods (Breytspraak & George, 1982). It provides organization for one's life experiences giving a sense of coherence and continuity across time (Rosenberg, 1979; also see Markus & Herzog, 1991). Demo (1992) argued that consideration of self-concept must include both a structure and a process, that is, "a dynamic structure that responds to situational stimuli, incorporates new elements, rearranges, adjusts, and stabilizes temporarily before encountering new stimuli and undergoing further revisions" (p. 322). He further suggested that the theory underlying the view of self-concept as structure and process recognizes the consistent core of self-identity while recognizing that social interaction will change the configuration of the self-concept. Self-concept is the "product of reflexive activity but it is also susceptible to change as the individual encounters new roles, situations and life transitions" (Demo, 1992, p. 303). How individuals negotiate these changes depends on the content, organization and functioning of their self-concepts (Markus & Herzog, 1991).

While people may experience the same life events, they respond to these events in different and distinct ways. How a given event impacts on an individual seems to centre not only on "objective indicators of its severity or stressfulness, but on whether the event is importantly self-relevant and on how it has been interpreted and given personal meaning. It is how a person frames an event ... that is significant" (Markus & Herzog, 1991, p. 110). Markus and Herzog contended that "as an active interpretive framework, the self-concept integrates an individual's experiences across time and provides continuity and meaning to them" (p. 110).

Despite recognition of the importance of self-concept, Demo maintained that research has tended to ignore linkages between changes in the life course and changes in self-concept. He suggested that it is important to examine life experiences and events that facilitate a stable self-concept and those that may disrupt the self-concept. There is a need to understand events that create disruptions in self-concept. Unpleasant and stigmatizing events may shatter one's confidence, disrupt one's social relationships, and present challenges to further adjustments (Demo, 1992). Markus and Herzog (1991) concluded, from their review of the research on self-concept and aging (Bengtson et al., 1985; Reker & Wong, 1988; Ryff, 1989; Whitbourne, 1985; also see Chapter 2), that there is a developing consensus about the importance of self-concept for understanding adult
development and aging. They argued that a self-concept perspective allows for consideration of why some individuals age well, feel strong, resilient and in control while others do not. Positive functioning depends on whether individuals find ways to maintain an overall positive view of themselves (Markus & Herzog, 1991). How an individual responds to events and experiences depends on the “mediating self-concept” (Markus & Herzog, 1991, p. 112). Self-concept is the product of social interaction including how people think about themselves in the past, what they know about themselves in the present and what they think is possible in the future (Markus & Herzog, 1991). It is the discrepancy between the present or extant self and the desired self that is thought to lead to change (Markus & Herzog, 1991; Rosenberg, 1979).

Most of the recent literature on aging and self-concept is concerned with “successful aging” and does not consider people who, as well as aging, have chronic illnesses. As people live longer, there is an increasing likelihood of chronic illnesses that may result in disabilities. Similarly, the literature on chronic illness does not include older people (see Chapter 2). Most often it describes young and middle-aged people with disabilities (e.g., people with rheumatoid arthritis). For examples, see the work of Bury (1982), Locker (1983) and Williams (1984). This research often focuses on the disruption and losses associated with chronic illness: the loss of personal, material and social resources and ultimately, for some people, the loss of self. Extensive research conducted on self-concept and chronic illness by Charmaz (1991) included only a brief mention of older people as expecting narrowed and restricted lives as a result of chronic illness. There is also a body of literature that considers what it is like to age with a pre-existing disability (e.g., people with spinal cord injuries acquired as young adults, people with poliomyelitis acquired in childhood). The basic premise of this research is that the physical course of aging may be accelerated for people with lifelong disabilities (see for example The Developmental Consulting Program, 1988; Rosenthal, McColl, & McNair, 1992; Zola, 1988, 1990). There is a paucity of research that considers what it is like when aging and chronic illness arise at the same time; a situation that will become increasingly prevalent as more people live longer and acquire chronic illnesses, the scenario of living longer but in worsening health (Verbrugge, 1990, 1991). Thus, the consideration of self-concept, aging and chronic illness in this thesis adds a different perspective to the current literature.

The previous discussion would suggest that the study of self-concept is essential to understanding the perspectives people have of themselves as they age and develop chronic illnesses and how these perspectives, in turn, lead to social actions that allow them to manage their day-to-day lives. Studying women with osteoporosis provides an opportunity to consider how self-concept may be affected when aging and chronic illness coalesce and how their self-concepts impact on how they manage their lives as women aging with osteoporosis. Throughout the next chapters, I will discuss the findings from the study including the self-concepts of the women I interviewed, that is, how they talked about themselves in the present, how they thought they were in the past and how
they think they will be in the future. I will consider what meaning aging and chronic illness had for these women and, then, examine how their self-concepts and the meanings of aging and chronic illness are related. This analysis will add new knowledge of how women who are aging and acquire a chronic illness manage their self-concepts and the coping strategies they utilize to manage their day-to-day lives.

The purpose of this chapter is to explore in depth how the women in this study viewed their present, past and future selves. This will provide the basis for subsequent chapters as I begin to examine the similarities and differences amongst the women relative to the meaning that aging and chronic illness holds for them. These extensive data on self-concept, gathered using qualitative and quantitative methods, will add depth to our current knowledge of how aging and chronic illness influence the self-concepts of women as they live day-to-day.

The qualitative and quantitative nature of the data allows for consideration of self-concept using Rosenberg’s conceptual framework of the structural aspects of extant, desired and presenting selves as described in Chapter 2. The process aspects, self-concept motives of self-esteem and self-consistency, will be included in Chapter 7. In this chapter, I will examine the diversity of self-concepts across the 28 women I interviewed.

The women discussed their ideas about themselves during face-to-face interviews as well as responding to fixed answer questions on a questionnaire. The interviews and questionnaire responses are only an indication of the self-concepts of the women at two points in time. Analysis was conducted using each participant’s interview transcript and questionnaire responses. Through the selection of codes, the components of self-concept were identified. Extant self (how one sees one’s self) was considered through responses to specific questions asked during the interview (How would you describe yourself as a person? What are your strong points? your weaknesses?). Desired self (how one would like to see one’s self) was appraised considering responses to the questions: If you could stay the same age all your life, what age would you choose and why? What do you think you will be doing three years from now? What do you look forward to now? Do you make plans for the future? If you could live your whole life over, what would you do differently? Presenting self (how one shows one’s self to others) was assessed by considering answers to the question: how would others describe you? Responses to the questionnaires were utilized to complement the interview

12 The original questions included in the interview to access ideas about the desired self were: If you could live your whole life over, what would you do differently? If you could stay the same age all your life, which age would you choose? Why? Ideas about change and how one would like to see oneself were also elicited through the questions: What do you think you will be doing three years from now? What do you look forward to now? Do you make plans for the future?

13 The question that I asked to explore presenting self was “How would others describe you?”. In retrospect, I think a better question would have been “How would you describe yourself to
data. For example, the questions on environmental mastery, purpose in life and self-acceptance from the work of Ryff (1989; Ryff & Essex, 1991) were compared to the interview data in order to reinforce or confirm the placement of women in particular groups. This process will be described in more detail and examples given later in this chapter in the section on the structure of the self-concept. Other questions were also considered; for example, in the last six months, have you been unhappy or depressed more than usual for a considerable length of time (two weeks or more)? During the past few weeks, how often (i.e., often, sometimes or never) have you felt very lonely and remote from other people? depressed and very unhappy? How do you feel about your life as a whole very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied? Would you describe yourself as very happy, somewhat happy, somewhat unhappy, or very unhappy?

In addition to the structural components of self-concept, reading of the transcripts of the interviews led to the identification of the self-concept processes including the self-esteem motive and the self-consistency motive. The self-concept motives are central to the individual’s motivational system and facilitate the enhancement, maintenance and protection of the self (Rosenberg, 1979). These motives will be elaborated on in Chapter 7 in the examination of the relationships between the self-concept and the meanings of aging and chronic illness.

In considering the structural aspects of self-concept, I developed a summary table for each participant including the components of self-concept (extant self, desired self, and presenting self). See Appendix 6 for an example. Re-analysis of each interview as well as questionnaire responses resulted in further synthesis of the structure and process of self-concept for each woman. Throughout the reading and re-reading of the transcripts, I realized the complexities of the lives of the women I interviewed and how difficult it was to separate the structure and process of self-concept into discrete factors that correspond to how the women think about and describe themselves.

As discussed in Chapter 3, early on in the interviewing process, I realized the need to give the women’s lives more context by asking each woman to tell me about her life story before discussing the specific aspects of self-concept (Gubrium, 1993). Earlier life events were often described as having an influence on how the women characterized themselves in the present and how they thought they would be in the future. Life events, such as surviving the Holocaust and providing care for spouses and children who were dying, had an impact on how they described themselves. Descriptions of themselves could not be separated from the complexities of their lives. The ways they thought about themselves were enmeshed in the ways they had interpreted and re-

others?” (although one can only guess as to whether this would have elicited better data). The use of the former question has resulted in the need to focus on how the participants think others perceive them in discussions related to presenting selves.
interpreted their lives over time to shape the narratives they provided during the interviews as they discussed themselves and related the ideas about themselves to aging and osteoporosis.

Although, given the previous comments, it may seem artificial to separate self-concept from the larger context of the women's lives, I will examine the various ways in which the women portrayed themselves. In subsequent chapters, the self conceptions will be related to the meaning of aging and chronic illness for the women and how these influence how the women manage their lives as aging women with osteoporosis.

**Self-concepts of the Participants**

Self-concept, as it will be discussed in this thesis, includes both the structural and process aspects described by Rosenberg (1979) unless otherwise stated. The structural aspects of the self-concepts of the women who participated in this study varied across the extant, desired and presenting selves. I will describe how the women talked about each of these aspects of the self. How the women described the self-concept processes involved in the development, maintenance and enhancement of self-concept—the self-concept motives (i.e., self-esteem and self-consistency) will be considered relative to the meanings of aging and chronic illness in Chapter 7.

**The Structure of the Self-concept**

During the analysis of the data related to the structure of self-concept, three ways in which the women perceived themselves emerged: the competent self, the contradictory self and the ineffectual self. The identification of these groups evolved over time as I analyzed and re-analyzed the data. Initially I grouped the women into two dichotomous groups, one for those who seemed to describe themselves in very positive ways, the other for those who talked about themselves using very negative terms. These categories soon seemed too limiting. The complexities of how the women talked about themselves were not captured within this dichotomy. While there were women who held either positive or negative views of themselves, there were others who seemed to present pictures of themselves that were not clearly positive or negative. Rather they seemed to present conflicting ideas about themselves. After several attempts at trying to make sense of the data, I classified them into three groups. Inclusion in one of the three groups was based on their responses to questions 1-5 on the interview schedule (how would you describe yourself? What are your strong points? Your weaknesses? How would you describe yourself in the past? How have you changed or stayed the same over your life? How would others describe you? et cetera). I then looked for particular themes across the women; for example what kinds of words did the women use to describe themselves? Were the words predominantly positive or negative? How did they describe their relationships with other people? What activities did they describe themselves as participating in? Were these activities valued? How did they discuss their lives overall? Was there balance in their lives? Did they feel that they had some control over their lives? Did they plan for the future? When
considering one group of women (n = 12) who described themselves in very positive, confident ways (the competent self), they held favourable opinions of themselves. They described good relationships with others. They were self-assured. Work gave their lives meaning. They were confident that they could exert personal control over their lives. They planned for the future. Each of the three groups will be described in detail later in the chapter. There was a contrasting group (n = 8) who talked about themselves in very negative and critical ways (the ineffectual self) and a third group (n = 8) who characterized themselves in conflicting or contradictory ways (the contradictory self). They spoke about themselves in very tentative terms, sometimes they were positive and self-assured and at other times, negative and critical. After each of the women had been placed in one of the three groups, I then used the scores on Ryff’s scale of well-being as a check to reinforce and confirm their placement. No one changed groups based on her scores of Ryff’s scale. Rather I tried to understand why her scores might be different from my general impression of the participant during the interview. For the most part, participants’ scores on Ryff’s well-being scale reinforced their placement in a particular group. However, there were four women (P115, P116, P129, P203) who did not definitely “fit” into one of the groups. In those situations, I reconsidered the data I had on each of them focusing on an overall impression of their predominant characterization of their selves. I also used the scores from the three scales included from Ryff’s (1989) scale of well-being. I will use the situation of one woman (P129) as an example of how the interview and questionnaire results enhanced my understanding of their self-concepts. The interview took place in January. This woman presented herself during the interview as being very hesitant to go out and participate in volunteer activities. Despite her comments about how bored she was, she could not bring herself to leave the house on her own because of her fear of falling. The previous winter she had fallen and fractured her ankle which had resulted in a diagnosis of osteoporosis. But she did describe herself as participating fully in gardening activities in the summer months. When I looked at her scores on Ryff’s scale of well-being she had high scores on environmental mastery, self-acceptance and purpose in life. She had completed the questionnaire in the October before the interview and after a summer spent at the cottage participating fully in gardening and those activities required to maintain the cottage. During the interview she had assured me that summer was an important time in her life when she was able to fully participate in valued activities. The interview and questionnaire were providing a view of this woman’s ideas about herself at two points in time.

While dividing the women into three groups may seem artificial given the diversity of the women in this study, the categories provide an effective means by which to organize the data for this chapter and are grounded in the data. Also, because this is a snap-shot at only two points in time, it may be possible that the women move across the three groupings over time.

The women in each of the groups I created will be described using Rosenberg’s structural aspects of the self: the extant self, the desired self and the presenting self. Each of these aspects
will be reviewed briefly.

**The extant self**

The extant self is how one sees oneself and includes four areas: the content or parts of the self, the structure or relationship among the parts, the dimensions or ways of describing the parts and the whole, and the ego-extensions or the boundaries of the self (Rosenberg, 1979). Each of these areas will be described briefly (also see Chapter 2). The content of the self-concept includes social identity components such as, age, gender, ethnicity, family status, et cetera; dispositions or qualities such as, abilities, attitudes, habits, and values; and physical characteristics. The structure of the self-concept considers the relationships among the content components. Different components of the content may be of more importance than others. The dimensions of self-concept are related to one’s attitudes or feelings toward one’s self as an object. Self-attitudes may differ in content, direction, intensity, et cetera. The self is viewed from the individual’s unique perspective in terms of biography and in harmony with her interests and concerns. Ego-extensions integrate external elements into the self such as “my company” or “my university” and are associated with emotions of pride or shame. Others have referred to this aspect of self as current or present selves and usually use similar parameters to describe this aspect of self-concept (see for example Markus & Herzog, 1991).

Generally the women in the study described themselves in terms of personal characteristics, qualities or dispositions which emerge from social experiences (Rosenberg, 1979) rather than in terms of social roles and identities which are defined within a particular society (Bengtson et al., 1985; Rosenberg, 1979).

**The desired self**

Rosenberg (1979) argued that the desired self (how one would like to see one’s self) is the reference point against which the extant self is viewed and judged. In order for change to occur in the self-concept there must be a discrepancy between the desired and extant self. One strives to become more like one’s desired self.

He *works* [italics added] to become a ‘better person’, *strives* to realize his ambitions, *struggles* to censor his unacceptable impulses, *selectively directs* his efforts in the immediate situation or in the long run to converting the self he wishes to observe or to maintaining a desired self against the forces that threaten to blemish it .... *much of human behaviour is motivated by the wish to attain, to maintain or to retain a desired self.* (Rosenberg, 1979, p. 45)

The desired self includes the idealized or ultimate image, the committed image or the self-picture we take seriously, and the moral image or what we feel we must, ought or should be. As one strives to attain one’s idealized or ultimate image, there may be feelings of strain because the standards against which one is judging oneself are difficult to achieve. The result may be self-contempt (Horney, 1945 cited in Rosenberg, 1979). The committed image is the self-picture which is taken
seriously. One usually compares oneself to this image which may be well within one's reach. It is the striving to meet this committed image that creates change in the extant self. The moral image, which is what one feels one must, ought or should be, has three aspects: conscience which is associated with norms of morality; role demands which prescribe those activities required of one occupying particular roles; and personal or idiosyncratic self-demands. Inability to meet this moral image may lead to guilt, shame and ultimately self-condemnation (Rosenberg, 1979). As noted earlier Rosenberg argued that “the gap between the extant self-concept and the desired self (idealized, committed, moral) is thus a source of perpetual concern to the human being” (p. 44).

Markus and Wurf (1987) conceptualized the desired self as “possible selves” and added another dimension to the concept. In addition to possible selves being the selves one would like to be, they added the dimension of selves that one is afraid of becoming, the feared self (Markus & Herzog, 1991). This concept is useful when considering the self-concepts of people who are aging and have chronic illnesses. The individual may wish to narrow the discrepancy between the extant self and the desired self or increase the discrepancy between the extant self and the feared self (Markus & Herzog, 1991).

The presenting self

One of the goals of the presenting self is “impression management” (Goffman, 1956) through which one controls one’s actions in order to act in accordance with the type of person one wishes to appear (Rosenberg, 1979). There is a need to establish and present a self that is in keeping with one’s extant self. Therefore, the individual presents a self that is within her control. The response of others is required to confirm one’s extant self. Rosenberg suggested that there are several objectives for presenting particular selves: social approval (this may require that with different types of people we must present different selves to gain their attention), validation of the extant self (selves are presented to confirm a self-picture or test a self-hypothesis--a favourable impression made on others produces a favourable impression on ourselves), and conformity to social norms and rules (we act in certain ways in our society based on learning what is appropriate behaviour). Although there is a greater variability in the presenting self than in the extant and desired selves, there is a core of self-presentation that is trans-situational (Rosenberg, 1979).

Generally people select presenting selves that are functional as well as “comfortable and congenial, suited to their dispositions and consonant with their extant self-concepts” (Rosenberg, 1979, p. 50). Thus, the presenting self includes what the individual does to convey a particular self to others and how the individual thinks others perceive her. In this study, I focused on how the women think

14 There is another objective for presenting particular selves to others described by Goffman; that is, that people present selves to get their own way. If I can get you to see me in a particular way, then you will treat me in a certain way. We present a self to pursue our own interests.
others perceive them.

The extant, desired and presenting selves will be considered in the three groupings of women: those women with competent selves, with contradictory selves and with ineffectual selves.

**The Competent Self**

The women in this group (n = 12), whom I have identified as presenting competent selves, described themselves (i.e., extant self) in very positive or affirmative ways using words such as, busy, happy, lucky, fortunate, blessed, active, strong, caring, and optimistic. They portrayed themselves as having an enthusiasm for life. They had favourable opinions of themselves and were outgoing and independent. They were self-assured, content and satisfied with themselves. They had good relationships with others. Work, either paid or unpaid, gave meaning to their lives. Some described an inner strength or peace, a spiritual aspect in their lives. Generally, they emanated self-confidence. They seemed certain that they could overcome obstacles and exert personal control over their lives. They seemed to have attained a balance in their lives between doing things for others and doing things for themselves.¹⁵ For example, one woman described herself in an affirmative way, that is, as happy, as strong, as having a sense of humour and as being very active. She had good relationships with her children. She was divorced and had maintained a friendship with her ex-husband. She had many friends who lived all over the world with whom she had continued to be in touch and visit over the years. She summed up her feeling about herself as a person by saying:¹⁶

*Life is good now. I’m a happy person …. I believe I’m a strong person. …. I’m pretty serious but I have a excellent sense of humour which is good and that’s got me through a lot. Ah what else can I say. I’m generous, very generous and kind …. I’m complex I guess. I’m very friendly and yet I’m very shy. On a one to one I’m fine, but put me in a group and I just clam up. I’m very active--what you call an A [type] personality I think. I just never stop …. I’m so lucky ah I mean I’ve got friends from high school …. long lasting friendships …. I’m lucky because I have a zest for life. (P210, age 63)*

Her zest or enthusiasm for life was characteristic of other women in this group as well. Another woman, who held favourable opinions of herself, described how content she was with her life, in particular her health, her family life and her friends. She considered herself to be very fortunate. In the face of challenges that came along, she was confident that she could exert personal control to manage them and put them into perspective relative to the rest of her life.

¹⁵ Women with competent selves had the highest scores of the three groups on Ryff’s (1989) scale of well-being (i.e., subsections on environmental mastery, purpose in life and self-acceptance). This is based on questionnaires being returned by 11 of the 12 women in this group. With respect to overall mental health, seven of 11 reported that they felt neither lonely or remote nor depressed or unhappy while four of the 11 sometimes felt that way. See questions 13m and 17 of the questionnaire.

¹⁶ Throughout this thesis some details about participants’ lives have been changed to ensure anonymity.
P: I'm a very positive person, a very happy person. I think I try and deal with the little things that come along in life in perspective. And I guess I'm more giving you feedback that other people tell me. I'm very happy.
SW: So that's more what people tell you?
P: That's how I feel too. I feel very lucky. I have no health problems that I know of. I have a nice family environment. I'm delighted, of course, with my daughter .... she's ... the light of my life .... I'm very fortunate, I have wonderful friends ... a lot of close friends. (P121, age 54)

Some women described themselves by referring to the social roles they held, for example, wife, mother, grandmother, friend, worker and volunteer. (The importance of paid or unpaid work will be discussed later in this section.) Being a “good” wife and mother provided meaning for some. Rosenberg (1979) suggested that feelings of personal worth often hinge on role models in our society. People hold ideas about the standards that constitute a “good” wife or mother which become the standards against which they evaluate themselves. One woman described herself as a good wife and mother. She had grown up believing that this was her role as a woman in our society and she explained how she felt she had fulfilled her role in a competent way. She felt “blessed” by the resultant satisfying relationships she had with her spouse and children. She said,

P: I consider myself to have been a good wife and a good mother and that's what I was brought up to do and to be. And I think I've done that.
SW: And that’s been satisfying?
P: Yes, it has. And I have a husband who when I wanted to do things like going back to [work] and doing my music encouraged me all the way. But that’s part of my being blessed, isn't it? Because not everybody can say that [they have a supportive husband]. (P109, age 60)

Another woman, who was divorced, recounted how she had handled raising her children herself. Her competence as a single parent had resulted in her feeling particularly close to her children and very supported by them over the years. Their support continued now that she was disabled with osteoporosis providing her with a sense of continuity across her life (Markus & Herzog, 1991). This continuing support led her to describe herself as “blessed”. She said,

I raised three [children] by myself .... I did a lot of things with my [children]. We had a lot of fun together, let's put it that way. To me it wasn't difficult raising them by myself--it was fun. We did things together and I guess I’m reaping the rewards of that now because we're very close .... I'm very blessed that I have three great [children] who are supportive. (P127, age 58)

“Feeling blessed” may relate to ideas of being fortunate, lucky and grateful or it may confer a religious or spiritual aspect to the lives of some of the women. The importance of the spiritual aspects of the lives of the women in this study will be discussed later.

Other women talked about being content with their lives, a realization of being satisfied with themselves and their reality. They described their feelings of optimism (i.e., they referred to optimism as a characteristic of themselves). One woman, when asked "What would you say are
your strong points?", talked about her optimism and her confidence that she could manage challenging situations as they came along. In addition to her feelings of personal control, she also discussed feeling content to be on her own and feeling satisfied with the simple things in life.

Oh, [I have] patience, maybe optimism and ... I can usually find something positive in a downer situation or an ability to accept it until the positive things come along .... Perhaps I'm content to be on my own. I don't have to have a lot of external stimulation or a very busy stimulation. I don't need a lot of people contact to give me pleasure and so when I don't have that, like if there's a bad day [this is related to winter weather] and I have to stay home, that doesn't really upset me particularly. I guess a sense of humour and simple things give me pleasure. I don't have to have something very exotic to interest me or satisfy me. That's all I can think of. (P122, age 66)

Some women clearly stated that their optimism was not idealistic but realistic. One woman asserted that her optimism did not mean that she thought her chronic illnesses would get better but rather that she had not put her life on hold because of them and she continued to plan for the future despite her physical limitations. She described how she had become stronger because of having to manage significant life events, such as the Holocaust and loss of her immediate family, the recent death of her husband, the ongoing care of an adult child with learning problems and her own chronic illnesses. Despite these life events, she had maintained her sense of humour, her ability to laugh at herself.

[I'm] an optimist but a realist .... I'm not an optimist to the point of thinking that everything is going to be fine. I know that osteoporosis doesn't get better .... I guess [I am strong]. Out of all the things that I've gone through I'm still having my sense of humour, so I can still laugh at myself and the rest of the world. (P203, age 64)

The importance of life events in how the women in this study saw themselves in the present was a theme among the women's descriptions of themselves. Markus and Herzog (1991) argued that, while people may experience the same life events, they respond to these events in dissimilar ways. An event's impact on an individual is related to whether the event is relevant to the individual and to how it is interpreted and given personal meaning. Markus and Herzog asserted that the self-concept integrates one's experiences across time and provides consistency and interpretation to the experiences. The challenges that some women with competent selves had faced in the past had been important stimuli for change and growth--change and growth that they felt had provided them with skills to enhance their mastery of situations they found themselves in now. One woman, who had been divorced and had multiple surgeries because of her osteoporosis, talked about the learning and growth that had resulted from her life experiences. She felt these had made her stronger and more able to master situations that might arise in the future. She said,

17 Although the focus of the first part of the interviews was on self-concept, the women in the study were aware of my interest in osteoporosis. Thus, a few focused their discussion on their chronic illnesses despite my attempts to emphasize self-concept more generally. This may have resulted in an over-emphasis on the importance of osteoporosis for these women.
I bounced back from some bad things that have happened to me in my life, learning from them I think and being stronger. I'm not a depressed person, I might have a bad day. But I [know] ... a lot of people who have bad days or weeks .... I never have that. I just am not that kind of person. (P210, age 63)

Another woman, who described herself as sickly from the time she was a child and now had epilepsy as well as osteoporosis, said, “Despite the stuff I've gone through, I think that I'm remarkably cheerful.” (P209, age 65). Her mastery of previous situations allowed her to deal with current limitations imposed by chronic illness and maintain a lighthearted, positive outlook on life. Another women spoke about how she thought she had changed over the years because of her life experiences which included divorce and raising her children as a single parent. She had been forced to become more independent and outgoing. These events had resulted in the development of new qualities that had broadened her ability to participate in new activities (Breytspraak, 1984) and she was currently involved in establishing a self-help group for women with osteoporosis. She said, “I'm outgoing, I wasn't always. I got that way after the divorce. And independent, definitely.” (P206, age 61).

As mentioned previously, some of the women (5 of 12) described themselves as having a spiritual side to their lives which made a difference in how they perceived themselves and how they managed their lives on a day-to-day basis. For some, this spiritual aspect had been important throughout their lives, providing continuity over time (Kaufman, 1986). One woman talked about how retirement had given her more time to meditate which in turn had given her “an inner peace and stability and [had led to her] spiritual growth". Her life was full as she participated in valued activities.18

I think of myself as a well person who is a member of a large family, somewhat reduced now but still very close to family, very involved in my parish life and very conscious of the spiritual side of life. I've had an interesting work life and now that I'm retired, I'm enjoying all the pleasures of retirement very much. I'm a person who likes a fair bit of quiet time and that's probably a little bit because I have lived alone for quite some time ... but I enjoy things that I can do on my own .... I'm very conscious that life is something temporary and to me it's a journey back to God and I try to live my life that way. Now that I have more time to devote to it, I spend more time on spiritual things and I'm part of a very active ... parish where there are lots of activities just there waiting to become involved in. (P122, age 66)

The women who engaged in full or part-time employment (4 of 12) described work as an integral part of how they perceived themselves. Work provided them with rewarding experiences that shaped their ideas about themselves as competent workers. One woman described how

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18 This woman's ways of talking about herself in the qualitative interview was reinforced by her high scores on Ryff's (1989) scale of well-being particularly on the dimensions of environmental mastery (has a sense of competence in managing the environment, makes effective use of opportunities, chooses and creates contexts suitable to personal needs and values) and purpose in life (has goals in life and a sense of directedness; feels there is meaning to present and past life; holds beliefs that give life purpose; has aims and objectives for living).
enjoying her work had a positive impact on her mental outlook--work was not a burden but rather brought her a great deal of fulfilment.

Work is good, I enjoy my job ... [I've been] nine years in this job .... And I think [enjoying my work] helps, like your mental outlook ... it's not a chore to get up and go to work. And we're very busy [lowers her voice tape unclear; elaborates on work environment] ... when you have nice working surroundings ... it's not a chore. (P108, age 59)

Another woman described her career as a social worker. While currently she was working within a private social service agency, she described how much she had enjoyed her various jobs over the course of her career. Her career provided her with focus and meaning in her life. She said,

At that time [in the past], I had a fabulous job .... I used to whistle on my way to work I was so happy .... I truly love my [current] job. I really love my work .... I work well under pressure for instance. I thrive on that, I thrive on having something to look forward to all the time. (P210, age 63)

Those not in the paid workforce described how volunteering, church activities, self-help or support group activities defined how they viewed themselves as committed volunteers (4 of 12). These activities kept them engaged as participants in their communities. One woman said, “It's a great community life .... it's a very active life .... I like people, I'm sociable. I always entered into everything, I was into committees at the club” (P202, age 80). Another woman, who described herself as having a great deal of energy talked about herself as a “people person”. She described how this had drawn her to particular volunteer work and paid employment and how she has continued to be involved in activities involving people now that she had retired. Her competence as a volunteer had led to her employment in an agency providing an information referral service. This continued involvement in helping others provided her with a consistent picture of herself over time (Markus & Herzog, 1991). She said,

I have worked in social services, information referral services ... the [local mental health facility] decided to do a 5 year pilot project and they set up an information referral service and I was one of the first [people] there as a volunteer .... I'm always interested in information and referral services and public relations, those are the two fields--and sales. I've always been a people person. I've never had a job where I haven't had contact with the public .... [since retirement] we started [a support service for older adults] which is a very big operation today .... through that I ran fund raising programs ... for 12 years. (P118, age 71)

Those who had given up paid work or volunteering (3 of 12) due to physical limitations anticipated their return to such activities in the future. These activities had provided them with a sense of accomplishment and reinforced their view of themselves as capable workers or volunteers. While for some women a return to these activities may not be realistic, they continued to describe themselves relative to these valued activities and their plans for the future included a return to these activities. One woman who had given up her job because of health problems spent a great deal of time during the interview talking about her life as a teacher and its importance to her despite my
attempts to move on to other topics. She described in detail the various teaching positions she had held over her 20 year career. Being a teacher was still very much a part of how she saw herself (P203, age 64). It provided her with a sense of continuity and competence that was in contrast to her current situation and the physical limitations she was experiencing as a result of her osteoporosis. Another woman, who was very disabled by pain and limited mobility, felt confident that she could overcome her disability to return to volunteer work she had done previously. This work had made her feel valued and worthwhile in the past and she looked forward to becoming involved in it in the future. She said,

Like my goal now is to get myself strong enough and feeling well enough that I can give a day down at Princess Margaret [a facility providing care to people with cancer]. I'm very good with hair and makeup so I like to donate a day a week down there doing that and that makes me feel good and maybe helpful. I understand they do have a special room and place where they do this now, so I'd like to go down and do this. (P127, age 58)

When asked what they would be doing in the future, women with competent selves said that they wanted to continue doing the same things they were doing now. They were content with the way they were currently living their lives and saw no need to change. They wanted to "keep going" and remain active. They continued to plan for the future. Their extant and desired selves were very similar and they did not see the necessity to modify their lives to any great extent. They seemed to compare their extant selves with their committed images which were within their reach rather than their idealized images which may not be attainable (Rosenberg, 1979). They seemed to maintain a consistent self-concept.

Staying the same age was often the response the women in this group gave to the question, "If you could stay the same age, what age would you choose?". They were happy with their current age. Their lives were filled with meaningful roles and activities that they wished to maintain. One woman said "Right where I am. I don't want to become 80 (LAUGHS). I like being 78" (P107, age 78). Another woman said, "Oh, I'd say 67 [her current age] .... Yes, I am [happy], yes, 'cause I'm retired. Oh, I could go back a year, 66. I'd still be retired then." (P123, age 67). Aging had its rewards. For some, it was being retired. For another woman it was saying "no" when people asked her to get involved in projects in which she had no interest.

Seventy-one ... it isn't a bad age, no. It's a more relaxed age. You've got time to say "no" if you don't want to do anything. If you want to get involved you can but it isn't the end of the world to say "no" any more to somebody who wants you to volunteer for this or that. (P118, age 71)

Continuing to perceive oneself as a competent worker or volunteer was one of the themes that emerged in the data from this group of women with competent selves. They wished to continue working as long as possible to maintain their extant selves as competent workers. Their committed images included their continued involvement in paid and/or unpaid work.
When asked what she would be doing in the future, one woman, who had previously talked about how much she enjoyed her work and described its importance to her well-being, said, “I’ll probably work up until I can’t work any more because I’ve got to be doing something. I have to keep going” (P108, age 59). Work provided her with enjoyable experiences which she thought were important to her positive mental outlook and led her to see herself as a competent worker and, we may infer, bolstered her more general view of herself as a competent person. She hoped to continue to lead an active life which included work and leisure activities. But she also expressed some fear or uncertainty about the future when she said “So I am just hoping that I can keep going. I might work [until] 65, 70” (P108, age 59). Although her extant and desired selves were very similar, she did express some concerns about her future. This may reflect the discussion by Markus and Herzog (1991) about possible selves and, in particular, feared possible selves. While people may struggle to narrow the discrepancy between the extant and desired or possible selves, they may wish to increase the discrepancy between the extant and feared possible selves. This woman expressed her desire to be a competent worker but she feared the disabling aspects of osteoporosis and wondered what its impact would be on her future as a worker.

Similar to the women in this group who worked for pay, those who volunteered also wished to remain engaged in this valued activity. Their committed image included seeing themselves as competent volunteers. One woman, when asked what she would be doing in five years, responded by discussing valued activities in which she was engaged. She said, “Travelling .... and also my volunteer work. I think volunteer work is very good for you and I think it helps to keep you young” (P109, age 60). She continued to be involved in a number of volunteer activities and compared her commitment to volunteering to a full-time job. She described how her interest in people had led her to volunteer with Meals on Wheels, at a home for the aged and a community health agency. Volunteering was an integral part of how she talked about herself and she remained committed to an image of herself in the future as an active volunteer involved in her community. Throughout the interview, she avoided any discussion about limitations she might be experiencing as a result of her osteoporosis. Rather she maintained a view of herself as active and involved in a variety of valued activities. She would participate in these valued activities in the future.

Maintaining a view of oneself as healthy was part of the desired self of women in this group. One woman, who characterized herself as having a high energy level and as being very active, hoped to stay healthy. Despite her osteoporosis she was committed to her self-picture as healthy and

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19 The link between the desired self (how one would like to see one’s self) and questions about the future are supported by the work of Hooker and Kaus (1994) as well as Markus and Herzog (1992). They described possible selves as “positive images of self in the future” (p. 126). They also argued that possible selves are “not simply global, vague wishes or concerns for the future; rather they are durable aspects of consciousness that give meaning to the future” (p. 127).
wished to stay that way in the future. “I would hope that I would continue in good health because I’ve been very lucky and I don’t think I’d be too patient with being restricted a lot” (P121, age 54). She had a busy social life, participated in an exercise program and worked part-time. As discussed above, Markus and Herzog (1991) have suggested that as people age there is a shift in focus to “preventing feared possible selves, such as illness and dependency, from becoming realities” (p. 117).

Continuing to see oneself as independent was another aspect desired by women with competent selves. One woman, who was currently living with her daughter because of her disability, when asked what she thought the future held for her, talked about her wish to live independently again. She had been very active, involved in her community and volunteer work prior to having spinal fractures as a result of her osteoporosis. She missed living in her own house and wanted to get back to her hobbies. When she originally moved in with her daughter, she had been very limited by the recent fractures. But now she was able to manage day-to-day activities on her own and used a scooter to move about in the community. Living on her own again seemed like an attainable goal. She was confident that she could achieve her committed image and narrow the discrepancy between her desired self and her extant self as an independent person. She said,

P: I hope to get my own apartment and just be some place round here to be close to the family. I’d love my own place again, I miss my home.
SW: So do you have any concerns about the future?
P: No, not really. I’m quite content and happy.
SW: What sort of things do you look forward to?
P: Well, I would like to have my eyesight a little better because ... this is my hobby up here [indicating stained glass pictures] .... I do a lot of sculpturing, busts, heads and those are the two main [hobbies] and both of them take a fair amount of time [and good eye sight]. (P202, age 80)

When asked “If you could live your whole life over again, what would you do differently?”, this same woman talked about how content she was with her life. Despite some hardships over the years, she felt she had had a satisfying life. There was no need for her to contemplate a different life. Her extant and desired selves were closely aligned.

P: It’s funny that’s something you often say, that you’d like to start all over, but I wouldn’t want to start all over today. No way, no, I’m quite happy with my life. I’ve had a good life. It’s been a hard one but I’ve enjoyed it.
SW: Hard in what way?
P: Well, sickness and one thing, you know, family, and when you try and bring up a youngster, and work all day, and fortunately I had my mother with me so she was at home. You work hard most of your life. (P202, age 80)

The women with competent selves described presenting selves to others which were closely aligned to their extant selves. The feedback they received from others reinforced or confirmed how they wished to see themselves. While there is some variability in how they presented themselves to others, there seemed to be a core self across interactions with others. As Rosenberg (1979) has
argued, they presented particular selves for social approval, for validation of their extant selves and for conformity to social norms and rules. When asked how they thought others would describe them, the women in this group used words that they had used to define themselves (i.e., words like fair, honest, active, involved, thoughtful, stable, reliable, and supportive). They talked about presenting selves that were in keeping with their own ideas about themselves as competent. They respected themselves and accepted themselves as they were and felt that others viewed them in similar ways. One woman said "I think probably [others would describe me] as somebody who is stable and patient and reliable and hopefully a good friend, supportive of people ... if I make a commitment I would very seldom break that commitment" (P122, age 66). This latter comment about commitment may reflect Rosenberg's conformity to social norms and rules: we act in certain ways based on societal expectations. Making a commitment and then keeping it would be such an expectation within our society. This woman reported that over time she had received feedback from others that had been positive and similar to her self-picture. This led to a match between her extant and presenting self and illustrates Rosenberg's validation of the extant self, a favourable impression on others results in a congruous self-picture.

Other women with competent selves also related how others perceived them in terms that validated or reinforced their extant selves. One woman talked about how her sister would described her as a "shopaholic", someone who was out to find a bargain; as "opinionated ... generous (PAUSE) you know giving money or time .... (PAUSE) laid back in a lot of ways" (P128, age 64). She had characterized herself in similar ways. Another woman recounted what her friends said about how she managed her pain and osteoporosis. She said,

Oh, I think that they always say, I can only speak of the women in this building, and the couple of men who are friendly and nice--um, "you always have a smile on your face even though we know you went through a rough summer" .... the people here, my friends would say, regardless of my pain I always have a smile on my face or a smile in my voice or whatever it is. (P209, age 65)

She had also portrayed herself in similar ways. She was able to substantiate or validate her extant self through feedback from others about her presenting self. "The responses of others are required not only for confirmation but for lifelong reconfirmation of our working self-hypotheses" (Rosenberg, 1979, p. 49).

Some women with competent selves discussed the variations in the selves they presented in different situations. Their perceptions of how others would describe them are supportive of Rosenberg's (1979) ideas about the presenting self. He maintained that the presenting self is not the same in all situations; rather, we present different sides of ourselves to our family, to friends and to acquaintances (James, 1890 as cited in Rosenberg, 1979). However despite these different sides of ourselves that we present to others, there is a more or less consistent self we present but this is more variable than the extant or desired selves. One woman reported how she thought her family
saw her, which was different than how her friends and fellow volunteers would portray her. She thought her family saw her in a similar way to how she perceived herself, proving validation of her extant self:

I’m very fair .. I’m a listener, I listen to what people have to say. I am not afraid to make a decision. And I’m very forthright. But this is [how I present myself] in the family .... which is not the same necessarily as ... a person outside the family would see [me]. (P109, age 60)

She thought that others outside the family, while seeing her in similar ways, would also view her differently. She explained how she thought a close woman friend would describe her. In addition to being honest and forthright, she thought her friend thought of her as “strong”, a term she did not use in characterizing herself nor a term she used when explaining how her family would see her. Being strong may represent a characteristic that is important to her friend and thus, fulfills the objective of social approval (i.e., presenting different selves to different people to gain their attention) suggested by Rosenberg (1979).

She sees me as being a very honest person and very forthright. Yes she would think that. She thinks that I am very strong. I don’t necessarily see myself that way but she thinks that I am strong and if I am asked I don’t hesitate to give my opinion providing I’m asked. (P109, age 60)

While presenting a core self across most situations, she did recount how she presented a somewhat different self in some situations. The self she presented to the women with whom she volunteered was different. She felt that they did not know the “real me”. Rather they had a limited view of her, a view that she controlled by remaining somewhat aloof from them. Rosenberg (1979) argued that the presenting self is the “product of intention and decision” (p. 50). The self we present to others is under our control.

I think that generally people like me ... I feel it .... And in a sense perhaps because I don’t allow people to get too terribly close to me, maybe they don’t know the real me, I don’t know .... once again is it shyness or is it the private person in me? .... they don’t know what’s going on inside. I’m a sensitive person and I tend to think of that when I relate to other people. Whereas I would chastise our children I don’t feel I have any right to chastise people I work with as a volunteer, let’s say. And that isn’t the real me then, is it? Whereas as a working person and I’m running something that’s different. That’s my job to do that but it’s not my job as a volunteer to chastise or tell people what to do. (P109, age 60)

This woman’s presenting self also seemed to reflect her need to conform to social norms and rules when she discussed how she saw her relationship with the women with whom she volunteered. A supervisory role with employees was different than her association with volunteers. The latter relationship did not allow her to have any control over the work done by her fellow volunteers even when she may be in an position that required that certain tasks needed to be accomplished to fulfill expectations of the organization. One is not able to be critical of the work of other volunteers in the same way that one might be able to reproach employees or family members. Presenting oneself as a competent volunteer requires displaying a self that meets certain social norms and rules.
In summary, women with competent selves characterized themselves in very positive, self-assured ways. They were optimistic and had an enthusiasm for life. The self-respect they had for themselves led them to describe a confidence that they could overcome challenges and exert control over their lives. Their lives were balanced and full of valued activities. They were happy to continue as they were, doing what they were doing. Their extant and desired selves seemed to be closely aligned and their committed images seemed to be within their reach. When asked how they would like to see themselves, they wished to maintain their extant self by continuing to perceive themselves as competent, that is, as working or volunteering, as independent and as healthy. Despite their usual views of themselves as competent and their expectations that these concepts of themselves would be attainable, these women did mention feared possible selves; in general, however, they felt capable of maintaining control over their lives in the future despite the onset of aging and chronic illness. Their committed images seemed to be within reach. They were very confident that others would describe them as they had described themselves. They spoke of their presenting selves in ways that would suggest close alignment with their extant selves, presenting selves that were comfortable and compatible with their extant selves. They received feedback from others that validated the views they held of themselves as competent. While generally they displayed core selves across situations, there were some variations. These different presenting selves were often revealed in different situations for social approval or to conform to social norms and rules.

The Contradictory Self

In contrast to the women just described who generally talked about themselves using very positive terms, who seemed self-assured and who recounted how content and satisfied they were with their lives, there were other women who portrayed themselves in contradictory ways \((n = 8)\). These women have what I have termed “contradictory selves”. On the one hand, they talked about themselves as busy, caring, confident, happy, lucky, outgoing and strong-willed. On the other hand, they also characterized themselves as anxious and stressed, as needing support and reassurance from others, and as having little time for themselves. They seemed to be striving to do more despite describing feelings of burden and resentment about the expectations of others. They seemed to be struggling to maintain a balance in their lives but continued to have difficulty saying “no” when asked by others to take on additional tasks. This lack of consistency in how they described themselves may indicate that, while they have ideas about how they want to or should behave (i.e., their desired selves as strong, as caring, and as getting along with others), when they judge themselves (i.e., their extant selves) against these standards, they find themselves wanting. They need endorsement and encouragement from others. They are overwhelmed and annoyed at having to provide care to others. They feel stressed by the need to monitor their behaviour while with others. Rosenberg (1979) has argued that the gap between the extant self and desired self may be “a
source of perpetual concern” (p. 44) to the individual. One may feel driven, strained and frustrated in one’s attempts to live up to an idealized or moral image. Failed attempts to live up to these images one has for oneself may lead to pathological consequences of self-hatred and contempt (Rosenberg, 1979). In the context of this study, some women expressed low self-esteem or feelings of self-worth about what they were able to do within the constraints of other commitments and their health. Some also voiced concern about their inability to control their lives and the things that happen to them (Rosenberg, 1979). The quotations that follow illustrate how they described themselves and the contradictory nature of their self-conceptions.20

One woman, when asked how she would describe herself as a person, depicted herself as happy, outgoing and having strong beliefs but also as needing reinforcement from others for the decisions she makes. She said:

I would say I am quite realistic. I tend to be happy .... I am outgoing, I do show my disappointments. And need people .... in terms of support. You see I quite often need reassurance. I have strong beliefs but I do need reassurance. I have to talk it out with someone, when the problems arrive and that sort of thing. (P114, age 66)

When asked about her strengths, this same woman revealed how she has strong beliefs which she holds “more or less” constant. This qualifying comment about the strength of her beliefs corresponds with her next comments about her self-doubt and lack of self-confidence and conveys a tentativeness to her ideas about herself and her lack of ability to reconcile how she sees herself and how she would like to be (i.e., her extant and desired selves).21 She said:

P: Oh, my dear, I don’t analyze myself that much. My strong point is that I am more or less constant in my beliefs, that would be my strong point. And again, how would I say, I tend to judge myself. You know I don’t come to any decisions or any beliefs without thinking it over first and I believe that is my strong point. And my weakness is that I tend to doubt myself.

SW: So if you were making decisions you would have doubts about whether those were the right decisions?

P: If I allow myself to doubt I would go really--so lately, since I have realized that I have tried to keep out of doubting myself. In other words I need more self-confidence. That’s about it. (P114, age 66)

While aware of her feelings of self-doubt and of her need to be more confident, she continued to

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20 Their scores on environmental mastery, purpose in life and self-acceptance from Ryff’s scale of well-being fell between those with competent selves and those with ineffectual selves. While three women reported that they felt neither lonely or remote nor depressed or unhappy, five women felt that way sometimes.

21 The ambivalent way this woman talked about her self was reinforced by her lower scores on Ryff’s (1989) scale of well-being particularly her on the dimensions of environmental mastery (has difficulty managing everyday affairs; feels unable to change or improve surrounding contexts; lacks sense of control over external world) and self-acceptance (feels dissatisfied with self; is troubled about certain personality qualities, wishes to be different than one is) but her higher scores on purpose in life (has goals in life and a sense of directedness; feels there is meaning to present and past life; holds beliefs that give life purpose; has aims and objectives of living).
strive for the self-confidence that would allow her to make decisions in accordance with her beliefs. Rosenberg (1979) has described self-confidence as the anticipation that one can successfully master challenges or overcome obstacles, as the belief that one can make things happen in accordance with one’s inner wishes. Self-confidence results in an individual becoming an active agent in her own life, competent and displaying an internal locus of control. This woman’s lack of self-confidence led to her inability to take action based on her strong beliefs, a situation that led her to see herself in discrepant ways.

Some women (4 of 8) talked about being very busy but this often resulted in their overextending themselves and having little time for themselves. Being busy meant an active life involved in valued activities that, on the one hand, gave them a sense of accomplishment and success but, on the other hand, left them fatigued and required that they give attention to the limitations imposed by chronic illnesses. Being busy was exhilarating and created a positive sense of self but made them aware of the restrictions brought on by aging and chronic illness producing an ambivalent sense of self. One woman, who recently retired, described how involved she was in volunteer work to the point where she felt tired. She realized that she needed to hold back or she would continue to be asked to do more. However, she had created a dilemma for herself. She enjoyed her involvement in her volunteer work but she was tired and felt she had over-extended herself. The demands of others to be involved in more activities seemed to play a role in how she talked about herself. She was unable to maintain a self-picture of herself that included the energy to do all the things she would like to do or that others wanted her to do. She said,

Now I’m doing volunteer work at the art gallery and leading ... a very busy life .... like anything else you take on it turns out to be much more involved. If you show the least interest, well then they [ask you to do more]. I’m serving on the executive and so there’s a training session tonight for volunteers I have to be involved in and then I have to go to executive meetings and then I do my day [at the gallery] on Wednesdays .... I do enjoy it, but I sometimes get too tired and think I’ve over done it, because I’ve also joined a volunteer committee of [another community agency]. It’s quite a busy time. But I do like it. But you just have to hold back sometimes because people ask you to do more things all the time (LAUGHS). (P116, age 65)

Another woman, who worked part-time, was also very involved in volunteer work. She enjoyed her commitment to volunteerism but at the same time she often found it overwhelming. She never completed one task before moving on to the next, a situation that she found frustrating but that she was unable to change. Earlier in the interview she referred to herself as a “perfectionist”, as someone who had always strived to have everything perfect. This striving resulted in living her life at a hectic pace, a situation that led her to feel ambivalent and hopeful that one day she would have time to “sit back” and relax. She said,

I’m busy, busy all the time. I never seem to have any free time. I do work part-time at a few different little things but I am also involved in a lot of things that I don’t get paid for (LAUGHS) .... I have piles of [papers] at home ‘cause I come home from one thing and I
dump the [material]. And it would be nice to sort them out and put everything where it goes and sum up something and throw out the excess but there isn’t time. You got to get on to the next project. That’s the story of my life. I’m running, running, running and I’m always saying “Some day I am going to have time [for myself] to sit back”. (P103, age 59)

At times being busy involved caring for others but this could also become a burden. The same woman continued by talking about wanting to help other people and about her involvement in caring for neighbours and family who were elderly. She described the ambivalence she felt towards those people for whom she provided care. While she described herself as a caring person, she expressed her resentment for the situations in which she often found herself but she seemed unable to change her life to take more time for herself. She seemed unable to overcome her commitment to others and to control her own life or “be an active agent” (Rosenberg, 1979) in her own life. Her selflessness resulted in her describing herself in disparaging ways: as a “sucker” who allowed people to “walk over” her. Although she stated that she was learning to overcome this situation by saying “no”, nothing in our conversation suggested that she had accomplished this yet. It may be that her moral image of herself prevented her from taking action to change her commitments.

I’m a sucker for helping the neighbours whenever anybody wants or needs something. I look after half of the elderly people [in the neighbourhood] .... I’m looking after my [step-mother] now too because her own [children] can’t be bothered. I’m spending about 15 hours a week [with her] .... This is where I will be going when I leave here. I was just at her bank before I came here to look after things. It’s just, I don’t know, I would like a little more time for me .... I say "yes" too quickly but I am learning to overcome that one .... I could never say "no" to anybody but I’ve learned that I’ve got to say no sometimes because I can’t take on everything everybody asks me to do .... I let people walk over me a lot. But again I’m learning. I’m finally learning. I’m getting close to 60 and I’m finally learning to not let people walk on me (LAUGHS). (P103, age 59)

Busy lives also often led the women to describe themselves as stressed. One woman portrayed herself as goal-oriented now that she was retired and working on some home renovations. But she also related how this resulted in her placing herself under stress as she had done when she was working. While she recognized that this stress was self-imposed and that maintaining a balanced life was important, she did not take time out of her busy schedule to alleviate the stress. She said,

I have my mind on a goal ... I was like that at work too. I would zero in on a goal and just work, sort of tense myself up actually and that’s another thing, at work, I put myself under stress. You know there was work to do so I did my best to do it. But I would advise other people not to do that (LAUGHS) .... I was doing secretarial work .... I had about five or six people asking me to do things and you had to juggle, decide which was most important and try to do them all actually as fast as possible. So as I say I put myself under stress and didn’t relieve my stress enough .... like hiking on the weekend or something like that would have been good for me. (P123, age 67)

She continued to discuss how stressful she found interacting with other people and ultimately how she felt that the stress she had been under from various causes had contributed to her developing osteoporosis. She attempted to make sense of her osteoporosis by reviewing her biography. This
may reflect Williams’ (1984) discussion of narrative reconstruction in which people attempt to reconstruct the past to give meaning to the present.

P: I am the type of person who tries to get along with people and that is stressful as far as I’m concerned. I stress myself, I try and get along with people [tape unclear] .... I have a seemingly stressful body. I suppose it’s sort of intrinsic, you know. Maybe it’s a build up of all the years. I don’t know, maybe it’s because of menopause, because I don’t have the estrogen in my system, who knows? ....

SW: What do you think caused your osteoporosis?

P: Lack of exercise and stress I think. I think it’s stress. As I said before, [stress] is a very bad thing with people. (P123, age 67)

When asked questions related to the desired self, women with contradictory selves often talked about how they would like to change some aspects of their lives. When describing their extant selves, they discussed their struggle to maintain a balance in their lives. They were often involved in situations where they felt burdened and resentful of doing things for others while not having enough time for themselves. Thus, when asked what they would change in their lives, they often mentioned being busy. They wanted “more time” for themselves, to be able to say “no” and thus, be less involved in activities that they perceived others wanted them to do. They wanted to “put themselves first”. They wanted to be able to take more control of their lives but they often found themselves in situations where they felt morally obliged to do things for others. Rosenberg (1979) described one component of the desired self as the moral image: what one feels one must, ought or should be. He further delineated three aspects of the moral image as conscience, role demands, and personal or idiosyncratic self-demands. The inability to meet the demands of the moral image can lead to guilt, shame and self-condemnation. This concept of the moral image is evident in conversations with the women with contradictory selves and will be illustrated below.

For some of the women in this group, putting oneself first meant that they wished to alter their role demands, take more control of their lives and consider their own interests rather than the interests of their families although this was in contrast to how they had lived their lives until now. One woman, who had a daughter with special needs and who had cared for her mother after she had a stroke, talked about how she would put herself first more often if she could live her life over again. She would put her own interests ahead of those of her husband and children as well as her mother and sister. She had spent her life caring for others and often felt burdened by the demands of this caregiver role. She said:

I would have more self-confidence, much more. I would be a bit more—not aggressive. Like a little more, I never put myself first before. I believe that is a mistake. [I put] my family—my husband and children and my mother and my late sister [first] .... that’s what I’d change in my life. I would be more, not aggressive, more outgoing for my own interest. (P114, age 66)

Another woman related how she continued to strive for personal autonomy. She described herself as having “periodic depression”, clinical depression for which she had sought professional help over the years. While having been free of depression for some time now, she continued to
challenge herself to change her extant self to be more like the person she would like to be, more able to resist pressure from others. As an example she discussed how difficult she found dealing with family issues and her feelings that she was the one everyone in the family sought out when there were problems. She wanted to be able to withdraw from these conflict-ridden situations but felt obliged to become involved and unable to protect herself from assuming responsibility in these circumstances. While striving to assume more personal autonomy, she was unable to turn down requests from family members without a justification to legitimate her refusal. These contradictions between her extant and moral image continued to trouble her and led to feelings of guilt and self-condemnation, results discussed by Rosenberg (1979).

I find it hard to deal with unpleasant things in the family. I find it hard to stick up for myself. And people keep putting more on me and I'm never very good at handling that--I don't say "no" very well. And I always think I have to have an excuse to say "no", that if I don't have one then I have to make something up, because you can't just say "no" or I think I can't just say "no" (LAUGHS). I can't really do that right now. (P116, age 65)

For others with contradictory selves, putting themselves first meant before other people who were not family. They seemed to be struggling to acknowledge the legitimacy of their own needs. One woman, who was discussed earlier, explained how she had become very involved as a volunteer on a number of committees at her church. She was also called on frequently by her neighbours and friends if they needed help. She felt that she was constantly doing things for others and had little time to do what she wanted to do. She recounted her feelings of guilt if she took time to sit and read a book. She described herself as feeling younger than her 59 years and that others treated her as younger as well. This resulted in others having unrealistic expectations of what she could accomplish in a day. But she also realized that she had unrealistic expectations of herself. These thoughts may reflect Rosenberg's (1979) personal or idiosyncratic self-demands which are part of the moral image. She felt she needed to give some attention to her actual age and pace herself better given that age. She said,

Some day I am going to have time to sit back .... I always volunteered my time for everything. I was always busy, busy, busy, too busy most of the time. And didn't have enough time for myself .... so I don't know, it was always tomorrow and tomorrow and tomorrow I'll get around to doing what I want to do. And now it's well, when I get my house fixed then I'll be able to just sit back ... so I am actually cutting out some things .... I am trying to slow down a little. I'm trying to get rid of some of the things .... some day I am just going to sit back .... And I keep telling myself I have to take some time and sit back and (PAUSE) mentally get myself into the spot where I really am [relative to my actual age]. (P103, age 59)

Women with contradictory selves were often not sure what selves they presented to others. Because they viewed themselves in contradictory ways and there was a discrepancy between their extant and desired selves, impression management was an ongoing dilemma for them. As a result, they did not receive clear feedback from others that reinforced or confirmed how they presented
themselves to others or how they wished to appear. For the most part, there was no validation for their extant selves. But there were some women in the group who felt others would describe them in positive ways that were in keeping with their desired or moral images of themselves. Their need for social approval and to conform to social norms and rules seemed to result in images of their presenting selves as more positive than their own views of themselves.

Initially when asked, some of the women in this group (3 of 8) did not know how others would describe them but with some encouragement and time, they were usually able to respond to the question. They characterized how other people would view them in conflicting ways, similar to the ways in which they portrayed themselves. One woman discussed the discrepancy between how friends and acquaintances might perceive her and how her husband had described her in the past. Her husband had described her as having "an inner strength" when her mother and father died only nine months apart. This attribute of strength had also been mentioned to her by a friend as they discussed her recent surgery for cancer. But she was not sure how the people in her apartment complex saw her. She wondered if people viewed her as strong and self-sufficient or as aloof and unfriendly. This uncertainty about how others perceived her may reflect her own contradictory self-picture and, thus, the self she presented to others. She is unable to validate the positive aspects of her extant self. While she had characterized herself as strong-willed and self-sufficient, she had also talked about the isolated nature of her life. She had lost close friends through death but she had not replaced them with new friends. She had not gone out of her way to make friends. While people in her seniors' apartment had attempted to befriend her, she had resisted their invitations.

I met this woman downtown and she said "Oh we knew that you were strong" .... people are amazed that I came home from the hospital [after surgery for cancer] and didn't have homecare .... but I looked after myself .... Well, this one friend in the building thinks I am just fantastic, that I came home ... didn't have anyone to help me, I did it all by myself .... I don't complain about [the cancer] and I'm going ahead with the [chemotherapy] treatments and doing what I have to do .... I think most people would think that I don't mix very well. That I'm quiet and yet if I was in a group I could talk lots and carry on a conversation. But coming and going, I talk to people when I come in and they talk to me ... and I've gotten to know quite a few quite personally but not to visit back and forth and I guess I like that. I like that privacy .... some people when they get sick get food sent into them. Well that doesn't happen to me. Why? Do I come across as being self-sufficient? or unfriendly? I don't think it's unfriendly but I think maybe I'm self-sufficient. (P107, age 78)

The lack of a consistent or positive extant self resulted in an inability for women with contradictory selves to present a strong self to others. This could create a lack of feedback from others and an inability to validate an extant or desired self. One woman expressed concern about whether others found her difficult to get along with but was able to conclude from the actions of her co-workers that they liked her. Receiving feedback from others that she was liked provided validation of her extant self as trying "to get along with people" despite the stress she felt this effort created for her. When asked how she thought others would describe her, she said:
I really don't know (PAUSE) Quiet, again that comes in. Not having very strong opinions, that's probably another one. I don't know how easy they think I actually am to get along with, I have no idea. Now the people at work, I think they liked me 'cause they gave me a nice party going away and they gave me a nice gift and they keep asking me back to lunches and things and so there must be something about me that they liked (LAUGHS). That's about all I can think of. (P123, age 67)

She had described herself in similar ways and had difficulty describing her extant self including strengths and weaknesses. Without a strong view of herself, it was difficult for her to imagine how others saw her.

Another woman responded to the question "How would other people describe you?" only after I shared some of my own insight into how I think others perceive me.

P: I don't know. I have no idea. No. I don't know (PAUSE) interesting, I never thought about it (PAUSE)
SW: Well, I guess ... something I find interesting is that people see me as very calm and cool and collected, and sort of together.
P: Oh, well the girls tease me .... they call me [Mrs] Fuss because I fuss about everything. But I don't know after that how they feel .... I can be hyper .... I don't know what they say. I've never asked anybody, nobody's ever said (LAUGHS) they've probably never had the nerve to. (P119, age 58)

This lack of feedback from others made it difficult for her to validate positive aspects of her extant self and to reinforce these images of herself.

Women with contradictory selves based on moral images seemed to spend a great deal of time in impression management presenting selves that were in keeping with their desired selves. They felt that others would see them in more positive ways than they viewed themselves. When discussing their extant selves, they had presented contradictory selves but when asked how others would describe them, they thought others viewed them in mostly positive ways. This may be an attempt to bolster their extant selves or to nullify the contradictory nature of their extant selves. One woman, who was attempting to accept her own limitations brought on by osteoporosis, did not present a self who tired easily and needed to take rests during the day; rather, she maintained an image of herself as a very active person involved in proving care for others as well as being very active in the social aspects of her neighbourhood. When asked how other people would describe her, she pointed out the contrasts:

They look at me as being a very friendly person .... I'm always the person to call on if you need something fixed .... people tend to think of me as being this younger-than-I-am very energetic person. They think of me as being so full of energy and racing around all the time whereas in reality I get tired very quickly and I need to rest a far bit. I zoom, zoom, zoom and then I flake [out]. I have to have a good long time in bed at night .... I've got to have a certain amount of rest or I'm just useless. And so although they may see me zoom, zoom, zoom, they may not realize that I go into the house and put something in the oven and sit down for half an hour and look at a book while it's cooking instead of other things I ought to be doing, sorting things out or something ... people think that I have limitless energy. And people always figure that if something goes wrong call [me]. (P103, age 59)
Another woman portrayed herself in conflicting ways when discussing her extant self. While on the one hand she had strong beliefs, on the other hand, she doubted herself. But she seemed to present a very positive self to others, one that did not include her self-doubt. She said,

I think they would describe me as honest because that’s what I am and it comes through. I think that’s my strongest point, that I am honest. Friendly--those who are my friends they like me and there are those that dislike me because of my strong beliefs. (P114, age 66)

Similar to this woman, another woman reflected that others saw her as a source of help, as strong and caring, as taking charge when needed and as always there if family needed her. In contrast, when she talked about her extant self, she disclosed her unhappiness at feeling obliged to become involved in family issues and wanted to be able to remove herself from those situations (P116, age 65).

In summary, women with contradictory selves talked about themselves in discrepant ways. For example, while on the one hand they saw themselves as caring and strong, they also mentioned self-doubt and feelings of burden and resentment about caring for others. As they evaluated themselves, they seemed critical of how they managed their lives and seemed to lack respect for themselves. They engaged in a constant struggle to balance and take control of their lives and seemed to lack the self-confidence to successfully change their lives. They were striving to achieve personal autonomy and striving to acknowledge the legitimacy of their own needs while at the same time feeling guilty and self-critical if they did not meet societal, role or self-demands. They wanted to have more time for themselves, to be able to refuse to do things that were not of interest to them, and put themselves first before family and friends. Their extant and desired selves seemed at odds but they seemed committed to trying to change their extant selves despite the fact that they realized this might be difficult. They were striving to change their extant selves to desired selves, particularly in accordance with their idealized and moral images of what one feels one must, ought or should be. These data support Rosenberg’s (1979) discussion about the moral image. They were often not sure of how others would see them. They did not have strong positive extant selves and as a result did not have clear self-pictures that they presented to others. This, along with the discrepancy between their extant and desired selves, may have led them to present contradictory selves to others. This may have resulted in a lack of validation of their extant selves by others.

Some women depicted presenting selves that were contradictory as were their extant selves. Others presented selves that were more closely aligned with their desired or moral selves than their extant selves. Among the latter, their presenting selves seemed to be related to the need for social approval and to conform to social norms and rules.

**The Ineffectual Self**

In contrast to the ways the women above saw themselves, there was a third way that participants perceived themselves. They had negative views of themselves. Moreover, these women
had difficulty articulating how they saw themselves.\textsuperscript{22} I have characterized these women \((n = 8)\) as having ineffectual selves. One woman, when asked to characterize herself, said, "I can't answer, those questions drive me nuts. I can't." (P115, age 69). Another said, "Oh, my gosh, I don't know." (P111, age 75). With further prodding from the interviewer, they were often able to speak about themselves but were very critical of themselves often using words like inferior, alone, fat, old, depressed, stupid, foolish, when characterizing themselves. They described themselves in terms that would suggest a lack of respect for the self or a feeling of worthlessness. While they were able to discuss their weaknesses, they could not express any strengths. They recounted their inability to master certain situations and the depression that resulted from this inability to change their lives. They spoke of the reclusive nature of their lives and the poor relationships they had with family and friends.\textsuperscript{21}

Feelings of worthlessness were palpable as they described themselves in disparaging ways, as having ineffectual selves. One woman said, "Look at me. I look so fat and old .... I guess I'm sort of dumb" (P111, age 74). Another woman openly acknowledged that her self-esteem was low and that she was depressed.\textsuperscript{24} She said,

I've got fat since I started sitting around doing nothing. My self image is about as low as it can go .... I'm just down to the point where I'm so down and I think, "Oh, geez, you're at the very lowest now" .... I get angry and hostile, part of the depression. (P208, age 70)

Amongst the women in this group, most (7 of 8) responded to the questions in the questionnaire as

\textsuperscript{22} The inability of women with ineffectual selves to describe themselves may be related to two different issues. It may be that their inability to describe themselves may be related to their unhappiness with themselves. Or it may be that certain groups of people are not able to articulate such things which may result in the researcher systematically not hearing their perspectives. The methodology might interact with the social patterning of inarticulation and lack of self-reflection. This will be discussed more in the concluding chapter.

\textsuperscript{23} Women with ineffectual selves had the lowest scores on Ryff's scale of well-being (environmental mastery, purpose in life and self-acceptance). With respect to overall mental health, one woman reported never feeling lonely or depressed, two reported sometimes feeling that way and four women reported being depressed more than usual for a considerable length of time and often or sometimes being lonely or depressed. One woman did not return the questionnaire but during the interview she talked openly about feeling lonely and depressed over an extended period of time.

\textsuperscript{24} This woman's ideas about herself were also confirmed in her responses to the questions in the questionnaire related to Ryff's (1989) scale of well-being. Her scores were consistently low across the dimensions of self-acceptance (feels dissatisfied with self; is troubled about certain personal qualities, wishes to be different than one is), environmental mastery (has difficulty managing everyday affairs; feels unable to change or improve surrounding context; is unaware of opportunities; lacks sense of control over external world), and purpose in life (lacks a sense of meaning in life; has few goals; lacks a sense of direction; has no outlook or beliefs that give life meaning).
being unhappy and depressed more than usual, often or sometimes or openly discussing their depression during the interviews. In his own work on high school students, Rosenberg (1979) found that 80% of those with the lowest self-esteem were highly depressed. Here too there seems to be a relationship between low self-esteem and depression.

Other women in this group (5 of 8) also referred directly to their self-concepts. One woman described the poor opinion she had of herself and why she thought of herself in this way. She felt that her poor self-esteem was related to her childhood and her perception that her mother did not want her. She recalled how her mother had constantly criticized her and favoured her sister. Despite the fact that she was 75 years old, had a family of her own and had worked over the years, she continued to focus on the impact her early life had on her extant self over 60 years later. Rosenberg (1979) has suggested that people develop self-pictures early in life and frequently hold on to these ideas long after the actual self has changed.

I know I try to be nice to people and loving and that but I unfortunately don’t have a good opinion of myself. I think it’s perhaps as a child my mother didn’t want me .... And of course it’s given me an inferiority complex, I think. (P111, age 75)

The fact that these women were able to describe their weaknesses but not their strengths seems to reflect a despairing evaluation of the self, a lack of self-respect, an ineffectual self. The following conversation occurred with another woman after she had stated that she could not describe herself as a person:

SW: What are your strong points?
P: I don’t know. (PAUSE)
SW: Weak ones?
P: Oh, weak ones, I smoke too much. That’s a weak point .... which gets driven home every day for the rest of your life .... Well, [smoking is] more or less a social disaster. I don’t know, I probably have lots of weak points. As you get older you can’t make up your mind about things, this kind of thing. I don’t know. (P115, age 69)

When asked about her strong points, another woman suggested that her difficulty in describing herself was related to being alone and having little contact with others. Self-concept emerges primarily from social experiences (Markus & Herzog, 1991; Rosenberg, 1979). For this woman, the isolated nature of her life led to a lack of opportunity for feedback from others, making it difficult for her to have a clear self-picture. Despite her comment that she did have friends who did not live in her seniors’ apartment complex, she preferred to be on her own rather than socialize with other residents whom she described as “gossips”. Her seeming inability to change her social situation perpetuated her poor self-concept as ineffectual. She said,

I don’t know if I have any strong points .... I love people but I don’t think I have any strong points .... Well it’s hard to say because I’m always alone. I don’t mix with the people in here because they’re a bunch of gossips. And as soon as you leave they are talking about you. And I don’t like that. So maybe one night a week I’ll go down to bingo .... And then I’ll just come upstairs again. I’d rather be on my own like that. (P111, age 75)
Being alone was a theme in the lives of the women with ineffectual selves and seemed to result from a variety of situations. Not only did being alone preclude opportunities for feedback about their selves from others, it also reinforced discrediting views of themselves (Charmaz, 1991). While they seemed aware of the situations, they seemed unable to change the contexts within which they lived. They continued to perpetuate views of themselves as ineffectual.

Some (5 of 8) described poor relationships with family and friends which they perceived as arising from their own negative attributes. One woman described how her stubbornness had led her to actively refuse help from her family when they attempted to provide her with assistance to overcome the disabling aspects of her chronic illnesses. Although she realized in retrospect that this had a negative impact on her and her relationships with her family, she seemed unable to change her situation. She said, "I pushed my kids away from me because of my own stubbornness .... I'd be sick so many days up there [indicating upstairs] but I wouldn't let none of them help me" (P101, age 60). She lived with her husband but she talked about how they each went their own way and often did not speak to each other for days: "I'd go my way, I'd come in, we'd never speak. He sleeps in his room and I have my own room and it's been like that now since what, it's 10 years" (P101, age 60). Despite the fact that she and her husband shared the same house, she considered that she was on her own, alone. She said:

I've been alone, almost I'd say about 10 years on my own since my son [had cancer] but the family rallied around when I had my operation [this fall] .... I never spoke to none of my family because there were a lot of arguments and fights. (P101, age 60)

Another woman described how, after her retirement, she has been unable to engage in new leisure activities because she lacked the self-confidence to go out on her own and initiate new contacts without her husband. She talked about her boredom but she was still unable to overcome her anxiety about going out on her own. Her inability to master her situation left her confined to her home during the day when her husband was at work.

And I was talking to my husband just last night about it and I said I want to go over into one of the seniors' groups and see what goes on but I haven't got the nerve to do it myself because I've never done that. If I knew somebody who already belonged that I could go with. My husband is more outgoing than I am. He knows all these neighbours and in all the years we've lived here I only know a couple .... So I find that, maybe I'll get the nerve up to do this one day but I just want to stay home. (P129, age 64)

She also spoke of her inability to become involved in volunteering. While she suggested that this was related to her fear of falling since being diagnosed with osteoporosis25, she seemed to lack the confidence to go out on her own. At other times during the interview, she talked about being nervous when she goes out alone; other than going to work she rarely went out without other family

\[25\] The interview took place during the winter and she had previously fractured her ankle after falling on some ice.
members. Her lack of self-confidence seemed to result in a passivity which Charmaz (1991) suggested was a result of the loss of self. Charmaz argued that the loss of self can result from discredited definitions of the self arising out of unmet expectations the person may have of herself and those that may arise out of interactions with others. “Feeling badly” about her inability to change her situation was the essence of the discussion that follows. This phrase was used to discredit herself and characterize her ineffectual self.

I've been going to get [involved] in volunteer work but I just haven’t got around to it. In fact I was just for a medical last week and Dr K asked, she said "Are you volunteering?" And I said "No". I feel kind of bad about it right now but I really don’t know what I want to do .... I thought, I guess I'm more into helping older people ... I thought of going up to the [seniors’] apartment buildings up here and seein' if I could do anything to help those older people up there with shopping and things like that. But a year ago I broke my ankle. I fell on ice at the store. And I'm scared to go out in this [winter] weather now. I get that if I go out I'm watching everywhere I go - I'm so scared of falling especially since they tell me now I've got osteoporosis, you know. (P129, age 64)

Women with ineffectual selves talked about their need to change in very dramatic or fundamental ways. Their idealized images of themselves created anxiety when they realized how different their desired selves were from their extant selves. Their perceived inability to take control over their lives made change seem elusive. For some women (3 of 8), the changes they identified would be possible (albeit with a great deal of effort on their part) but for others (4 of 8) the changes could never be achieved. Rosenberg (1979) suggested that the inability to reach one’s idealized image may result in feelings of strain and ultimate self-contempt. These feelings of strain and self-contempt were evident among the women with ineffectual selves.

Some women wanted to make fundamental changes that could not be accomplished because of their stage in life. One woman, when asked what she would do if she could live her life over, talked about the changes she would make in her life. She would like the chance to improve her education and employment opportunities, to be successful in a career and to make a contribution through her work. Throughout the interview she had described herself as feeling inferior, as always alone and as not mixing well with others. Her son had recently accused her and her deceased husband of abandoning him as a child and of child abuse. She was saddened by her son’s attitude toward her but had been unable to change his beliefs about the past during his recent visit. He had left in anger and had not been in touch with her since. This confrontation seemed to add to her views of herself as ineffectual. She also talked throughout the interview about wanting a “nice, quiet and peaceful” life. This seemed in contrast to how she saw her life and her relationships with her family and others. The part of the conversation that follows took place after the discussion about abuse.

I would like to be born very smart and go to university and get a degree and all that. I’d like to make something of myself and not just be someone who sits in a chair watching television all the time. I would like really to be, you know, do something worthwhile. I get, I think what
the heck am I doing here. Why was I born? I haven't done anything, you know. And it seems like such a waste of time to me. So that's what I'd like to do. I'd like to be good at math .... I would like to be born more intelligent so that I could go to university and get a degree and all that. (P111, age 75)

Another woman believed that she could change and that, in fact, she must alter her extant self if she is to have companionship and caring as she grows old. Throughout the interview, she recounted her troubled relationships with her family. Despite her disabilities from arthritis and osteoporosis, she had refused help from her family in the past. But a short time prior to the interview she realized that, in order to continue living with her family, she needed to take active steps toward altering her behaviour. She suggested that the family problems arose from her own attitudes and disposition and her husband's alcohol abuse. She seemed to recognize the need for reciprocity in her relationships with her family now. This action toward changing her extant self to be more like her desired (idealized) self seemed to be taking its toll on her mental health. She cried throughout the interview and openly acknowledged her depression. This was also verified in her responses on the questionnaire.26

So it was (PAUSE) a lot had to do with me because I'm very stubborn. If you hurt me, as I said, I won't give in. And it's no good. You realize it's no good. You've got to make, I don't know how you say it. My daughter says "Mom, you got to meet half way. You can't be like that. Life is too short". And she's right, the kids' right. But I'm very stubborn in my own way and I shouldn't be because there's going to be a day when you need somebody to be there to help you as you get older, you know. That's what I said to [my husband] because we both care a lot for each other but we're too stubborn to give in. You know what I mean? And I don't know, but if we can make things work now I would like it because I'm older now .... But if we can sort of make things work without the drink and I would like to ... because it's a hard world out there .... I'm giving in more and .. I'm communicating a bit more and I'm talking more .... in a family you've got to give and take in every thing, you know. So I realize that life is too short so make the best of it. (P101, age 60)

Planning for the future demonstrates how the women in this study might attempt to narrow the gap between their extant and desired selves. For women with ineffectual selves, how they would narrow this gap seemed elusive. They were unable to discuss ways to change their extant self to more closely mirror their idealized selves. When asked what they would be doing in the future, some women with ineffectual selves (3 of 8) said that they would be doing the same as now although they were not happy with their current situations while others (3 of 8) said they had no plans or they would probably be dead in five years. One woman presented a conflicting picture when asked what she would be doing in the future. While she was not happy with her current activity

26 She responded "yes" to the question, "in the past six months have you been unhappy and depressed more than usual for a considerable length of time (two weeks or more)?". She responded "sometimes" to questions about feeling "very lonely or remote from other people" and "depressed and very unhappy" during the past few weeks. Her scores on Ryff's questions about environmental mastery, purpose in life and self-acceptance were generally low.
level, she maintained that she would be doing the same things in five years. Despite her current depression\(^27\) which she described as chronic, she stated that there were still things that she looked forward to although she was not able to be very specific about what those activities might be. She seemed confused and frustrated in her attempts to bring her extant self closer to her idealized self.

P: I haven’t really been able to pull myself out of this slump .... My biggest problem right now is ... that I just can’t seem to get going ....

SW: What do you see yourself doing in 5 years?
P: Well ah probably just roughly the same things as I’m doing now you know .... there is still a lot to live for. I mean there is still a lot to do. (P201, age 65)

Feared selves or what one is afraid of becoming (Markus & Herzog, 1991) were also discussed by women with ineffectual selves. One woman wanted to increase the discrepancy between her extant and feared self. She openly talked about her depression and poor self image created by her osteoporosis and she believed that she would be dead in five years. Earlier in the interview, she had said “I’m biding my time. I’ve done all the things I want to do” (P208, age 70). She did not want to leave her home and live in a long term care facility. She described the active steps she had taken to confront the dependence she felt she might have to face in the future. Her desired or idealized self was fundamentally different than her extant self and was the basis for her depression. Her comments seemed to indicate her feelings of self-contempt. While she felt she had the right to end her own life, she realized that this might be perceived by others to be a selfish act. She said,

I’ll be dead! .... I’ve save myself some pills, I won’t tell you what. If it gets really rough, they’re for me. Now I sound bad and it probably is but that’s the way the ball bounces. I’m not going in a nursing home and I’m not going to be housed in here, so if and when the time comes, that’s the deal we have. Four or five years I doubt [I’ll be here] .... no I don’t expect to be around in five years and if I am, I’ll be knitting and reading and minding my own selfish little self hopefully with [my husband]. (P208, age 70)

Some women (4 of 8) wanted to turn the clock back to earlier times when they looked and felt younger and had no health problems. When asked “If you could stay the same age all of your life, what age would you choose?”, one woman said:

Oh, I think somewhere in your fifties. You’re still reasonably, you know, your face changes--if you look at old snapshots, you start to look old by past your mid-fifties. You’re still fairly healthy, fairly busy, fairly (PAUSE) I’d probably say my mid-fifties, between 50 and 55 (LAUGHS). (P115, age 69)

Another woman talked about an earlier time before she had been diagnosed with osteoporosis when

\(^27\) On the questionnaire, she responded “yes” to the question “In the past six months have you been unhappy and depressed more than usual for a considerable length of time?”. She also responded “often” to questions about feeling “very lonely and remote from other people” and “depressed or very unhappy” during the past few weeks. Also her scores on Ryff’s questions on environmental mastery, purpose in life and self-acceptance were very low.
she felt life was at its best. Recently she had been experiencing reductions in her ability to be independent because of limitations imposed on her by her osteoporosis. She said:

I think I would have to say when I was about, around 40 .... this osteoporosis came on me so [suddenly], I had a very early menopausal stage ... by the time I was 40, that was it .... I think that was probably the best time of my life, I was free to come and go and do, I had my own car, I had my own money, I was married and I had kids sure, but I was still out doing my own thing .... In other words I was independent, even though, I kept the house and it was good. (P208, age 70)

Two women with ineffectual selves recounted presenting selves to others which were negative. They lacked the self-respect to present positive self-pictures. Their presenting selves were similar to the extant selves they had described. They had used words such as, inferior, old, depressed, stupid and foolish to describe themselves. Without a favourable self-picture available to them to present to others, they were unable to produce a favourable impression on themselves through feedback from others. They were only able to validate negative views of themselves. Other women in this group (4 of 8), who had had difficulty describing their extant selves, were not sure of the self-pictures they presented to others. The difficulties the women had describing themselves and their reclusiveness may have made it problematic for them to present a self-picture to others. The lack of contact with others also made it difficult to get feedback from others in order to validate their self-concepts.

One woman had difficulty describing her extant self and when she was able to characterize herself, she discussed her weaknesses rather than her strengths, the poor opinion she had of herself and her inability to make friends and the resultant isolation. When asked how others would describe her, she said: "I don't have the faintest idea honestly (LAUGHS)--maybe I'd better not think about that" (P111, age 75). She seemed to fear what others might think of her. They may have the same disparaging ideas about her as she had about herself. Similar to this woman, another woman, when asked how her son would describe her, said "I haven't a clue" (P112, age 76). She was unable to imagine how her son would describe her and may have feared the impression he had of her. Charmaz (1983) argued that a loss of self can result from experiencing discrediting definitions of the self which arise out of unmet expectations that are held either by the individual or by those with whom the individual interacts. In the situation of these two women, it may be that their poor self-concepts arose from the devalued perceptions they thought others had of them as well as their own discrediting definitions.

Although in the situations of these two women, they were not able to speak openly about how others might perceive them, another woman openly described how she felt her family held negative views about her based on their unmet expectations about what she should be able to do as a woman with osteoporosis. She had portrayed herself as defensive and crying frequently and felt that her children viewed her in a similar way. She was house-bound and at the time of the interview
the only people who visited were her children. She felt that her daughter-in-law had little appreciation for how disabled she was by her osteoporosis. Her daughter-in-law constantly talked about other people with osteoporosis who continued to be active, working and driving while her mother-in-law was only able to walk short distances with a walker and spent much of the day lying in bed. This participant felt unable to change her daughter-in-law’s view of her. She was unable to legitimate her disability to her daughter-in-law. Recently their interactions always seemed to end in the participant feeling defensive and crying. Her lack of interactions with others outside of her family left her unable to change her presenting self. She continued to hold disparaging perceptions of herself that were reinforced by her family and led to her poor self-concept.

The last couple of weeks I’ve been very weepy .... Not feeling sorry for myself, I probably got what I deserve but ah it’s almost like (PAUSE) people don’t mean it but this is the type of thing that people can’t understand, I know they can’t. So it’s always on my mind [tape unclear] .... I stopped asking people up (PAUSE) my friends, my close friends I don’t [see them] .... You get remarks like ... my daughter-in-law ... she says oh, her aunt has osteoporosis, this other friend has osteo, someone else has osteo, and I say yes, my sister has osteo. But they’re walking, they’re driving or they’re doing things .... They’re not like [their osteoporosis] is not advanced. Do you know what I mean? (P213, age 61)

While Rosenberg (1979) argued that there might be differences in the presenting self across different situations, he concluded that there is also a core self displayed across situations. People select presenting selves that are functional, comfortable and congenial and in keeping with their extant selves. But one woman in this group explained that she presented a very different self to her family than to her neighbours. As a result, she believed that her husband would describe her in very different ways than her neighbours would. She seemed to seek the social approval of her neighbours by conforming to social norms and rules (Rosenberg, 1979). But within her family she behaved in ways that reinforced her negative self-picture as an ineffectual person. She attributed these differences in her presenting self to problems in her relationships with her family, problems that did not exist in her associations with her friends and neighbours. If “hurt” by people (in this case her family) she behaved in one way and if not she acted in a different way. It may be that her core self was how she behaves when with friends and neighbours. The ineffectual self may have developed over the past several years as a result of her family life which she felt had been strained over the past 10 years. She suggested that this was a result of a lack of support on her husband’s part during a time when one of their children had been critically ill. Instead of supporting her and their child, he had become involved in another relationship and had begun to drink heavily. She felt that he had failed to provide the critical support she needed at that time. While this had occurred over 10 years ago, she continued to feel that she had been hurt badly by his behaviour toward her and it would require extensive work by both of them to change this situation. Her husband and family saw her as being stubborn and not accepting help despite her disabilities, qualities in keeping with her
extant self but also that she was more caring and giving with other people outside the family. She explained why she felt this was so. "My husband would say I am better with other people than I am at home. And I am 'cause I love other people and I don't have to (PAUSE) they don't criticize you or put you down. They're grateful for what you do" (P101, age 60). She talked about how she would be described differently by her friends and neighbours. She felt that her neighbours appreciated her caring while her family did not.

Now you can talk to [my neighbour] across the street or you can talk to [another neighbour] ... or any of the neighbours, we have been on the street 30 years almost. And there isn't anything I wouldn't do for any of them .... more than I would for my own [family]. As sick as I was I would still go out and do for them but if there was anything to be done at home I wouldn't have the (PAUSE) will to do it or I wouldn't want to, let's say stubbornness. I wouldn't want to give in to do it at home. But yet I would go out and do it. But I get along with anybody. Anybody you could speak to I've never had any trouble with .... I'll do anything for anybody and I'll go out of my way but don't hurt me. Don't, you know like, I don't know how you put it but just don't hurt me because then I won't bother. (P101, age 60)

In summary, women with ineffectual selves described themselves in disparaging ways that indicated a lack of self-respect. Their ability to focus on weaknesses and inability to report any strengths reinforced feelings of worthlessness. Their inability to change their lives led to poor relationships with others, to depression, to increasing reclusiveness and to passivity. The reclusive nature of their lives had led to few interactions with others—interactions required to have a strong sense of self. They recounted their depression over their inability to change situations or control their lives. They spoke about desired or idealized selves that required fundamental changes in their extant selves. Some women were attempting changes that seemed within their reach although the effort required seemed overwhelming and inhibited by their depression. For other women, their idealized selves were clearly out of reach or required that they return to an earlier time in their lives before they were old and disabled by their osteoporosis. The failure to meet their idealized images resulted in what Rosenberg (1979) described as self-contempt or self-hatred. They seemed unable to take control of their lives. They were unhappy with how things in their lives had turned out. They yearned to have more tangible accomplishments or to change in fairly dramatic ways. For some, this meant being younger and healthier. For others, this meant fundamental changes in how they interacted with others. Clearly, some of these changes were idealistic and could not be realized. This led to frustration or resignation on the part of these women. They presented selves to others that were in keeping with their extant selves. They were able to validate negative views of themselves in their interactions with others. The reclusive nature of their lives meant that they did not have opportunities to interact with others and, thus, lacked the feedback that might offset their negative views of themselves.
Discussion

Rosenberg (1979) argued that the self-concept (including the extant, desired and presenting selves) is “a cognitive structure, a set of ideas about something” (p. 50) but it is not static. Rather “self-concept matters, makes a difference, is motivated” (p. 51). He described it as a “motivational system”. People wish to incorporate certain aspects, components, or dimensions into their self-concepts. This desire motivates them to actively change their extant selves to more closely match their desired selves. The motive to change the self-concept occurs through the self-esteem and self-consistency motives.

This chapter provides an in-depth examination of the self-concepts of a group of 28 women who are aging with osteoporosis. The depth with which these women characterized their extant, desired and presenting selves provides a perspective on the complexity of the selves of older women with chronic illnesses. This complexity is in contrast to generally held perspectives that would suggest that there is a dichotomy of either positive or negative self-concepts among this population. This information on the self-concept and the resultant grouping of women into three groups, while simplistic given the complexities of their lives, provides a structure within which to continue to analyze the data on the relationships between the meanings of aging and chronic illness and the self-concepts of the participants in this study. See Table 5-1 for a comparison of the structural aspects of self-concept across the three groups of women.

Women with competent selves disclosed self-concepts in which their extant, desired and presenting selves were very closely aligned. They held favourable opinions of themselves and were self-assured. Because of their positive self-concepts, they were confident that they could overcome challenges and exert control over changes brought about by aging and chronic illness. They were certain that they could continue to live balanced lives and to participate in meaningful and valued activities in the future. They were confident that they could maintain views of themselves as competent workers, as healthy and as independent. They felt that they displayed a consistent core self across situations and that they presented a coherent sense of self to others. They were able to validate their self-concepts as competent by presenting selves to others that were consistent with their extant selves as well as receiving feedback from others that confirmed their extant selves.

Women with contradictory selves described themselves in discrepant ways. There was an incongruity between their extant, desired and presenting selves. The discrepancy between their extant and desired selves resulted in a striving to align these two aspects of their selves but they
Table 5-1: Comparison of structural aspects of self-concept across three groups of women

<table>
<thead>
<tr>
<th></th>
<th>Competent selves (n = 12)</th>
<th>Contradictory selves (n = 8)</th>
<th>Ineffectual selves (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Extant self</strong></td>
<td>• positive views</td>
<td>• conflicting views</td>
<td>• negative views</td>
</tr>
<tr>
<td></td>
<td>• self-confident</td>
<td>• striving for self-confidence</td>
<td>• lack of confidence</td>
</tr>
<tr>
<td></td>
<td>• high self-esteem</td>
<td>• low self-esteem, self-worth</td>
<td>• poor self-esteem</td>
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<td></td>
<td>• self-respect</td>
<td>• ambivalent sense of self</td>
<td>• lack self-respect</td>
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<td></td>
<td>• personal control</td>
<td>• unable to control</td>
<td>• unable to control</td>
</tr>
<tr>
<td></td>
<td>• balanced life, valued activities</td>
<td>• struggle to balance</td>
<td>• lack balance</td>
</tr>
<tr>
<td></td>
<td>• good relationships with others</td>
<td>• ambivalent relationships with others</td>
<td>• poor relationships with others</td>
</tr>
<tr>
<td></td>
<td>• never lonely and depressed</td>
<td>• sometimes lonely and depressed</td>
<td>• often lonely and depressed</td>
</tr>
<tr>
<td></td>
<td>• Ryff scores = high</td>
<td>• Ryff scores = high to low</td>
<td>• Ryff scores = low</td>
</tr>
<tr>
<td><strong>Desired self</strong></td>
<td>• committed image</td>
<td>• moral image</td>
<td>• idealized image</td>
</tr>
<tr>
<td></td>
<td>• aligned with extant self</td>
<td>• discrepancy with extant self</td>
<td>• discrepancy with extant self</td>
</tr>
<tr>
<td></td>
<td>• doing same things (worker, etc)</td>
<td>• more control</td>
<td>• change in dramatic ways</td>
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<td></td>
<td>• healthy</td>
<td>• alter role demands</td>
<td>• healthy</td>
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<td></td>
<td>• independent</td>
<td>• personal autonomy</td>
<td>• younger</td>
</tr>
<tr>
<td><strong>Presenting self</strong></td>
<td>• aligned with extant self</td>
<td>• presenting self in keeping with moral self, in contrast to extant self</td>
<td>• negative self presented to others</td>
</tr>
<tr>
<td></td>
<td>• others would describe them as they describe self</td>
<td>• difficulty knowing how others viewed them</td>
<td>• fear what others might think</td>
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<tr>
<td></td>
<td>• validation of extant self</td>
<td>• no validation of positive extant self</td>
<td>• validation of negative views</td>
</tr>
<tr>
<td></td>
<td>• comfortable, compatible with extant self</td>
<td>• need for social approval, conform to social norms</td>
<td>• lack of interaction with others</td>
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seemed to lack the self-confidence to change their extant selves to more closely resemble their desired selves. They seemed to be endeavou ring to fulfil their moral image of themselves or what they felt they must, ought or should be. But this created a great deal of conflict for them. They were struggling to gain control over their lives and to strike a balance between doing things for others and doing things for themselves. They were struggling to gain personal autonomy and to acknowledge the legitimacy of their own needs. Without strong views of themselves, they had difficulty presenting strong selves to others. Thus, they were unsure of the picture they presented to others and were unable to validate any positive aspects of their selves through feedback from others.

Women with ineffectual selves described the incongruity between their extant and desired selves but their extant and presenting selves were similar. They generally had difficulty speaking about themselves, knowing how others would describe them and discussing what they would be doing in the future. When they were able to talk about themselves it was in disparaging ways which suggested a lack of self-respect and self-worth. They lacked the ability to master situations which arose as the result of aging and chronic illnesses. Given the importance of interaction with others in forming and maintaining self-concept, the solitary nature of the lives of these women may have contributed to their poor self-concepts. They seemed unable to realize their idealized selves which would require fundamental change and seemed overwhelming and inhibited by depression. The inability to close the gap between their desired and extant selves led to feelings of self-contempt. Similarly, their lack of plans for the future might indicate their concerns about what the future might bring. Their lack of self-respect led to problems in presenting themselves to others. Without a positive self-picture, they were only able to validate their extant selves with negative feedback from others. Their lack of interaction with others also intensified their inability to gain different views of themselves that might change their poor self-picture.

As discussed earlier in this chapter, the original focus of this thesis was on the structural aspects of self-concept rather than on the processes or the self-concept motives. During the analysis of the data, however, it became evident that the women were relating more information than just descriptions about their extant, desired and presenting selves but were also talking about how they protected, maintained and enhanced their self-concepts over time. These self-concept motives will be examined relative to the meanings of aging and chronic illness in Chapter 7.

The next chapter examines the meaning of aging and of chronic illness for the participants in this study.
As discussed in Chapter 2, within an interpretive perspective, social interaction is viewed as an interpretive process in which meanings evolve and change over the course of that interaction (Wilson, 1971). Individuals are regarded as active, conscious, purposive and self-reflecting, “capable of symbolization and symbolic manipulation” (Reker & Wong, 1988, p. 216). Individuals are seen as active agents who construct their social actions based on the meanings and interpretations they give to their environment (Cuff & Payne, 1984). Meaning informs social action, arises out of social interaction and must be established before goal-directed behaviour can occur (McColl & Wittner, 1990; Reinharz, 1987; Weigert et al., 1986). These capacities allow people “to transcend time boundaries of past, present, and future; to reminisce; to anticipate; to give meaning to existence. As a result, the individual has acquired tremendous flexibility in the interpretation of all life events” (Reker & Wong, 1988, p. 216). Reker and Wong also argued that meanings are both subjective and intersubjective, derived from interactions and the individual’s interpretations of the interactions.

Relative to aging, Keller and associates (1989), in their study of well older adults, found that respondents’ overall impressions of aging were very positive although the social, physical, emotional and cognitive changes they associated with aging were almost uniformly negative. Responses to questions about the meaning of aging were grouped by the investigators into five categories: aging as a natural and gradual process without remarkable features; aging as a period of life evaluation, philosophical reflection, or increased wisdom and maturity; aging as a period of increased freedom, new interests, and fewer demands; aging as associated with physical health difficulties or concerns about health; and aging as a period of losses, both interpersonal and job related. These meanings were espoused by older adults who were in good health. Women in this study may have different views of aging because they are aging and have osteoporosis.

Bury (1988) argued that meaning, as it relates to chronic illness, should be considered as both consequences and significance. Consequences are the problems which chronic illness, disability (activity restriction) and handicap (social disadvantage) create for the individual: “the problems, consequences and costs which [chronic illness] entails” (p. 91). He gives as examples of consequences, financial problems, employment problems, and problems of personal care. These are all potential consequences for women with osteoporosis who participated in this study. Significance represents the implications that chronic illness carries within a particular society. Fear of stigma and discrimination originate “not so much from the disability as from the significance accorded the condition by others” (p.92) in our society. An example of the significance of osteoporosis in our society was given by Coney (1994). She argued that the campaign to raise public awareness of
osteoporosis has taught us to fear it. The symbol of osteoporosis is the old woman with the dowager’s hump.

Distressingly bent over, she appears with regularity on book covers, in articles in the popular press, and in advertisements in medical journals—in fact, anything to do with osteoporosis. She is often shown as the final stage of a sequence of increasingly stooped daughter/mother/grandmother photographs implying that this is the eventual fate of normal middle-aged women .... in a culture where women are valued for their appearance, the image of the deformed woman ... touches our worst fears about aging. (Coney, 1994, p. 128)

She argued that while this might be the course of the disease for some, it was not the predominant picture of osteoporosis but rather reflected a small proportion of women with osteoporosis. The significance of osteoporosis in our society may have an impact on the women in this study.

It is not always possible (or appropriate) to differentiate between these two aspects of meaning—consequences and significance—given that Bury has argued that the experiences of chronic illness “always operate simultaneously at these two levels” (Bury, 1988, p. 92). Rather it is important to recognize that these two aspects may be operating in any given situation. It seems appropriate to extend these concepts to aging as well, given the implications of aging at both the personal and societal levels. Also, in this study, there is a possible overlap of issues of aging and chronic illness for these women who are aging with osteoporosis.

Chronic illness has been described as biographical disruption (Bury, 1982), as disability and disadvantage (Locker, 1983), and as a time of narrative reconstruction (Williams, 1984). Charmaz (1991) has differentiated among different meanings given to chronic illness by the participants in her studies. Some viewed chronic illness as interruption—as temporary, of short duration and with a predictable outcome. They expected to get better soon and had little or no concept of chronic illness or disability. Others perceived it as intrusion demanding continued attention, allotted time and forced accommodation. Chronic illness was part of life in which symptoms were expected and planned around. They felt a threat to control of self and situation and uncertainty. Still others understood chronic illness as immersion. Illness ordered their lives, they reconstructed their lives based on illness and the requirements of illness came first, defining their pursuits. Women in this study may share similar perspectives about chronic illness.

This chapter will examine the findings of the study as they relate to the second research question, "What meanings or perspectives do older women with osteoporosis have on aging and chronic illness?". The findings are described in two sections, with consideration given to aging and to chronic illness separately although there is overlap between the two concepts.

Early reading of the data resulted in the emergence of different ways the women in this study talked about themselves as aged or aging and as chronically ill. Subsequent re-reading of the transcripts and the development of summary tables including the meaning of aging and of chronic illness (see example in Appendix 7) resulted in the emergence of the themes examined below. It is
important when considering meanings for the women’s voices to be heard through verbatim quotations (Clandinin & Connelly, 1994; Denzin, 1994); therefore, verbatim quotations are used throughout the chapter to illustrate the meanings of aging and of chronic illness held by the participants.

The Meaning of Aging

The participants' descriptions of aging were reviewed using responses to questions such as “How do you feel about getting old?”, “What is the hardest thing/best thing about getting old?”, “What are the advantages/disadvantages of getting old?”. See Appendix 2 for the complete interview schedule. Common or recurring themes emerged from the data across participants. These five themes include: aging as a natural process, as part of living; aging as a time of increased wisdom and forthrightness; aging as a time of changing priorities and new found freedom; aging as a time of loneliness and uncertainty; and aging as a time of deterioration and loss of independence. Each of these themes will be illustrated with verbatim quotations.28 These themes are very similar to the themes reported by Keller et al. (1989). Their participants were well older adults living in the community. The similarity of these themes may reflect societal views of the meaning of aging for older adults. These views may be held by older adults whether or not they have any chronic illnesses.

Aging as a Natural Process, as Part of Life

One of the themes about the meaning of aging that emerged from the data was that aging is a natural process, is part of life and of little concern (14 of 28 participants). Keller et al. (1989) reported similar findings in their sample of healthy community dwelling older adults. Women accepted their aging as part of life, were comfortable with their age and in some cases had difficulty realizing their age. They felt younger than their years. While experiencing some physical changes, they remained active and their lives continued to be filled with valued activities. They expected to live long productive lives. While considering that aging was a natural process, there was an acceptance of the inevitability of aging and death. There was little one could do to change the process of aging but remaining engaged in valued activities helps to focus one’s life on living.

One woman’s comments illustrated succinctly the view of aging as a natural process, as inevitable and not something to be feared; when asked how she felt about getting old, she said, “I don’t worry about it except that I know that I will [get older] and I fully accept it” (P209, age 65). Another woman said, “You get old and well, that’s part of life and you accept it” (P127, age 58). Another woman, when asked how she felt about getting older, answered simply by saying “it’s part of life” (P203, age 64) and quickly moved on to other topics. Another woman described the

28 Note that people could be coded into more than one category.
longevity or successful aging she saw amongst family and friends. She hoped she would remain as active and involved in her community as she aged. She said, "I know seven people very well who are over the age of 90, a few of them are relatives. And if I'm as good as they are, I'll be happy" (P118, age 71).

Physical changes were seen as inevitable, as part of the natural process of aging and were not perceived as negative. One woman mentioned the difference between how she felt and how she looked physically. Physical changes were inescapable but she continued to feel well and engage in valued activities. "I notice that I'm changing ... I feel wonderful ... then I look in the mirror and I see that I am getting older but that's part of living. So I don't dwell on it, I really don't" (P109, age 60).

Another woman talked about feeling comfortable with her age. Because aging was a natural process she felt no need to conceal her age although other women in her family did.

I've never minded growing older. And my mother and my sisters have always covered or bleached their hair, and I've never done that, I never had any desire to. I don't wear make-up except a little lipstick, I just don't (LAUGHS) you know. I've never felt the need to disguise my age. (P116, 65)

Another woman discussed the challenge she had realizing her age. She had little grey hair and others considered her youthful. But she felt a need to give more consideration to her actual age. Otherwise, she asserted, she might suddenly realize she is old and disabled and she has not fulfilled all her goals in life.

My biggest problem in this whole aging thing is ... I have a little difficulty within myself realizing how old I am. I think mainly because people perceive of me as being younger than I am .... [but I need to] mentally get myself into the spot where I really am. Or maybe I don't need to. I don't know. (LAUGHS) I keep thinking if I don't I might get a really big shock some day when I suddenly wake up and realize "Hey, I'm elderly. I'm maybe a bit disabled and I'm maybe this [and that] and heck where did life go". (P103, age 59)

Aging can be viewed as being part of life if it does not interfere with doing valued activities. Engaging in meaningful and valued activities can help focus one's life on living. In response to the question "What has been the hardest thing about growing old?", one woman talked about her awareness of some changes in her physical capacity brought on by age. Despite these limitations she finds her life to be full of meaningful activities.

I don't think there has been the hardest thing [about growing old] for me. I don't mind it, I don't mind anything I've experienced now which is really a reduction in capacity which is perhaps as much as anything because I don't have to try hard to get this done by this time. That was working and now I'm retired. I don't care, I don't mind saying to somebody I'm 66, I'm getting old, so what. Age, the chronological age doesn't mean anything to me. There are lots of things to do, I don't find days empty, the road ahead doesn't look long and boring and dull. (P122, age 66)

Another woman reflected on the importance of remaining engaged in activities for her.

I don't mind being older so long as I can still do the things I want to. I suppose everybody says that but that's true. I have never minded getting older. I've never minded for instance,
telling people how old I am. It doesn’t phase me at all. (P123, age 67)

Acceptance seemed to be a component of the meaning of aging as a natural process for some women and included the need to plan for the future. Planning for the future suggests the optimism described by Reker and Wong (1988)—the anticipation of activities, events and the attainment of life goals. One woman said:

I think getting older has its advantages, it has its disadvantages, something’s going to happen to us all .... So I think to make some plans for your old age. Get involved in something. But I have joined the seniors’ club .... It’s a question of acceptance, I know we can’t avoid it. (P206, age 61)

While suggesting that aging is a normal process, this does not preclude the possibility of disability and the inevitability of death for some women. One woman acknowledged her acceptance of the finitude of life (Marshall, 1980). "It’s a normal process for everybody and every day everybody is older and that’s how I look at it. It doesn’t bother me ... I wouldn’t like to live forever, you know” (P114, age 66). Another woman said, “Death comes to everyone—it’s part of living” (P206, age 61). Another woman talked about the changes that were occurring in her life as she aged. This included the death of close family members. She said,

There haven’t been any real sad times except the loss of family, parents, a brother and a sister. But it’s just all part of life and living, you know. They were older, much older than I am and ill. It’s not quite so hard to let go if you know somebody that’s been suffering for a long time. (P121, age 54)

The meaning of aging as a natural process and as part of life emerged as an important theme for many women. Within this theme, aging does not seem to be either positive or negative but rather neutral, as inevitable and as part of living. Despite physical changes associated with aging, it is seen as possible to remain actively involved in meaningful, discretionary activities. Remaining engaged in valued activities helps to focus life on living. Planning for the future remains an important goal. Acceptance of aging does not eliminate the possibilities of disability and the inevitability of death.

Aging as a Time of Increased Wisdom and Forthrightness

The second theme about the meaning of aging was that aging is a time of increased wisdom and forthrightness (5 of 28). Wisdom and experience acquired over the years and the resulting confidence served as preparation for coping with their lives as women who were aging with osteoporosis, and for being open and forthright.

Similar to the participants in the study by Keller et al. (1989), some women described themselves as wiser, more experienced and more aware of the community resources available to them than they were when they were younger. Wisdom and experience helped inform their responses to new people and new situations. One woman said, "You get a little wiser I guess. I think you do. You certainly learn how to cope with people and with situations and you learn not to over-react" (P121, age 54). Another woman said,
There's a lot of advantages [to aging] because we certainly know more …. I know ... much more than I knew back then .... I like to think that I can pass along a little of what I’ve learned to my daughters and maybe, even their friends”. (P127, age 58)

Knowing what resources were available allowed one woman to feel she could manage her aging without concern. She stated, "I have a fairly good idea of the resources which are out there. If I need Wheeltrans, it’s there. I know how to go about getting it and things like that, so I’m not worried about aging” (P122, age 66).

In response to questions about the advantages of getting older, some women responded that they were now able to be more open in communications with others than they had been in the past. One woman said, "I think gradually I’m learning to speak my mind more, not be offensive but just little things whereas maybe I would not have said something before. As I said, it’s a very slow process." (P123, age 67). “Speaking one’s mind” has the potential of enhancing or jeopardizing interactions with others. While some people may welcome open dialogue, other people may find openness threatening to their knowledge and position. This latter situation may be the case in the interaction described by another woman. The woman, whose doctor had suggested that she take hormone replacement therapy for her osteoporosis, was able to express her concerns about hormones. She had previously had cancer and was afraid to take hormones because of the possibility of cancer reoccurring. She suggested that her forthrightness was a result of her age and life stage. While previously she might not have spoken openly with her doctor about her concerns, now she had no reservations about voicing her apprehension. She said,

She wanted me to go on hormones and I said "Okay you give me 300 percent guarantee that I won’t get cancer again and I’ll go on hormones. But otherwise forget it" .... yeah you know that’s one thing at my age I would never have said earlier. But she just hit me the wrong way I mean. (P128, age 64)

The meaning of aging as a time of increased wisdom and forthrightness emerged as another theme. Increased wisdom can enhance the understanding of people and situations, which leads to better management of situations than in the past. Forthrightness can be beneficial in some situations, increasing the openness of communications. But it also has the potential to bring one into situations that could be contentious. Being open and forthright requires careful monitoring to ensure positive outcomes in interactions with others.

Aging as a Time of Changing Priorities and New Found Freedom

A third theme about the meaning of aging that emerged was aging as a time of changing priorities and new found freedom (4 of 28). This is similar to the theme of aging as a period of increased freedom, new interests and fewer demands described by Keller et al. (1989). Being clear about priorities for time use and being retired allowed the women in this study to have more free time to pursue activities of interest. They are able to say "no" more easily now when they are asked to do something they do not want to do whereas in the past they would have said "yes" even
though they did not want to do it. There is a choice as to whether to become involved in particular activities or not.

One woman talked about feeling comfortable being 71 years old and about the freedom she felt she had to become engaged or not in particular activities.

It's a more relaxed age. You [can say] no if you don't want to do anything. If you want to get involved you can but it isn't the end of the world to say no any more to somebody who wants you to volunteer for this or that .... over the years I never said no to anything. And some times I really got myself into things to the point of how am I going to handle this ... will I be okay .... I questioned myself but now oh, if I don't feel like doing it I'll do something else instead. Like if you're in organizations you can get pin-pointed for something that you think, so at this age "I don't feel like doing that, I'll do something else. Let somebody else do it who wants to do it". (P118, age 71)

Two recently retired women were particularly pleased with their new found freedom to become involved in leisure or discretionary activities that had interested them in the past but for which they had previously had no time. Also there was a realization that they could use their time as they wished--an awareness of the choice to become engaged in activities or not, an awareness that free time allows one to engage in valued activities. One of these women commented,

Now that I have more time to devote to [meditation], I spend more time on spiritual things and I'm part of a very active ... parish where there are lots of activities just there waiting ... to become involved in .... I now have more time. I also have learned not to take on too many things because you do ... move more slowly, you accomplish less and I also believe that retirement is a bit of a reward so ... in a way I deserve being able to choose what I will do, how much I will do and ... I have learned to make fewer commitments and then I can do all of them and also have some free time to do things spontaneously. (P122, age 66)

The meaning of aging as a time of changing priorities and new found freedom involves having and making choices about the preferred activities in which to engage. It is possible to feel less obliged to take on tasks that are priorities for others. Making choices about what activities to engage in leaves time free to pursue spontaneous ventures. Retirement provides time to pursue activities previously put aside due to time constraints.

**Aging as a Time of Loneliness and Uncertainty**

Another theme about the meaning of aging was aging as a time of loneliness and uncertainty (8 of 28). In this theme, while aging is a part of life and is often accompanied by wisdom and new found freedom, it can also create situations of loneliness and uncertainty. Loneliness is often the result of people dying--spouses, family and friends. This may result in having no one to provide companionship and caring as one ages. This is similar to the theme of losses described by Keller et al. (1989) in which a small number of their participants discussed the death of a spouse. Aging as a time of uncertainty is related to concerns about health and one's ability to participate in valued activities. This is similar to the theme of concerns about physical health difficulty and concern reported by Keller et al. (1989) although this was represented by a small portion of participants among their sample of well older adults. This may also be similar to the findings of Charmaz (1991).
She found that older adults expected to feel worse with age and that there was an "appropriateness" of illness with aging.

Being alone for one woman meant the death of two husbands and a male friend. When asked how her life had been changed by osteoporosis, she explained that her life had not been changed so much by osteoporosis but by the deaths of these individuals with whom she had shared plans for the future. Now she was alone and had no plans for the future. She said,

Mostly I don't think so much the osteoporosis [has changed my life plans] as husbands dying [have]. We had plans, we used to go to Florida in the winter. We had a nice place [names the town and development] and it was really lovely. And then, of course, you see all these plans change and then, of course, it's since then that I got the osteoporosis. So when they had died, husbands, I didn't have any more plans. I had a very nice friend and he died last year so it seems to me I shouldn't have any more because they all die (LAUGHS). I don't know what it is but .... everybody loved [names her friend]. It just seemed that everybody loved him. All the men admired and liked him. He was a nice man. But he died (LAUGHS) so now I'm just here alone (PAUSE) anyway. (P111, age 75)

Another woman's concerns about aging being a time of loneliness were related to being alone with no one to care about her. She often provided care to elderly people in her neighbourhood. This experience provided the basis for her apprehension. In these circumstances, she explained how one must accept aging and "make the best of it". Making the best of aging suggests conceding to the changes or situations precipitate by aging even if that meant being alone and lonely.

Growing old is just something you accept. You make the best of it .... [the hardest thing about growing old is] thinking about being alone. This is what I feel. Sitting alone and having nobody. Because I feel that with a lot of [the] seniors that I go to visit and see, I'm there for a couple of hours. And their life is so different. They're so happy, talkative but when you leave them it's so different .... this is why I say that elderly people should never be left alone. (P101, age 60)

Some women characterized aging as a time of uncertainty in which there were concerns about health and its impact on one's ability to participate in valued activities. One woman talked about aging bringing about a series of illnesses and that, when one seemed to get better, there was always another illness to take its place. It was difficult to plan for the future when one is concerned about one's health. But this uncertainty about her health seemed to be something that she shared with many of her elderly peers. She said,

Well, you always think that whatever is bothering you today will go away tomorrow and (LAUGHS) it's always replaced by something else. Um, this seems to be kind of general. I hate always being aware of my health. You know, I was always such an active person. I was always in things and always going places and ... not always thinking about health. But there comes a time when health always seems to be in the uppermost part. And people, well, an awful lot of people, that's about all they talk about. (P112, age 76)

Another woman was very concerned about the uncertainty of her health and, in particular, what diseases she might acquire and how she would handle these illnesses. She was particularly concerned about blindness and Alzheimer's Disease. But she talked most about Alzheimer's Disease,
a disease that is generally feared in our society and a disease that seems devastating for those with the disease and their families. This woman prided herself on her intellectual abilities and the thought of not being able to remember important things was quite distressing for her. She said,

When I think about aging I think that the thing that really worries me is that so far ... I'm not too bad, I've got osteoporosis but I don't have a bad heart .... I have low blood pressure which is a lot better than having high blood pressure. I seem to have a sound heart, sound lungs .... but then the little thought at the back of my mind always says yes but you never know when you're going to get it you know (LAUGHS). And that worries me because I think the two things that frighten me the most are going blind and Alzheimer's disease. And I was having supper with some friends the other night and they said well if it's Alzheimer's disease it shouldn't worry you because you wouldn't know anything about it ... but I think I would know. And it would really bother me I think. Like sometimes I'll lie here and I will try to think of the name of something .... and for a minute I got into a real panic and suddenly I remembered you know you mean if you search long enough it's always there. (P201, age 65)

Another woman also associated getting old with being sick. Although she had a family history of longevity and health, she seemed somewhat uncertain that she would escape illness as she aged. She was aware of physical changes she was undergoing and although she was not particularly happy about these changes she realized there was little she could do about them. Although she felt she had to accept these changes as part of the aging process, they added an element of uncertainty as she contemplated what aging might mean to her in the future.

I don't look forward to being old and sick. My family has a pretty good history of living to a ripe old age. My mother was 84. I feel that's pretty good, a lot of time .... She was very well. It's very important to me to keep your sense of humour through all the things that happen. I'm not very happy to see my skin tones go and my chin start drooping and my crow's feet. I'm not particularly vain but it's just a reminder that gravity is doing its number. And I don't like that too much but that's all part of aging. (P121, age 54)

The meaning of aging as a time of loneliness and uncertainty emerged as a theme for the women in this study. Within this theme, aging is viewed as a time of being left alone by the death of family and friends. This results in plans for the future having to be changed or postponed. Loneliness might also mean having no one to care for you when you become old and disabled. Aging as a time of uncertainty is often related to concerns about health. Poor health makes it difficult to participate in valued activities and to plan for the future. There is also an uncertainty of developing chronic illnesses such as Alzheimer's disease with its devastating impact on those with the illness and their families.

**Aging as a Time of Deterioration and Loss of Independence**

Another theme about the meaning of aging that emerged was that aging is a time of deterioration and loss of independence (15 of 28). Women associated aging as deterioration with physical and psychological changes. Aging was inevitable but out of one's control. Aging was identified with chronic illness, and specifically with osteoporosis. Loss of independence ranged from losing one's ability to drive to institutionalization. Not all of the women related this meaning of aging...
to themselves. Rather these were spoken of as happening to others. This is similar to the findings of Matthews (1979) in which the participants in her study, while sharing society’s stereotypical views of old people, rejected the label of old for themselves but used it to describe age peers. This is also similar to the themes about losses and health concerns in the work of Keller et al. (1989), although in their study these represented the responses of a small number of well older adults. This theme may be more reflective of Charmaz’s work with people experiencing chronic illness, in particular, those who thought of chronic illness as intrusion. The women in this study are aging and have chronic illnesses. Aging as deterioration and loss of independence is a reality for some of them. Similar impressions of aging are also the predominant perceptions of aging in our society where value is placed on youth and productivity.

Women in this study talked about the “golden years” as a myth of aging. One woman portrayed the essence of this myth in her comment, “These golden years aren’t what they’re cracked up to be”. Aging was described as “horrible” and “annoying”, accompanied by physical aches, pains and fatigue. Aging was characterized as something that was inevitable and beyond and individual’s control. Some women portrayed aging as a time of losses in independence, resulting in institutionalization. For others, their diagnosis of osteoporosis signalled old age.

One woman, who is very involved in sports, captured the essence of the problems she attributed to aging. She described how angry she felt because she was not as strong or supple as she had been earlier in her life. She wondered if she was going to be able to continue to participate in sports. While she was not concerned about how she looked, she was concerned about her physical deterioration. When asked how she felt about growing old, she said,

I get mad when I think [of aging] in relation to my golf .... I’m mad that I think how hard can I work at my golf to really be a whole lot better ... it takes me probably longer to stay better ... now. And that makes me annoyed .... [I’m] just not as strong, as mentally or physically as strong as I think I need to be and I keep thinking gee, I hope I can keep this up .... I know damn well I probably can’t [keep golfing] because of my age so I resent that. And after that I couldn’t care less, I’m not worried about face lifts and those kinds of things ... if I’m going to be 60 or 70 I’m going to be that .... I guess it’s related physically to and it’s probably as my mother would say “These golden years aren’t what they’re cracked up to be”. I guess when you can’t walk. I thought to myself one day when I had to run some place, I thought “Gosh, I can’t run any more”. You know that sort of [thing]. I’m amazed you know. I never recognized because I never ran anyway. I’m not somebody that runs but I do walk and I guess I feel that the process in my body does hurt a bit and walking my back can hurt me a bit and my feet, my feet can hurt and my hands. I don’t know if that’s a little arthritis. (P119, age 57)

Other women reported their deterioration as a general fatigue—“tired in your bones”—while others recounted specific “aches and pains”. One woman said, “Physically I wish I didn’t get so tired and you find ... you get tired from doing nothing sometimes and this is irritating” (P115, age 69).

While some women expressed mild irritation with aging, others were more emphatic about their thoughts on aging. Aging was a time of physical changes and of deterioration. One woman,
when asked how she felt about getting old, said,

I don’t like [aging] one bit. No, they tell me it’s the golden years and I really don’t believe it. I mean I feel, inside I feel 30 but outside I am so tired all the time. I’m weary and my back aches and then my hands get sore and my eyes are bothering me. And I think, I get terrible headaches all the time and I think this is crazy and they keep telling me it’s the golden years .... I would like to grow old gracefully and I’m not obviously. But that’s what I’d like. I have seen people maybe 80 walking around with rosy cheeks and robust and lovely. And you know that would be okay. But not this way, just sitting here feeling sorry for yourself all the time. (P111, age 75)

Physical deterioration might result in psychological changes as well. This woman was depressed. While this depression was not only related to aging, her physical deterioration contributed to her feelings of hopelessness and despair. There was also a realization that there was little that she could do to change the process of aging. Aging is inevitable and out of one’s control. Another woman said, “I think that I’m not aging as gracefully as I would like to .... so I get a little angry with myself although I don’t really have control” (P126, age 64).

Others also described aging as more than general physical changes, that is, as deteriorating health and, more specifically, the onset of osteoporosis. Some women were told, usually by their family physicians, that the onset of osteoporosis was to be expected with old age. This may be similar to the experiences of women in a study conducted by Belgrave (1985, 1990). Her participants saw chronic illness as a normative experience, as mundane, and as something to be expected and accepted with age. In the present study, not everyone regarded the onset of osteoporosis as part of normal aging. Some women in this study have led very active lives and suddenly found their activities to be very limited due to their osteoporosis. The onset of osteoporosis was an extraordinary event that altered their lives in many ways. One of these women, when asked how she felt about growing old, responded,

Well, up until I got osteoporosis, I wasn’t old. And then suddenly I became very old and I became very old very fast I didn’t realize I had osteoporosis. I didn’t ease into it, it happened. I was skiing and skating and riding a bike and there wasn’t anything I didn’t do. Then I broke some ribs, quite accidentally. I rolled over in bed and I hurt myself, I screamed in the night, I said “I don’t know what’s happening to me”. Now this might be about six, eight years ago and I went to the doctor and he said, “Oh, you’ve fractured some ribs” and I said, “How do you fracture ribs?” He said, “You’re getting old” and I thought “Dammit, I am not getting old, something’s wrong” but he didn’t pursue it and they healed and I didn’t pursue it. (P208, age 70)

The issue of aging and osteoporosis is complex. On the one hand, osteoporosis is related to aging and menopause. Traditionally in our society, menopause is seen as a marker signalling a loss of reproductive capacity and thus, aging. On the other hand, while this may be the view generally held, osteoporosis is a disease process separate from usual aging.

Aging as a time of loss of independence was portrayed across a spectrum of activities from losing one’s license to being institutionalized. One woman talked about how difficult it would be to
have to give up driving since it allowed her to be independent; to do her own shopping, to visit friends and to attend church. She said,

You talk about aging. I dread giving up my car because it spells freedom. But I may not be able to afford to run it if my income’s depleted. Um, and I may not be able to healthwise so you have to take that in your stride if you can face up to that. But that’s a hard thing to give up. (P107, age 78)

Loss of independence was also associated with becoming a burden. Becoming old and disabled might lead to the lack of capacity to care for oneself. This might result in a need to impose on family members to provide the essential care. One woman expressed her amazement at suddenly being 70 years old but then she noticed physical changes. She expressed her concern about becoming old and disabled and thus, a burden for her family. If she becomes sick, she does not want to live long. This latter comment seemed linked to a family situation. She had a family member who was 96 and living in a long term care facility. This family member was bed-ridden and required total care. As this participant thought about her family member and her own aging and history of cancer, she expressed concern about becoming old and a burden to her family.

Suddenly I got birthday cards on your big day, 70, and I thought oh, it can’t be, you know, oh, it is ... but I hadn’t really thought about it ’til then. And now I realize that I am slowing down .... I find that I can’t walk too far, I get out of breath and I’ve just had an ECG and some other tests on my chest and heart and I guess it’s suddenly hit me that, yes, I am getting old .... I guess it really hit me when I hit 70 ... that I am getting old .... I don’t want to be a burden. And I just hope that ... if I am sick, I don’t linger. (P120, age 71)

Other women alluded to their concerns about changes in mental capacity with aging. These changes in mental capacity could result in a loss of independence and a need for care. One woman is concerned that a change in mental capacity might result in her becoming a burden to her family. She does not want to move from her own apartment to live with her daughter.

I wouldn’t want to be 80 and 85 and be a burden on somebody, no. But as long as I have my faculties and I can do things for myself ... it’s not going to bother me. I may end up living with my daughter or something which is going to kill me, you know. Having to move in because I find that I am quite comfortable here with what I have. (P108, age 59).

Aging as loss of independence may mean becoming institutionalized. One woman related her experiences of aging with the aging of her parents and in-laws. All four had been institutionalized once they were unable to manage independently in their own homes. She recounted her own fears of aging in relation to these experiences (P126, age 63). Similarly, another woman described the deterioration she observed in people living in long term care facilities and her own fear at not being able to control her aging.

I see so many people in nursing homes, very tragic cases, and I don’t think I want to live that long. I can’t control that and a lot of people think that way .... I’m a little fearful of getting older. I see so many people in our nursing home here [she lived in a seniors’ housing complex which included different levels of care] just sit around all day and they’re not well, they’ve got poor health, limitations. (P107, age 78)
The meaning of aging as a time of deterioration and loss of independence emerged as a theme. Within the theme, general physical deterioration as well as specific changes manifested by chronic illnesses were considered part of aging. Deterioration could also signify changes in mental capacity. Loss of independence, as the consequences of physical and mental deterioration, might result in the need for care by family or institutionalization. Becoming a burden to family members is feared.

In summary, there was a scope of responses to questions about the meaning of aging. Five themes emerged from the data on the meaning of aging for the women in this study: aging as a natural process, as part of living; aging as a time of increased wisdom and forthrightness; aging as a time of changing priorities and new found freedom; aging as a time of loneliness and uncertainty; and aging as a time of deterioration and loss of independence. The first three themes are similar to those reported by Keller et al. (1989) as the views held by older adults who were well and, thus, might reflect more general ideas about aging in our society. The latter two themes seem more specific to women with chronic illness than to older adults who are in good health although participants in the study by Keller and colleagues did include themes of losses and concerns about health. These responses represented only a small number of well older adults. These themes of aging as a time of loneliness and uncertainty and as a time of deterioration and loss of independence are relevant for women in this study who considered aging to be closely associated with chronic illness. In Chapter 7 these themes will be examined relative to the three groupings of women described in Chapter 5.

The next section will deal with the meanings or perspectives the women in this study have concerning chronic illness.

The Meaning of Chronic Illness

The participants’ descriptions of chronic illnesses were reviewed using responses to questions such as “How did you know you had osteoporosis?”, “How have things changed in your day-to-day life since you developed osteoporosis?” and “What advice would you give to someone newly diagnosed with osteoporosis?” (see Appendix 2 for interview schedule). Common or recurring themes about living with chronic illnesses emerging from the data were: chronic illness as mundane; chronic illness as inconsequential; chronic illness as adaptation; chronic illness as unpredictable; and chronic illness as overwhelming. Each of these themes will be examined using verbatim quotations.

Chronic Illness as Mundane

One of the themes about the meaning of chronic illness that emerged from the data is that chronic illness is mundane (Belgrave, 1990), is “no big deal”, and is something to be accepted (6 of 28). Women were not concerned about their osteoporosis and it had not had a noticeable impact on their lives. Chronic illness is part of life and is something to be expected with aging. This is similar to
the findings of Belgrave (1985, 1990) and Charmaz (1991). Belgrave (1985) found that the majority of the woman in her study "accepted their ailments as an almost anticipated part of life" (p. 181). Although focusing on adults 35 to 60 years old, Charmaz (1991) did have some older participants in her study. She suggested that these older adults may respond differently to chronic illness than the younger people in her sample because of their age and life stage. She gave examples of verbatims which suggested that her older participants saw chronic illness as normative although they did express concern about dependence and abandonment. There is nothing that can be done to change the fact that one has osteoporosis so one takes the medications prescribed and continues with usual activities. Osteoporosis is also considered mundane because of the importance of other life events. These other life events take precedence over osteoporosis.

Some women stated that with age one should expect chronic illnesses, that chronic illnesses were natural with aging. One woman in this study described how she thought that probably people had osteoporosis without knowing it. She was not very worried about her own osteoporosis and, while she admitted that she might be discounting the impact osteoporosis might have on her in the future, she preferred to remain optimistic about it and to consider it to be natural with aging.

I'm not too concerned about it. To me, it's ... very natural and I would assume that a lot of people I know have it and don't even know they have it, you know, it's just a part of life. I don't have many real big concerns about it. Maybe I'm minimising it, maybe I'm in for a surprise down the road that I'm not prepared for but all I can do is what I can do medically for it and hope it doesn't .... I tend to not make a big deal out of things that I could get really down about because it's not the way I am, I just want to be positive. (P121, age 57)

Relative to other diseases one might develop, some women felt that osteoporosis was of little concern and was mundane. When compared to other illnesses, such as cancer, it seemed insignificant. One woman, when asked what she would tell another woman newly diagnosed with osteoporosis, said,

I don't think [osteoporosis is] a great big deal ... you've got it ... adjust ... it's not like you have been told you have cancer .... or diabetes, I think cancer is a lot worse. Um, [I] don't see [osteoporosis] as a big deal at all ... since I was 15 I've had posture problems and I don't relish the idea of getting worse in that department but hell, there's worse things. (P119, age 57)

Some women suggested that there was nothing they could do to change their osteoporosis other than take the prescribed medications and continue to live their lives as they had before their diagnoses. They wished to live active lives participating in valued activities rather than lives restricted by osteoporosis. Involvement in valued activities may allow little time for concern about osteoporosis. One woman, despite the advice of her doctor, continued to do the house and garden maintenance including getting up on ladders and washing windows on the second floor of her house and cleaning the eaves troughs. She was not prepared to live a restricted life unable to participate in meaningful activities.
I’ve got it so what do I do about it. There’s nothing I can do. I take these pills that’s it. Forget about it .... I do all of these other things like the painter came and painted the house but we have white eaves trough so I got the ladder up and I’m washing all the eaves trough .... [the doctor] said I shouldn’t skate, I shouldn’t ski ... I should be very careful going out once it’s icy and I thought "Oh my god, am I supposed to live my life in a closet. Forget it." (P128, age 64)

Another woman talked about how she continued to participate in activities that might be considered “risky” behaviours by her doctor but because she had no physical manifestations of osteoporosis that she was aware of, she could ignore her osteoporosis.

I’m a pretty active person and I do do things that are weight bearing like I sawed down a big fir tree that was taller than my neighbour’s two storey house .... you are using heavy saws and you’re pushing ... I do do a bit of this stuff and just lugging dry wall around and I did my front all in patio stones that weighed more than me and I had the man who delivered them lean them all against the tree and I “walked” each one until I got it where I wanted it and let it down. And I did a whole path down the side of my house and a little [patio] at the back ... but mind you when these osteoporosis doctors hear about that "you’re going to [fracture something]" .... I’m not really finding [osteoporosis] any inconvenience because I don’t have any crushed vertebrae therefore I’m not bent over or I don’t have any pain anywhere with it .... I guess because I don’t have any physical symptoms I forget that I have osteoporosis. (P103, age 59)

Some women considered osteoporosis to be mundane and sought no additional information about osteoporosis after their diagnoses. They did not want more detail than what the doctor had given them. One woman, who stated that she was not concerned about having osteoporosis, reported that she did not know much about osteoporosis and would probably not seek more information in the future. She said, "I don’t really know what osteoporosis does to you .... I am not the kind of person that worried about my symptoms" (P114, age 66). Another woman when asked if she had sought information about osteoporosis, said, "No. I think I would worry if I knew more about it" (P119, age 57). While this may be reflective of their attitude of osteoporosis as mundane, it may also indicate their denial of the impact that osteoporosis might have on their lives in the future. Also both of these women talked about other problems they had that overshadowed their concerns about osteoporosis. For example, one woman was distressed about what the future would hold for her daughter who has a developmental disability, once she and her husband were dead (P114, age 66). The other woman was concerned about cancer because she had fibrocystic breast disease (P119, age 57).

Within the theme of chronic illness as mundane, chronic illnesses are accepted as part of life, to be expected with aging and to be accepted. Chronic illness as mundane may allow one to continue to participate in valued activities minimizing or discounting the risk of further disability from chronic illnesses. Because there are no visible manifestations of chronic illness, it is reasonable to deny the possible impact it might have on life in the future. Other life events take precedence over chronic illnesses. Or continued participation in valued activities may produce a perception of chronic
illness as mundane. “Keeping busy” may allow little time for concern about osteoporosis.

**Chronic Illness as Inconsequential**

The second theme about the meaning of chronic illness was chronic illness as inconsequential (7 of 28). This meaning does not seem similar to views of chronic illness discussed in the literature. This may reflect the fact that most of the literature on chronic illness reports on studies of people with chronic illnesses acquired early in life and of a severity requiring considerable attention on a daily basis. It may be similar to Belgrave’s (1990) description of elderly women with chronic illness in which they considered themselves basically healthy and having a problem with which they had to deal to pursue their activities. Women in this study described their initial responses to learning about their osteoporosis as concern but because they had not experienced any fractures since their diagnoses, they found that they did not think about it very much anymore. It was only a minor inconvenience in their lives. They were determined to “get on with life” by continuing to do the things they had done before the onset of osteoporosis. While they continued to comply with medical regimens, they kept active and busy engaging in valued activities. They had made minor changes but, for the most part, they considered the progress of osteoporosis outside of their control. While they seemed resigned to its course, they were not particularly concerned about it changing their lives to any great degree.

Some women had initially been concerned about their diagnosis and possible implications of osteoporosis for them but with time and no noticeable changes in their bodies, they considered osteoporosis as inconsequential. One woman explained how she “just put it out of [her] mind” and led “as normal a life as possible”. She stated that her concern about osteoporosis had only lasted for a few months after her diagnosis and then she had become blasé because she had not experienced any more fractures and now she rarely considers it. She had resumed most of her pre-diagnosis activities although she had made minor changes. For example, she was careful when she went to the family cottage. There were large stones along the beach that she manoeuvred with great care to prevent falls and possible fractures. She said,

> Although at first ... it was uppermost in my thoughts, it hasn’t been for a long time. Oh I’d say for a few months at least it was something that I was really nervous about but I don’t think I am as nervous about it now or as concerned about it .... mostly I don’t think about it very much at all any more. (P116, age, 65)

The reaction of others was important to some women and determined how they responded to their osteoporosis as inconsequential. One woman felt that others would not be very aware of her osteoporosis since there were no visible symptoms and therefore, would not be understanding if she changed her life to any great degree. She had adopted a similar position. She said, “Go on with your life and forget about it. I don’t have much sympathy for anyone who harps on things. Go ahead and .... forget it .... nobody has any sympathy for someone that’s going to feel sorry for themselves”
Another woman, when asked what advice she would give to someone newly diagnosed with osteoporosis, recommended getting on with one’s life. Focusing on osteoporosis would limit one’s life too much. She said,

I would say keep busy. Keep active if you’re capable (PAUSES) and forget about it. You know keep active. If you can tolerate the calcium pills and if you can eat milk products, eat. You know go get advice first of all. Go to the doctor. Find the best available. See what he says. Have your tests. And then just go on doing what you’re doing. And if you’re going to keep on thinking about it you might as well lie down and fall asleep. You can’t live like that, you go on no matter what. (P203, age 64)

Some women did not view osteoporosis as something they could control. They seemed resigned to its outcome but not particularly concerned about how osteoporosis might change their lives. One woman recounted how she had first learned about her osteoporosis and her lack of concern about the diagnosis. While not something she felt she could control, she stated that she was not distressed about her diagnosis of osteoporosis because “whatever’s going to happen is going to happen”. This latter comment suggests she may be resigned to the course of osteoporosis. She said,

I saw [the doctor in the Metabolic Bone Clinic] over a period of time, almost every six months, not much longer than a year and all during that time, the calcium level was dropping ... which made him anxious. I didn’t get anxious because I kind of figured out, well, as long as I’m sensible and do what I should be doing in my life, then whatever’s going to happen is going to happen. I can’t control it beyond a certain point and I don’t know what I think I’m going to die of but it’s never this or it’s never that, whatever, so we’ll see in time. So that was the first awareness that I had ... this tendency [toward osteoporosis]. (P122, age 66)

The theme about the meaning of chronic illness as inconsequential denotes an acceptance of chronic illness and a need to get on with life in a way that is similar to life prior to a diagnosis of chronic illness. Remaining active and busy and participating in valued activities is essential. While not within one’s control, chronic illness will not change life to any great degree.

**Chronic Illness as Adaptation**

Another theme about the meaning of chronic illness is that chronic illness is adaptation (8 of 28). As with chronic illness as inconsequential, chronic illness as adaptation is not discussed in any detail in the literature on chronic illness. Rather it appears in the rehabilitation literature as an approach to adjusting to ongoing problems which may be the result of chronic illnesses. Women characterized their experiences with chronic illness as a time of adaptation. Despite their osteoporosis and any limitations this might bring, they tried to make adjustments or adaptations when necessary and for the most part, attempted to live their lives as they had prior to their diagnoses. They described the need to do the best they could to maintain active lives and meaningful activities. This is similar to the findings of Belgrave (1985, 1990) in which she discussed the women in her study as being ill but doing the best they could given their health problems. In this study, sometimes this adaptation involved giving up some activities or altering the way in which the
activities were accomplished. The need to maintain a positive attitude and enjoy life despite the limitations imposed by osteoporosis was also an important aspect of chronic illness as adaptation.

Some women outlined the changes that they had implemented in their lives to allow them to continue to participate in valued activities. For some, adaptation to previous health problems was useful in their adjustment to osteoporosis. One woman explained her approach to life with osteoporosis. While she initially thought she would experience fractures and end up being dependent for mobility, she quickly realized she had to overcome any disability and adapt to her osteoporosis. She had had previous back problems and had made adjustments in the ways she did things then. These changes were now second nature and similar to the changes someone with osteoporosis would make to protect her back from spinal fractures. She said:

At the beginning, I thought all my bones will break and I'll be in a wheelchair, but you get on [with life] after a couple of days you get over that and get on with it .... everybody has to learn to make it work for them, I think .... you need to know how to get on with your life. It doesn't end with [osteoporosis]. (P115, age 69)

Some women discussed adaptation as giving up some activities while changing others and maintaining still others. This required realization of one's limitations, of what one can and can not do. One woman talked about how she had adapted her life—doing what she could and delegating the things she could not do to others. Despite limitations of osteoporosis, she suggested that you could still do things you enjoyed by realizing what your restrictions were. She said:

I've just, you adapt your life to [your chronic illness]. I used to be a fussbudget, I'm not so much any more, and you have to adapt yourself that way .... I still like to cook. I think it was Easter time ... [my friend] helped me cook the turkey ... everybody helped ... and that was nice. I think you've got to realize you can't do what you did and you have to designate jobs [to others]. And you can still have the fun you used to have but you have to realize that you can't do what you did, or you have to do it differently. (P127, age 58)

The importance of developing and maintaining a positive attitude in the face of osteoporosis was mentioned by some women. Doing the best one could to keep going, to maintain activity levels, to adapt to changes brought about by osteoporosis and to maintain a positive frame of mind were important. One woman said, “I think it is just the way I am .... I just take things as they [come] and do the best that I can.” (P114, age 66). Another woman said, “I didn’t want to give in [to the pain] because as I said to you before you give in and it’s no good. You gotta keep fightin’ .... I keep going” (P101, age 60). When asked what advice she would give to someone newly diagnosed with osteoporosis, she described the need to accept osteoporosis, do one’s best to maintain activities within the limitations imposed, and get on with life—to persevere despite changes. She suggested that having a good attitude and not feeling sorry for one’s self were critical to enjoying the remainder of one’s life.

Accept it. Do the best you can. And have a good outlook. Think it over, sit back and realize the life you had before and what you’re going to go through now and say “well we all have to suffer, we’re not going to go through life perfect”. There’s a lot who go through life with
nothing but in this world make the best you can of it and be happy, be friendly and be compassionate and caring towards somebody else that’s going to come down with it. Don’t feel sorry for yourself because that’s the worst thing you can do. Be loving and help somebody else who is going through what you have already gone through. Help make [life] a little easier for them. Like talk to them, take them out, do little things for them. And explain what’s going to be coming next, you know. This is what you have to do. But enjoy the rest of your life, what you have. (P101, age 60)

Another woman described how important she thought a positive attitude was to good health. She tried to remain cheerful despite her osteoporosis. She said, “We’ve talked about attitude and I think that’s a very big factor in a person’s limitation. I think attitude has a great deal to do with health and that’s why I try to be optimistic” (P126, age 63).

The theme about the meaning of chronic illness as adaptation indicates a need for some adjustments to activities to maintain the overall quality of life as similar to before the onset of chronic illness. These adjustments might include giving up some activities or changing the ways in which activities are accomplished. The importance of doing the best one can to maintain an active life, to maintain previous valued activities and to maintain a positive attitude toward life are critical to successful adaptation to chronic illness.

**Chronic Illness as Unpredictable**

Another theme about the meaning of chronic illness that emerged from the data is that chronic illness is unpredictable and is a time of fear and uncertainty (16 of 28). Fear was often related to the fact that they might fracture their bones if they were not extremely careful about how they managed their day-to-day activities. Fear of falling also made some women reluctant to leave their houses, particularly in bad weather. This fear also created uncertainty for women who were employed or involved in volunteer work that required them to participate in restricted activities. Planning for the future was often difficult given that it was not always possible to predict how one’s health would be from day to day. Living one day at a time was often used to manage the unpredictability of lives with chronic illness. This is similar to chronic illness as biographical disruption described by Bury (1983) and to the intrusion that Charmaz (1991) described as one of the ways participants in her studies viewed chronic illness. Chronic illness as biographical disruption involved dramatic changes in one’s life with the need to alter expectations and plans for the future (Bury, 1983). Chronic illness as intrusion demanded continued attention and time. It created uncertainty and the threat of loss of control over illness and the self (Charmaz, 1991).

Many women talked about the fears and uncertainties that accompanied their diagnosis of osteoporosis. Fear and uncertainty were often related to the possibility of fractures if one falls. This unpredictability could lead to social isolation. One woman characterized the unpredictability of osteoporosis expressed by some women in her analogy of osteoporosis as “walking on eggs”. When asked how she knew that she had osteoporosis, she said,
Ah well I knew it because I was shrinking. I was over six feet and then I went for a check-up and the nurse said I was five foot ten and a half. I still can’t quite believe that….I always wanted to be shorter but (LAUGHS) I knew this couldn’t be true. And she said “oh yes you are” and she measured me again and she looked at the records, and she said “and you were last time too”. So I spoke to the doctor when I got in to see him and he said “well maybe we better have you checked”….that’s when I found out [that I had osteoporosis] and then he called me in he said he had news for me that I had a 40 percent bone loss in my lower spine….That was very scary. For a while after that I just went around like I was walking on eggs, I was so afraid to fall ….He said you have to be so careful of a spinal fracture.

(P116, age 65)

This fear of falling or being jarred and the resultant fractures often associated with osteoporosis led to a reluctance by some women to leave their homes. Over time, this could result in social isolation and in the restricted lives often associated with chronic illnesses (see for example Charmaz, 1991 and Locker, 1983). One woman said,

I was afraid of somebody bumping into me …. going into the subway, going down stairs, I’d be like holding on to the railing so no one would bump me because as soon as anyone would jar me, whether it was from the compression [fractures], the pain would like shot right up.

(P108, age 59)

Another woman had read the radiology report that accompanied her x-rays and had been alarmed at the amount of bone loss she had and how that might impact on her life. She was very anxious about usual mandatory activities until she had some reassurance from her own doctor. Her fear is palpable in the following quotation.

I think I’ve lost 41 per cent of my bone mass in that much time. That was enough to jar me. I was able to read ... the x-rays. [One of the doctors] gave them to me to take to [my doctor] so I was reading and it said, "extreme [bone loss]" ... in other words, don’t get out of bed, you might break your hip .... I was afraid to move. I was afraid if anybody bumped me. [My doctor] told me that that was true I’d lost that mass, but it didn’t mean my life was ended, you know. Nobody had said that before. (P208, age 70)

Another woman described her reluctance to go out in winter weather because previously she had fallen on some ice and fractured her ankle. Since her diagnosis of osteoporosis, she was particularly afraid of falling because she remembered her mother’s experiences with fractures. She had become somewhat housebound, unable to initiate involvement in volunteer work in her community because of her fear of falling.

A year ago I broke my ankle. I fell on ice at the store. And I’m scared to go out in this weather now. I get that if I go out I’m watching everywhere I go--I’m so scared of falling especially since they tell me now I’ve got osteoporosis, you know. My mom ended up, she had 2 broken hips. (P129, age 64)

Another woman said, "I’m pretty well confined in the winter, you see, because of the slipperiness, falling, it’s been an awful winter" (P202, age 80). As well as winter, rainy weather and crowds were also of concern for one woman. While she had always walked everywhere and used public transit, she now realized the risks to her if she fell or was bumped. She voiced her fear.
I think it took [a bad fracture of my leg] to make me realize ... you've got to be careful the rest of your life. I think it took that .... I am afraid to walk in the rain. See, again, I've never feared anything and I'm afraid now .... because if I slip and fall I'm going to break [my bones] .... The crowds just paralysed me. It would just take a little kid running by to knock my cane from under me or a mom with a stroller that might you know [cause me to fall] .... So I have to avoid crowds. (P210, age 63)

Chronic illness as unpredictable also meant uncertainty for some women. The possible need to give up work, paid or unpaid, because of its physical requirements was a concern for some. Bury (1982) described the uncertainty of chronic illness and how it can result in biographical disruption in which expectations and plans for the future must be re-examined. One woman, who worked with children, described the uncertainty she felt about whether she would have to give up her job because of her osteoporosis. While originally, when she was first diagnosed, there had been a possibility that her son who was disabled would have to be institutionalized because she would not be able to care for him, he had become self-reliant enough to stay at home. But now there is a likelihood that she will have to give up her job. She described how, after her divorce, her self-esteem had been completely "shattered" but work had helped her re-build her self-esteem. She talked about her current situation and her need to re-evaluate this.

Because of the trouble with the osteoporosis I've decided not to take any more children [into my care] that have to be carried up the stairs .... [with] the osteoporosis there's always a possibility of your hip going. Most people think that you fall and break your hip, you don't, your hip breaks and then you fall .... my 18 year old [son who is disabled], ah he doesn't walk without crutches. But fortunately he became so independent physically he is able to go up and down the stairs himself, even able to bath himself. Otherwise he would have to have gone [into residential care]. Two years ago Dr. Murray told me "I think you're going to have to redesign your lifestyle". (P206, age 61)

This same woman expressed concern about how the loss of work, which has a very positive effect on her self-esteem, might influence her life, creating some anxiety and uncertainty about her future.

Chronic illness as unpredictable created problems planning for the future and was expressed by comments of living “one day at a time”. Some women stopped planning for the future because they never knew how their health would be from day to day. Charmaz (1991) suggested that living day to day reduces the fear of the future being worse than the present. One woman explained how her osteoporosis made it difficult to plan ahead. While she had been very active before the onset of osteoporosis, it had created a level of uncertainty that was very frustrating for this woman. She said,

We were going to go to [Europe] this summer but we just didn't, I just wasn't really well enough in the spring to book and we didn't go, but we're thinking, touch wood, of going to [South America] in the winter so that should be nice you know, if I'm well. You see, it's hard to book ahead (PAUSES). (P208, age 70)

The theme of chronic illness as unpredictable connotes fear and uncertainty. Fear of falling and sustaining fractures overshadows lives, restricting participation in mandatory and discretionary
activities. This fear of falling often results in social isolation. Fear of fractures also leads to uncertainty concerning participation in paid employment or volunteering. Fear and uncertainty make planning for the future difficult. Chronic illness as unpredictable leads to living one day at a time.

**Chronic Illness as Overwhelming**

The final theme about the meaning of chronic illness is that chronic illness is overwhelming, is devastating and is an extraordinary event (8 of 28). This is in stark contrast to the meaning of chronic illness as mundane. Women were shocked by the changes that had taken place in their lives because of osteoporosis. They felt lonely and isolated because of their chronic illness. They were concerned about whether they would be able to remain in their own homes or if they would have to move to alternate housing. Pain permeated the lives of women, overwhelming them in their attempts to bring some routine and order to their lives. They described themselves as worthless and depressed as a result of the changes they attributed to chronic illness. Chronic illness as overwhelming is similar to chronic illness as disability and disadvantage described by Locker (1983), in which chronic illness results in losses of personal, material and social resources. It is also similar to chronic illness as immersion described by Charmaz (1991), in which illness orders life and people must reconstruct their lives based on the requirements of their illnesses. Chronic illness as overwhelming may create situations that place people at risk for a loss of self, as described by Charmaz (1983). Loss of self can result from living narrow, restricted lives, from social isolation, from experiencing discredited definitions of the self and from becoming a burden and losing power over the quality of life.

Some women described the disbelief they felt when they were first diagnosed with osteoporosis. Their lives had been changed dramatically by their diagnoses. While previously they had led active lives, they were very restricted by their osteoporosis. This in turn had an impact on their mental health. One woman, whose husband had died just before her diagnosis of osteoporosis, recounted how she had became depressed and agoraphobic. She had had a close relationship with her husband and without his support she felt unable to continue with her usual activities.

> When I first was diagnosed with osteoporosis it was such a shock to me. I mean nothing like this has ever really happened to me before except when I broke my hip .... for a whole year I went into a depressive state, that was so bad that .... I didn’t leave this apartment building for over 10 months. Ah I think it was just everything had come together I just sort of felt life just isn’t worth living any more ... I had this very good doctor, but he was frantic because he didn’t know ... he doesn’t do house calls, and you can’t treat a person if they won? even go down [to the office]. But I became actually frightened of going out and meet[ing] ... people. (P201, age 64)

Some women portrayed themselves as worthless and depressed. While prior to their diagnosis with osteoporosis, they had lives filled with meaningful activities, this had changed dramatically with the onset of osteoporosis. One woman related how she perceives herself since being diagnosed with osteoporosis. Having led a very active life of walking, bicycling, skiing and travelling, her life was now very restricted. Her experience of buying clothes provides an example of
how she perceived herself as a woman aging with osteoporosis. She had gone to buy some new clothes adapted for women with spinal deformities but she had been unable to buy anything because of her depression and her feelings of worthlessness. She said,

I've got fat since I started sitting around doing nothing. My self image is about as low as it can go .... [earlier this year] I [decided I was] going to get some new spring clothes so I [went] down to [a shop specializing in clothing for people with disabilities]. No sooner had I walked in there and here was a young woman [whom I knew] that worked in this little shop. She hauled out everything and anything. It was a rainy day, I'd worn my black raincoat that I'd had to take up because it's now trailing on the floor. I felt just like it looked--black and ugly. They showed me every dress in the place and I looked at myself in the mirror and I thought, "Oh, my god, you aren't worth any of these clothes, you look awful. You're overweight". Nothing was right so I said, "Keep your clothes" and the girl said to me, "What's the matter with you?" and I said, "Don't you recognize depression?" and I was just as low as a snake. Those clothes, if I'd have been great, they looked super on some of the women there but they made me look like death warmed over and that was the image I had of myself. (P208, age 70)

Some women perceived chronic illness to result in loneliness and isolation with the possibility of institutionalization or alternate housing. This is similar to the findings of Marshall (1980) and Charmaz (1991) that older people expressed greater fear of dependence, disability and abandonment than of death. One woman wondered what would happen to her in the future. She had spent a fair bit of time lately visiting her mother in a long term care facility as well as an aunt who lived in a nursing home. What she saw happening to older people living within the long term care system created a great deal of anxiety for her as she thought about her future with osteoporosis.

What if, because of my osteoporosis, I one day am crippled up like some of these people you know in these hospitals and I thought "Who is going to come and visit me?" I wonder .... these older ladies can break a hip and half the time [the doctors] don't bother to set them any more because they don't figure there's much point. They just leave these people .... [my aunt had broken her hip and she was in a wheelchair and when I would visit] she felt she was imposing on your time ... that's the way I think I would be too. I'd be feeling, if I was in that position and people came to visit me I would think "Oh, I am taking up their valuable time. What are they doing here with me?" I think I would be telling them to go away too. But I'd be feeling pretty lonely if they didn't come so I don't know (LAUGHS). I guess it's a dilemma. But no, I wonder sometimes especially because I see all these people up at this hospital where I'm going [to see my step-mother], I'm seeing all these people being completely helpless and somebody having to come and change all their diapers for them and I think "Gosh, ohhh, I can't be like this, I've got to keep myself [well]". (P103, age 58)

Another woman, who was very disabled by her osteoporosis, described how she had become lonely and isolated. She now spent more time lying in bed than she did sitting up in a chair. She had stopped seeing friends and family because she felt that they did not understand what it was like to have osteoporosis. She seemed overwhelmed by her osteoporosis. She said,

P: The last couple of weeks I've been very weepy. Not feeling sorry for myself, I probably got what I deserve but ah it's almost like (PAUSES) people don't mean it but this is the type of thing that people can't understand, I know they can't. So it's always on my mind. They can't understand .... I stopped asking people up (PAUSES) my friends, my close friends I don't (PAUSES)
SW: You don't see your friends much?
P: No. I don't ask [them to come and see me]. I know I'll have to go and lie down and I feel rude having to leave them. (P213, age 61)

She then described the situation with her son and daughter-in-law who lived near her and had provided some help in the past. They only came to see her occasionally and when they did arguments arose. She suggested that they did not understand what it was like to have osteoporosis—not everyone with osteoporosis is as disabled as she is.29

P: My daughter-in-law, you know ... she says oh, her aunt has osteo, this other friend has osteo, someone else has osteo, and I say yes, my sister has osteo. But they're walking, they're driving or they're doing things ... like it's not advanced—do you know what I mean?
SW: Umhm.
P: And I'm sure that they're in pain, I'm not saying (PAUSES)
SW: That they're not?
P: But they're (PAUSES) it's ... like so why aren't you doing (PAUSES)
SW: Why aren't you doing what they're doing?
P: This is what's going through my head and I get really ... sort of get on the defensive .... now it's almost like I feel I have to explain myself .... so maybe for other people it isn't a problem. But because I'm a very independent, proud person, for me it's a problem. And I give myself a problem because then I get myself upset you know. And then lately, pardon me, I don't know why I'm like this (CRYING) ... It's just this last couple of weeks, I've had a few run-ins with my family .... a lot of my own fault I know that .... I may say the wrong thing, I don't mean it though .... but it comes out wrong, but it's because the way they say something and I react. (P213, age 61)

The situation with her children was very distressing for this participant. As well as not seeing her son and his wife, she also did not see their daughter, her granddaughter. The other dilemma for her was where she would live when she was no longer able to manage on her own. While, in the past, her son had suggested that she live with him and his family, she realized that the tensions that exist in the relationship between her and her son and daughter-in-law would make such a move very difficult. She asked, "I'm in such a muddle right now .... I'm not old. When you're this bad what do you do? Where do you go?" (P213, age 61). These questions reflected this woman's fear and uncertainty about her future and her ability to live independently. Charmaz (1983) argued that people who live narrow, restricted lives full of uncertainty and fear and also those living in social isolation without participation in work, leisure or social relationships are at risk of losing their sense of self. While I would argue that this woman had not "lost" her sense of self (she was able to describe herself as a "very independent, proud person" which brought her into conflict with her family and isolated her more), I would suggest that she existed in a very tenuous situation given her physical limitations which isolated her.

Pain permeated the lives of some women. Pain often seemed to dominate their lives overwhelming them as they struggled to maintain some control over their lives. One woman, who

29 Portions of this quotation have been used previously.
was now taking morphine for her pain, described her pain. "The pain's constant. It never leaves and sometimes it's a lot worse and I get spasms with it and since my hip [joint replacement has] been done, I get spasms" (P127, age 58). Her pain had caused her to contemplate suicide in the past because she thought her life was not worth living. But she did not follow through because of the needs of her children to be cared for.

At one time I think I was suicidal almost about it. Except that I would never do anything because of my children but the pain got so severe, that I just thought my life isn't worth going on any more and this is so different for someone like me because I've always been an "up" person. (P127, age 58)

Bury (1982) described chronic illness as biographical disruption, arguing that chronic illness involves recognizing that pain and suffering are no longer the plight of others. Some explicitly asked the question, "why me?". One woman said, "I had advantages for which I am very grateful but at the same time I'm damn well mad that's it's me. Why wasn't it somebody else? Nobody I know, I wouldn't wish it on a dog." (P208, age 70). Other participants recognized that, while their lives had not been disrupt yet, pain could well interfere with their lives in the future.

The theme of chronic illness as overwhelming implies that lives are dramatically changed by chronic illness. The changes often result in feelings of worthlessness and depression. The onset of chronic illness is an extraordinary event in one’s life. Lives become narrowed and restricted by chronic illness. Loneliness and isolation often result. There is a fear of increasing dependency and institutionalization. Pain is burdensome and results in an inability to bring routine and order to lives.

In summary, chronic illness held various meanings for the women in this study. Five themes about the meaning of chronic illness were identified in the data: chronic illness as mundane; chronic illness as inconsequential; chronic illness as adaptation; chronic illness as unpredictable; and chronic illness as overwhelming. Chronic illness as mundane, inconsequential and adaptation is not the manner in which chronic illness is generally described in the literature. This may relate to the majority of the literature dealing with situations of people with life-long chronic illnesses which require ongoing monitoring and changes the lives of those involved significantly. The last two themes of chronic illness as unpredictable and as overwhelming reflect the literature cited in Chapter 2 (see for example the work of Bury [1983], Charmaz [1991], Locker [1983], Williams [1984]). In the next chapter, these themes will be examined relative to the three groups of women described in Chapter 5.

**Discussion**

Aging and chronic illness held various meanings for the women in this study. Five themes about the meaning of aging were identified in the data. The three themes of aging as a natural process and part of living, aging as a time of increased wisdom and forthrightness, and aging as a
time of changing priorities and new found freedom are similar to the meaning of aging described by Keller and colleagues (1989) as themes recounted by a group of well older adults living in the community. These themes may reflect general positive ideas about aging held by older adults in our society, the signs of "successful" aging in our society. The latter two themes of aging as a time of loneliness and uncertainty and aging as a time of deterioration and loss of independence, while describing concerns about health and losses as did those of Keller et al., seemed more specifically related to the actual diagnoses of chronic illnesses for the women in this study. These themes seem more intense and more in keeping with the meaning of chronic illness described in the literature on chronic illness than in the literature on aging, for example, in the work of Charmaz (1991) and Bury (1983) in which they describe the uncertainty and disruption of chronic illness. These themes may reflect the more negative ideas about aging described in the early years of research in aging and the ageist views still held by many people in our society. But they may also reflect a focus on the coalescence of aging and chronic illness for the women in this study. This interrelationship between aging and health will be discussed later in this section.

Five themes about the meaning of chronic illness were identified in the data. The first two themes of chronic illness as mundane and chronic illness as inconsequential are in keeping with the work of Belgrave (1990) in which she described the lives of older women with chronic illnesses. The women considered the experience of chronic illness as mundane and as normative, something to be expected with aging. Medical conditions that were not part of everyday life were insignificant to the self-concepts of the women in her study. Chronic illness as adaptation is not discussed in the literature on chronic illness but is an integral part of the rehabilitation literature in which it is presented as an approach to overcoming the disability and handicap of chronic illnesses. The last two themes about the meaning of chronic illness as unpredictable and chronic illness as overwhelming are similar to the literature on chronic illness in which chronic illness is portrayed as biographical disruption by Bury (1983), as disability and disadvantage by Locker (1983), as narrative reconstruction by Williams (1984) and as intrusion and immersion by Charmaz (1991).

There is an interrelationship between the meaning of aging and the meaning of chronic illness for some women in this study. Aging is associated with chronic illness in a very direct way. In particular, osteoporosis is associated with aging. This is a complex issue, in that, osteoporosis is a disease associated with menopause which is often seen as a marker of aging in our society but osteoporosis is a disease and not associated with usual aging. This coalescence of aging and chronic illness for some women in this study creates a complex relationship between the meanings of aging and chronic illness which has not been explored in the literature to any great extent. The relationships between these meanings and self-concept will be discussed in the next chapter.

Chapter 7 will address the remaining research questions, including how are aging and chronic illness related to the self-concept. This will be accomplished by examining the three groups of
women described in Chapter 5. Also the questions—How do the manifestations of osteoporosis relate to self-concept? and What strategies do older women with osteoporosis use to maintain their self-concepts in the face of aging and chronic illness?—will be considered.
CHAPTER 7

THE RELATIONSHIPS BETWEEN SELF-CONCEPT AND THE MEANINGS OF AGING AND CHRONIC ILLNESS

This chapter will address the remaining research questions: How are conceptions of aging and chronic illness related to the self-concept of the women in this study? How do the manifestations of osteoporosis (e.g., the severity of symptoms) relate to self-concept? and What strategies do older women with osteoporosis use to maintain their self-concepts in the face of aging and chronic illness? These questions will be examined by considering the self-concept motives of self-esteem and self-consistency (Rosenberg, 1979) and the meanings ascribed to aging and chronic illness.

According to Rosenberg (1979), self-concept and meaning are interrelated. Experiences of self must be transformed into meaning for personal experiences to be real. Meaning informs social action, arises out of social interactions and must be established before goal-directed behaviour can occur (McCall & Wittner, 1990; Reinharz, 1987; Weigart et al., 1986).

The relevance of meaning to self-concept has also been discussed by Markus and Herzog (1991). They argued that, while people may experience the same events in their lives, they respond to them in diverse and individual ways. The impact of a given event on an individual seems to depend on how she frames the event. The consequences associated with the event appear “to depend not only on objective indicators of its severity or stressfulness, but on whether the event is importantly self-relevant and on how it has been interpreted and given personal meaning” (Markus & Herzog, 1991, p. 110). In turn, how people manage the events of their lives “depends critically on the content, organization, and functioning of the self-concept .... the self-concept integrates an individual’s experiences across time and provides continuity and meaning to them” (p. 110). How the women in this study negotiate the events related to aging and chronic illness will depend on the meanings they ascribe to aging and chronic illness as well as on their self-concepts.

Thus, an understanding of the meaning of aging and the meaning of chronic illness is fundamental to the consideration of the self-concepts of the women in this study who were aging and had osteoporosis. The significance of aging and chronic illness to the self-concepts of the women will be examined by analyzing how the women in each of the three groups established in Chapter 5 enhanced, protected and maintained their self-concepts as aging and chronic illness coalesced. This analysis will be accomplished by considering the self-concept as process which includes Rosenberg’s (1979) self-concept motives of self-esteem and self-consistency. The women in each group will be discussed in separate sections below.
The Self-concept as Process

Analysis of data revealed the ways in which the women in the study enhanced, protected and maintained their self-concepts while dealing with aging and chronic illness. The processes or techniques used to maintain the structure of the self-concept can be examined using Rosenberg’s self-concept motives (self-esteem and self-consistency) and principles of self-concept formation (reflected appraisal, social comparison, self-attributions and psychological centrality) as well as the concept of coping as presented by Pearlin and Schooler (1978) and Bury (1991). These have been described in detail in Chapters 2 (literature review) and 3 (conceptual framework) but will be discussed here briefly.

The self-concept motives provide the motivational system for the enhancement and maintenance of the self-concept and include emotional and behavioural techniques (Rosenberg, 1979) or coping strategies (Bury, 1991; Pearlin & Schooler, 1978). More specifically, the self-esteem motive is the wish to think favourably about one’s self. The self-consistency motive is the wish to protect and maintain the self-concept against change in the face of potentially challenging evidence. Rosenberg’s principles of self-concept formation include reflective appraisals (perceptions of others influence how one views oneself and shape self-concept); social comparisons (individuals compare and judge themselves by comparing themselves to others and to their own standards or moral image); self-attributions (assessment of one’s abilities and competence based on one’s behaviour and its outcomes); and psychological centrality (hierarchical organization of various components of the self). Rosenberg’s ideas about the process of self-concept are employed in this chapter to clarify the relationships among self-concept, the meaning of aging and the meaning of chronic illness.

The emotional and behavioural techniques used to enhance, protect and maintain the self-concept have been discussed in the literature as coping. Pearlin and Schooler (1978) discussed coping as “the things peoples do to avoid being harmed by life-strains” (p. 2). They argued that the fundamental premise of the concept of coping is that “people are actively responsive to forces that impinge upon them” (p. 2). Bury (1991), in his discussion of adaptation to chronic illness, called for more attention to be given to the positive actions people take to manage chronic illness as well as the problems they face. He further argued that interpretive sociology, with its view of people as active agents, provides a theoretical approach within which to study the diversity of everyday experiences of living with chronic illness. He argued that there are two aspects to managing chronic illness. One aspect encompasses the cognitive processes "whereby the individual learns how to tolerate or put up with the effects of illness" (Bury, 1991, p. 460). It involves maintaining feelings of worth and a sense of coherence (Rosenberg’s self-concept motives) in spite of chronic illness (and/or aging) and maintaining a sense of value and meaning in life in spite of symptoms and their effects (Bury, 1991). The second aspect of managing chronic illness includes strategies or actions
participants take or what they do in the face of chronic illness (i.e., actions taken to mobilize resources and maximize favourable outcomes) to enhance, protect and maintain their self-concepts. Strategies mean skillfully manipulating social settings and appearances to minimize the impact of illness on interaction (Bury, 1991), mobilizing resources to advantage (Locker, 1983) and setting realistic goals in order to maintain everyday life (Bury, 1991). Bury also maintained that the use of strategies suggests "the need for a dynamic view of choice and constraint" as people weigh the effects of alternative actions. Strategies may be altered or changed over time. While Bury (1991) differentiated between cognitive coping and action strategies as separate ways of managing chronic illnesses, for the purposes of this thesis, these will be subsumed under the concept of strategies, recognizing the diversity of ways in which people manage their lives as they age and acquire a chronic illness. Although the methodology of this study did not allow me to observe change in managing aging and chronic illness over time, the reflective comments of the women may provide some insights into this change. Also the inclusion of women with different levels of disability from mild to severe may allow some perspective on how women with varying disability levels manage aging and chronic illness. Coping strategies may vary and change over the course of chronic illness as women move across disability levels from mild to severe.

Motivation for change of the self-concept requires that the individual is striving to achieve goals. Change is usually facilitated by the need to protect, maintain or enhance the self-concept and an awareness of the differences between the desired self and the extant self. Rosenberg argued that the self-esteem and self-consistency motives were essential for preserving, maintaining and enhancing the self. Each of the motives will be examined across the three groups of women discussed in Chapter 5. Data on the self-concept motives were not gathered directly; rather, attention was given to the structure of the self-concept. It was during the analysis of the data that it became clear to me that the women were discussing more than just how they saw or wished to see themselves; they were also explaining how they maintained these ideas about themselves over time. Therefore, it became clear that the strategies the women used to manage their lives could not be explored simply by considering the structural aspects of self-concept. At that time, I went back to Rosenberg's writings to read his discussion about the processes involved in consideration of the self-concept. I then reframed my analysis to include Rosenberg's ideas about the self-concept motives. The self-concept motives are central to the individual's motivational system and facilitate the enhancement, maintenance and protection of the self (Rosenberg, 1979). While ideally these processes should be examined over time, it is possible to get a sense of these motives through the reflective comments of the women in this study as they describe how they perceive they had changed over time. These ideas emerged from questions such as "How would you describe yourself in the past?" "How have you changed or stayed the same over your life?" "What are your plans for the future?" Thus, the examples used to illustrate the self-concept motives are primarily drawn from
conversations about aging and osteoporosis. This chapter will focus on the strategies used by the women in this study to protect, maintain and enhance their self-concepts within the context of aging and health. Throughout the chapter, I will give details of some women’s stories to illustrate how women in each group protected and maintained their self-concepts. These women’s stories reflect more generally the collective findings for the group and provide the reader with a more comprehensive picture of the lives of the women than is often projected with numerous quotations from different women.

Prior to discussing the specifics of the self-esteem and self-consistency motives, it is important to examine how the manifestations of osteoporosis (i.e., the severity of symptoms) relate to self-concept. Before beginning this research, I had assumed that the level of disability might be related to the self-concept of women with osteoporosis, that is, women with severe disability would have poorer self-concepts than women with mild disability. Analysis of the data and the placement of women in one of the three groups related to self-concept revealed that this assumption was not valid. (See Table 7-1 for the actual numbers in each category of disability in each group of women.) The self-concepts or the women were not related to their levels of disability. Among the women with competent selves, there were women with mild, moderate and severe disability. The women with severe disability were able to maintain competent selves despite the severity of their chronic illnesses. Women with contradictory selves had mild and moderate disability. Women with ineffectual selves had mild, moderate and severe disability. Thus, the levels of disability varied within and across the three groups of women and were not related to the self-concepts of the participants.

**The Self-esteem Motive**

The self-esteem motive is the wish to think well of one’s self. High self-esteem is characterized by self-respect and by considering one’s self a person of worth. The individual recognizes faults that he or she hopes to overcome. Low self-esteem is manifested by the lack of respect for one’s self, consideration of the self as unworthy, deficient and inadequate to master situations that may arise. Feelings of low self-esteem may lead to depression (Rosenberg, 1979).

This section of the chapter will examine how the conceptions of aging and chronic

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illness are related to the self-concepts of women with competent selves, contradictory selves and ineffectual selves. I will begin each sub-section with a brief overview of the findings described in Chapter 5.

**The competent self.** Women with competent selves held favourable opinions of themselves. They were self-assured and respected themselves as competent partners, parents, grandparents, friends, workers and volunteers. They felt they had good relationships with others. Valued activities gave meaning to their lives and they balanced obligatory and discretionary activities well. Particular life events had led to change and growth amongst the women with competent selves. They felt confident that they could overcome obstacles and could exert control over their lives. Throughout their lives they had not always viewed themselves in these ways but at the time of the interviews they displayed high self-esteem. Their desired or committed selves were closely aligned with their extant selves. They wished for continued involvement in meaningful roles and activities and to meet this goal they planned for the future. The selves they presented to others were similar to their extant selves. They sought social approval and validation of their extant selves through interactions with others. Feedback from others confirmed their own self-pictures as competent.

Women with competent selves considered aging as a natural process (10 of 12), as a time of increased wisdom and forthrightness (4 of 12), and as a time of changing priorities and new found freedom (3 of 12). They accepted aging as an inevitable part of life which brought benefits as well as change. For the most part, they were not concerned about aging or how it might change their lives in the future. While they noticed some changes in their physical abilities, these changes had not interfered with their ability to continue with valued activities and they accepted these changes as part of life. They continued to be self-assured and satisfied with their lives. Some felt that they had acquired wisdom and experience over the years. They were freer to "speak their minds". They refused to participate in activities that were not of interest whereas in the past they felt obliged or pressured by others to take on tasks. For those who had worked in their later years, retirement was perceived as a reward and they found their newly acquired free time quickly filled with preferred activities. They continued to consider themselves to be competent despite the changes they experienced with aging. However, there were some women with competent selves who were annoyed by the changes that aging brought to their lives. While not considering aging to be a time of loneliness and uncertainty or a time of deterioration and loss, they were not happy with the changes they saw. Despite the changes with aging, however, they continued to think favourably about themselves. The strategies they utilized to do this will be discussed later in this section.

Women with competent selves regarded chronic illness as mundane (3 of 12), as inconsequential (6 of 12) and as unpredictable (5 of 12). For those considering chronic illness as

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30 They had mild \(n=3\), moderate \(n=4\) and severe \(n=5\) disability as defined in Chapter 4.
mundane, it was something to be expected with aging and while they had made changes in their lives, for some of the women in this group these changes had been relatively minor and they were able to maintain views of themselves as competent as they engaged in valued and meaningful activities. Generally they did not perceive their chronic illnesses to be problematic—osteoarthritis was “no big deal” for them. Some of them feared other illnesses such as cancer, because they thought of cancer as life threatening whereas they did not think that they would die of osteoporosis. Some women considered chronic illness as inconsequential. While initially concerned about their osteoporosis and how it might change their lives, because they had not experienced any fractures they had become rather complacent about it. They did not think it would change their lives to any great degree. If it did change their lives, they were confident that they could master these challenges and exert control over their lives. While remaining positive, they were aware that the course of osteoporosis could be unpredictable and lead to fractures; thus, they avoided activities that would put them at risk for fractures, but for the most part they resumed their usual activities. There were other women whose osteoporosis had created many problems (5 of 12). I categorized them as having severe disability. They considered their illness to be unpredictable but they believed that they could overcome obstacles and lead an active life even if it required caution on their part to avoid behaviours which might result in fractures of their osteoporotic bones. Regardless of perceptions of chronic illness as mundane, inconsequential or unpredictable, women with competent selves viewed themselves as active agents as they aged with osteoporosis. They thought well of themselves, displaying self-acceptance and self-respect.

For the most part, women with competent selves regarded aging and chronic illness as manageable. When chronic illness was unpredictable, they felt confident that they could master changes that they expected might happen over time. They were certain that they could remain active and engage in meaningful, valued activities despite the changes that they might experience with aging and chronic illness. I will give details of two women’s stories to illustrate how women with competent selves continued to think well of themselves as aging women with osteoporosis.

Mastery of past life experiences had led to increased growth and change among some women with competent selves. As they assessed their self-attributions, they were certain that they could be active agents, taking control and managing situations that might arise in the future related to aging and chronic illness. Divorce and the subsequent need for paid employment had been the catalyst for change in the self-esteem of one woman. She spoke about the changes that she had experienced as a result of her divorce. She referred directly to how her self-esteem had improved over time. She described herself in the past as a good wife who “thought the wife’s role in life ... was having babies and washing shirts and socks” (P206, age 61) but as very withdrawn and shy. She talked about having to overcome her low self-esteem when she decided to leave her husband, taking her three young children with her. Paid employment had been important in reconstructing her
self-concept as a competent and worthy person, valued for the contribution she made to the lives of the children for whom she provided care. She characterized herself using words such as sensitive and caring, outgoing and independent. She now considers herself to be a competent mother, grandmother and worker.

But once I started [working], I found that I guess it was my self-esteem which had been completely shattered by the divorce. I started rebuilding it. But it took me several years to get to the point of admitting that I'm doing a darn good job and I've helped [the organization I work for] some. (P206, age 61)

She generally accepted aging and maintained feelings of self-acceptance as she aged. She considered aging as a natural process, as something to be expected and accepted. She described how she thought one could prepare for aging by remaining engaged in activities. When asked about the advantages or disadvantages of getting older, she talked about some of the financial perks like not having to pay to have cheques personalized at the bank. However, she felt that there were disadvantages as well. She said,31

Something’s going to happen to us all. The thing is you’ve got to think and plan for it .... get involved in something .... I have joined the senior’s club .... I went on a couple of outings with them. I might wander over later this week and find out if they’ve got Octoberfest lined up. If they have ... I might go. If I can find the time. [Aging is] a question of acceptance, I know we can’t avoid it .... And my mother unfortunately on the day she died never believed she was getting old. She really resented getting old. But it comes to all of us .... death comes to everybody, it’s part of living. (P206, age 61)

Chronic illness brought some unpredictability to her life.32 While she wanted to continue to provide care to young children, she was aware that she might have to give up her employment as her osteoporosis progressed; otherwise, she would be putting herself at risk for more spinal fractures because her work included lifting and carrying the children. After her initial diagnosis with osteoporosis, she had been angry and felt uncertain and fearful of the course it might take and her ability to continue to control the things that happened to her. However, after some time and involvement in a self-help group for women with osteoporosis, she felt able to cope with her chronic illness and maintain her positive feelings of self-worth. She talked about the value of self-help groups for women with osteoporosis. Self-help has recently gained recognition as “a social movement and self-help groups as settings that promote individual, interpersonal, and social change” (Luke, Roberts, & Rappaport, 1994, p. 88). She had been instrumental in starting a group in her community. She said,

We got by that period [after the initial diagnosis and the need for lifestyle changes] and

31 Portions of this quotation have been included in Chapter 6.

32 I classified her as having moderate disability based on a height loss of six inches and back deformity. She was unable to do IADL activities such as heavy housework. She complained of pain but related it to osteoarthritis rather than osteoporosis.
adjusted slowly .... the reason I got involved with the [self-help] group ... was when my eldest daughter said to me here one day, I went to pick something up from the floor, she says leave that I’ll pick it up, I don’t want to hear anything else about three more fractures. And I thought you little so-and-so, you little bitch, I’ll go out and find somebody who does want to listen. So I got together with a friend of mine and I said ... let’s start a group .... my idea for a group is two people with a common problem, supporting each other .... we’ve got about 30, between 30 to 35 [people who] turn out on a ... regular basis .... first you get the asthma which complicates your life to a certain degree, and you get that under control and then you’re hit with osteoporosis. Which I mean certainly puts limits on what you can do or the way you do it .... But I think as with any chronic illness there is a lot of anger. I think the people to worry about are the people who won’t admit their anger .... I think the anger’s got to be expressed to some degree. If you can’t do it with your own family and it can be distressing for a family, [then] the group is the place .... I find on the whole that [the women who attend the self-help group are] remarkably cheerful bunch of people. (P206, age 61)

She realized that she will have to give up her employment in the future because of her osteoporosis and had begun to plan for her retirement. She viewed herself as making the transition from competent worker to volunteer while maintaining her view of herself as worthwhile. She felt that she could maintain her self-concept as competent regardless of the changes brought about by her chronic illness through continued support from the self-help group she attended. Chronic illness had not become pivotal to her self-concept.

Another woman also talked about the impact of divorce on her self-concept as well as her experiences with multiple surgeries. “[My husband’s leaving] was the worst thing that ever happened to me in my life .... I was devastated by my husband’s desertion of the family .... that was the most difficult time in my life” (P210, age 63). While she had positive recollections of her life before the separation, the initial years after her husband left were very difficult for her. With the support of friends she had been able to overcome her feelings of depression and abandonment. This demonstrates the importance of reflective appraisal (Rosenberg, 1979) in the maintenance of self-esteem. Her friends’ continued view of her as competent seemed to bolstered her self-esteem. In retrospect she thought she gained strength from the experience. Now she thinks well of herself. She characterized herself as strong, happy, lucky, generous and assertive; as a competent mother, friend and worker. She said,

It’s been an active life. And a good life. There were those three years there when [my husband] left where .... I don’t even remember how I lived. I was not a good mother, I was so wrapped up in my own grief, and heartache that I don’t think I was a very good mother. I tried, and there are highlights but it’s almost like I don’t remember it. But life is good now. I’m a happy person .... [since the divorce] I’m a strong person .... the divorce really mellowed me .... I was a pretty black and white person before .... there were certain things that were important to me which I know now are not important. (P210, age 63)

When asked about aging, she talked about her displeasure with the process of aging. She was not happy with the physical changes that were occurring. However, she accepted and respected herself as an aging woman who was busy and engaged in meaningful work, who looked forward to retirement although she had some financial concerns, and who had a strong social network who
provided her with the support she needed to maintain her view of herself as competent. She said

P: I hate [aging]. I hate it with a passion. And I'm fighting it (LAUGHS) .... every step of the way. I don't appreciate it at all you know and I can see it. I've aged a lot since I broke my hip too. But I am very lucky in that I'm in excellent health with the exception of the osteoporosis .... I've got arthritis ... you get the aches and pains .... And your teeth are starting to go and I'm getting headaches and (LAUGHS) my eyes aren't what they used to be. Yeah I just think it's the pits, I hate it.

SW: Do you see any advantages?

P: Not a hell of a lot I've got to tell you (LAUGHS). Again I'm lucky because I have a zest for life, and I'm not going to let, I mean I'll have to be in bed before I'll let it really get me down, I'll have to have some horrible disease that makes me bedridden and they've got me tied down .... when I can't drive my car, they're going to slam the lid in my face. Because I just go all the time. But it makes a difference and I don't like it particularly.

(P210, age 63)

Her comments about aging and her apparent ability to overlook her negative feelings and continue to think well of herself may illustrate Rosenberg's (1979) ideas about psychological centrality. He argued that "a person's global self-esteem is based not solely on an assessment of his constituent qualities but on an assessment of the qualities that count" (p. 18). She was able to have negative feelings about aging without them affecting her overall self-concept as competent.

Her experiences with chronic illness had begun before her diagnosis of osteoporosis. As a result of an accident in which she had fractured her hip, she had spent a great deal of time in hospital for surgeries. In retrospect the internal fixation used initially to stabilize the fracture failed because of her osteoporosis. This was followed by a hip replacement. There had been complications requiring further surgery. She had subsequent fractures that had also meant a stay in hospital. The eventual diagnosis of osteoporosis had explained the problems she had had with the original hip fracture and its management. She believed that her current response to her osteoporosis was related to those experiences and her interactions with a psychotherapist over the course of her surgeries. She explained how this relationship had helped her maintain her self-esteem. She had taken more control over her medical care.

Between the couple of surgeries--I have a great GP here in town. And she suggested I see a psychotherapist. And she helped I must admit, I saw her a few times ... I couldn't afford to see her very often, but she and I hit it off really well and she's the one that helped me the most I think (PAUSE) meditating, getting over the fear of the surgery, being more assertive. You see here I was going along with this doctor that was not doing me any good at all. And she helped me when he left, God knows what I would have done if he hadn't left [the city] and I had to find a new surgeon. And I interviewed three. Because I knew I had to have surgery again. I interviewed them. One of [them] ... probably has the reputation [of being] the best in Canada. I couldn't stand him, he and I got into a verbal argument within five

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33 I classified her as having severe disability because in addition to having difficulty with heavy household chores, she also had difficulty with light chores. She had given up leisure activities. While she continued to work, she did so only in the months when there was no ice and snow and spent the winters in the southern United States. She had spinal deformity, had had multiple surgeries for fractures and used a cane for mobility.
minutes of (LAUGHS) meeting. So I crossed him off my list .... I would not have had the
guts to do that without this woman’s help I guess. And the visualization34 which I had never
done, of the medication helping .... your medication and it’s eating up the bad things and
letting the good stuff stay, just helping me be more aware of my body. I had a disadvantage
in that I had never been sick .... I wouldn’t have known how to handle [the surgeries], God
was with me I think. So I was very unaware because I’m very impatient and very unhappy
with my body. [My body] had let me down. And she helped me understand what was going on ....
the psychotherapy helped, the visualization, the understanding of how my body
worked. What I could expect from it (PAUSE) I think that’s what helped me through the
most and that wasn’t until after the second surgery .... it made such a difference in how I
recovered. It truly made a difference, I wasn’t fearful at all, I knew about the pain after,
but I wasn’t fearful. (P210, age 63)

Overall, she assessed her self-attributions (Rosenberg, 1979) positively based on her
experiences with managing her divorce and surgeries. The support of friends and a psychotherapist
provided her with validation of her competency. She maintained her self-concept as competent
despite her negative views of aging and the severe disability which resulted from her osteoporosis.

At the time of their interviews, women with competent selves displayed positive views of
themselves although this had not always been so across time. Thinking well of one’s self may be
facilitated through Rosenberg’s (1979) principles of self-concept formation: social comparisons,
reflective appraisals, self-attribution and psychological centrality. They had overcome feelings of low
self-esteem to attain feelings of self-worth and self-acceptance. Particular life events were relevant
to how these women with competent selves thought of themselves. These life events led to change
and growth and had resulted in improved self-esteem. This reflects the discussion by Markus
and Herzog (1991) about the importance of self-concept in the integration of experiences across time
providing continuity and meaning to them. Women with competent selves maintained positive self-
esteeem through social support of family, friends and health care providers. For the most part, they
viewed aging as positive. When they did have negative views of aging, these views did not seem to
alter their views of themselves as competent. Chronic illness was viewed across a spectrum from
mundane to unpredictable. However, despite the level of disability, women with competent selves
were not overwhelmed by their chronic illnesses. Rather, they seemed to accept their limitations.
While for some with severe disability, chronic illness was constantly on their minds because of the
need to manage their chronic illnesses on a daily basis, it had not become central to their self-
concepts. Thus, their conceptions of aging and chronic illness (whether positive or negative) did not
alter their views of themselves as competent. Even when they held primarily negative views of aging
and chronic illness, these ideas had not become pivotal to their sense of self. For women with
competent selves, the negative meanings of aging and chronic illness had not become

34 This technique has been used extensively with patients with cancer and discussed in the
literature by the Simontons--Carl, an oncologist, and Stephanie, a psychologist (Pennington, 1988).
This is often considered an alternative to traditional medical care.
psychologically central to their self-concepts.

**The contradictory self.** Women with contradictory selves struggled to align their extant and desired or moral selves, to take control over and balance their lives, to gain personal autonomy and to acknowledge the legitimacy of their own needs. They characterized themselves as busy, caring, confident, happy and outgoing but also as anxious, stressed, needing support and reassurance. They continued to strive to do more despite feelings of burden and resentment about the expectations of others. They wanted more time for themselves as they struggled to gain balance in their lives. They spoke openly about having to overcome their feelings of low self-esteem. While working toward increasing their self-acceptance and self-respect, positive self-esteem seemed elusive for some women with contradictory selves. Others felt that they had gained enough self-esteem over the years to be able to face current crises with more confidence than they might have in the past but they still felt some doubt about their abilities to take control over their lives. They were often unsure of what selves they presented to others and, without a clear self-picture, they had difficulty knowing how others viewed them. Without clear views of themselves, they did not receive clear feedback from others that reinforced positive extant selves. Their need for social approval and to conform to social norms seemed to result in diminishing self-esteem.

Women with contradictory selves viewed aging as both a natural process (4 of 8) and as a time of deterioration and loss of independence (7 of 8), as a time of poor health. Individual women held these opposing views. This further reflects the discrepant ways in which these women thought about themselves and their lives. While suggesting that aging was a part of living, their characterization was summed up by one woman’s comment, “These golden years aren’t what they’re cracked up to be”. They expected physical changes with aging but they were aware that aging was a time of mental and social losses as well. While they saw their own aging as inevitable, they felt that it was out of their control. This brought feelings of fear and uncertainty. They feared that age-related losses would result in increasing dependence, in becoming a burden to their family and in the need for institutionalization. They felt unable to control the deterioration and disability that might result from aging. They seemed to lack the self-confidence to feel they could overcome the changes brought on by aging.

As with aging, individual women within their own experience considered chronic illness in contradictory ways.\(^{35}\) They characterized chronic illness as mundane (3 of 8) and as adaptation (3 of 8) but also as unpredictable (4 of 8). Initial concern about their diagnoses often changed to indifference because they had no pain, fractures or deformities. Those who typified chronic illness as adaptation had given up some activities and changed the ways in which they performed other activities. They maintained that a positive attitude was essential for living successfully with a

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\(^{35}\) They had mild (n = 5) and moderate (n = 3) disability as described in Chapter 4.
chronic illness. Some women characterized chronic illness as unpredictable, as a time of fear and uncertainty. They were “walking on eggs”--afraid of falling and “breaking” or fracturing bones that would create further limitations. This fear of falling could lead to social isolation. The possibility of fractures also created an uncertainty about continuing to engage in volunteering and paid employment. Their lives had become uncertain and they had given up valued activities, both obligatory and discretionary activities. They felt unable to plan for the future given the unpredictable course of their osteoporosis. As with women with competent selves, I will utilize the stories of two women to illustrate how women with contradictory selves maintained their self-esteem.

In some situations, women with contradictory selves seemed to set insurmountable tasks for themselves. They had unrealistic expectations about their ability to manage tasks over which they had little control. No matter how well they performed, they could not meet their own expectations. One woman talked about striving for perfection in tasks she took on. This often created an untenable situation for her. For example, she tried to complete work that was perfect but this goal was often out of her control. Working hard and striving to maintain a positive mind-set were ways she used to ensure success in her undertakings but failure to meet her own expectations led to feelings of low self-esteem. When asked how she would describe herself in the past, she said “Ugh-ugh, well actually in the past I was very timid. Um, um, what’s the word I want. I didn’t have, um, I didn’t have much self-esteem, didn’t think I was worth much” (P103, age 59). She had worked hard over the years to prove herself, striving to gain a picture of herself as worthwhile but she continued to have difficulty aligning her extant and desired selves. Rosenberg (1979) suggested that social comparison, as well as comparing oneself to others, can also occur when one compares oneself to one’s own standards or moral image. It is this latter meaning of social comparison that seems to be the focus of this woman’s comments.

I know when I set my mind to do something I will be successful at it. Mainly because I put in a lot more work than the average person on something because I want it perfect .... I’ve always strived to have everything perfect, the best it could possibly be and that’s a bit of a downfall with me because I would be better off if I could say “Alright I’ll put this much effort into it and this will be more than acceptable and why does it have to be 100 percent” .... that’s something I have tried to work with ... but I don’t do too well because if I take something on I, when I have worked on an immigration case [she explained that it was possible to represent someone in an immigration situation without being a lawyer], I have worked for months on one [case] and I have been awake half the night because I sleep and I wake up with an idea or a thought or a way to word something, just the way to phrase something and I have to get up and write it down or I’ll forget it by morning. If I don’t get up and write it down I’m awake the rest of the night saying it over so I won’t forget it by morning. And so I don’t like taking on those jobs because they take so much out of me. I am so exhausted when it’s over. (P103, age 59)

While putting in 100 percent effort may have created some problems for her, she also felt her efforts were rewarded when others acknowledged her work. This praise from others (reflected appraisals) improved her feelings of self-worth temporarily but her underlying opinion of herself remained poor
because of unmet education potentials. She believed that she had the intellectual ability to have a career in teaching or law but she had given those aspirations up to raise her daughter as a single parent. She had worked hard to provide her daughter with opportunities but she had not fulfilled her own needs or desires for more education.

I enjoy the ego boosting [which resulted from the praise of those hearing immigration cases] ... but at the same time I have this sort of low opinion of myself in many ways too. Because I think um, heck I was born with above average ability and I never really ... I could have done something in this world maybe and I just didn't. (P103, age 59)

There was a discrepancy between how this woman talked about aging and about aging with a chronic illness. She considered aging to be a natural process. She had many family members who had lived into their 90s and she felt confident that she could manage her aging without problems. In fact, she had difficulty realizing how old she was. She was youthful looking and others treated her as younger. However, chronic illness created more concern for her. She was concerned that she might become old and disabled without having accomplished her life goals. She considered her osteoporosis as mundane and she was able to forget about it because she had no pain or deformities. However, she also saw it as overwhelming. She was anxious about becoming handicapped by osteoporosis and she would not want to become a burden to her family. She was concerned that she might be institutionalized and abandoned by her family. Her recent experiences with family members in long term care facilities concerned her. She saw people there who had been abandoned by their families. This is similar to the findings of Marshall (1980) and Charmaz (1991) that older adults may fear dependence, disability and abandonment more than death. While she worked hard to fulfil her moral self as caring and giving, she also felt ambivalent about providing care to others. However, she continued to extend herself for others. When she thought about her own future which might involve disability, she seemed to be fearful that others would not be there for her. While she expected a great deal of herself, she seemed unsure whether she could expect the same from others and worried that others may not feel the same moral obligations that she did. She said,

What if because of my osteoporosis I one day am crippled up like some of these people you know in these hospitals and I thought "Who is going to come and visit me I wonder". Like this lady that I go to see she has to wear a diaper. She wears hospital gowns. While I made her over a dozen now, hospital gowns in prints and with yokes in them and with lace around them .... And I thought "Who is going to do this for me?" (LAUGHS) "Anybody?" That worries me a little. I sort of start thinking what is going to happen if I am disabled. That is the one thing that kind of, because well as long as I could have lots to read I guess I'll be alright. But I don't want a little book mobile coming by with a little selection of who knows what .... I want the library computer so that I can dig up subjects and get into them (LAUGHS) ... anyway that's in the future and it may never be and one should never worry

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36 I classified her as having mild disability. She had no pain or deformity. She continued to engage in her usual activities.
about what may never come to be anyway (LAUGHS) .... If my own daughter didn't come to visit me I wouldn't bug her about it. I couldn't possibly. I would think "Well if she doesn't want to come she doesn't want to come". These ladies in that room [in the long term care facility] can't even pick up the phone. When I'm there I dial whoever they want to [talk to] and give the different ones the phone. I'm virtually the only visitor in there. Some of them have somebody who comes once in a while. (P103, age 58)

The contradictory nature of this woman's self meant that, while chronological age did not seem to concern her, her ideas about aging with a chronic illness did. The meaning of chronic illness was also a conflict for this woman. While for the most part, she could forget about her osteoporosis, she was also concerned about her future, given what she saw happening to people in long term care facilities. Her fears seemed related to becoming old, disabled and dependent on others and the fact that other people might not feel any obligation to provide her with the care she might need. Her own inability to align her extant and moral selves made her wonder if this might be a problem for others who might be in a position to provide care for her.

Life events were important as opportunities for change and growth for women with contradictory selves, as they were for women with competent selves. However, the discrepant nature of these women’s views of themselves led them to struggle to gain and maintain their self-respect. One woman described the strength she believed she had gained while living through a divorce. This life event had given her the determination she believed she needed to manage her life with cancer and osteoporosis (self-attribution). She also discussed how her faith had intensified as a result of her divorce. Early in the interview when asked to describe herself as a person, she seemed to view herself positively.

I didn’t have enough self-confidence. I lacked self-confidence [early in my life] .... I have changed. It was a devastating experience to be rejected [by my husband]. It was a very difficult time .... I think I am strong-willed. I'm not stubborn. Um I think I’m motivated to a point .... I had to overcome a terrible sense of low self-esteem because of the rejection .... I think I can make decisions better .... So that because of this [divorce], I would say that my faith has really been strengthened .... I think within myself I had a much deeper spiritual life. (P107, age 78)

But later in the interview, she presented a contradictory picture of herself. She seemed to doubt herself. These conflicting views of herself threatened her feelings of self-worth. While she expressed certainty that she could live independently, she was concerned about her ability to manage her finances. Without adequate financial resources she would have to give up her apartment. She lived on a fixed pension and had only a few investments. Low interest rates (in 1994) meant that she might not have enough money to maintain her current lifestyle, a situation that was not within her ability to control. She also had some underlying doubts about her faith. She was unable to attend church because of the effects of the chemotherapy she was receiving for her cancer. This created some concern for her and undermined her self-esteem.

I think I can make decisions better except when it comes to financial decisions. And my
brother has been a help but now he is withdrawing that help. He thinks I can [manage on my own]—"you know what you have to do, you know what you want to do, do it". Well that's not so easy. It's easy if you have ... a large income—not so easy when you have a smaller [income]. I'm concerned that my church does not mean as much to me now since I've been sick because I don't go. It happens that on the weekends I'm the weakest [from] the medication and I can stay home very, very nicely. I think I've only been about eight times since August [the interview took place in January] ... just sending my envelope [with an offering] is not participating in the church. It goes deeper than that. (P107, age 78)

This woman reported that she was happy with her age of 78 and would not want to change it but when she talked about aging she was fearful of getting old. She equated aging with physical deterioration and illness and losses, the loss of independence as well as the loss of friends. Replacing friends with new friends seemed a daunting task for her. She did not want to live as long as the people she knew and saw in the nursing home connected to her seniors' apartment building because of the potential for physical and mental losses but she realized that this was out of her control. While she was concerned about her osteoporosis becoming worse and leaving her more stooped "like a little old lady", she was much more concerned about the implications of her cancer. She had recently made a decision to undergo chemotherapy which had the potential of prolonging her life. But she wondered if she would have gone ahead with the treatment, if she had known about the side effects. Since beginning her treatment for cancer, she had become more isolated and she had given up obligatory and discretionary activities. Her cancer made her life more unpredictable and she was unable to make plans for the future.

Now I am not able to participate [in church] because I don't have the energy or the strength so I am quite, I don't like being a recluse at all but I have become a recluse to a degree, because I can't walk any distance and I'm driving. But my activities are so narrowed and I have lost a number of friends through death, very, very close friends and you don't replace those people. They're irreplaceable. You try but you don't .... I am confined and because this unknown quantity [cancer] within me. So far I'm okay. I had ultrasound about three weeks ago and it has not metastasized. So hopefully but the chemotherapy does a lot to a person .... if I had know the implications I don't think I would have gone into it. I might have regretted it if it flared up again. But at my time of life I'm not so sure that I want to prolong it forever. And I'm giving up a year of my life for the chemo[therapy] to maybe gain one year. And I see so many people in nursing homes, very tragic cases, and I don't think I want to live that long. I can't control that and a lot of people think that way .... I'm a little fearful of getting older. I see so many people in our nursing home here just sit around all day and they're not well, they've got poor health, limitations. That's why I said I wondered if I was wise taking the chemotherapy. Just take a chance. What's the point of extending my life a year except I want to live for my son and my grand[child]. Very much I want to live but I can also see the possibilities of becoming disabled, confined to a wheelchair, having Alzheimer's, having any number of things. (P107, age 78)

While on the one hand, she said she was not concerned about aging per se, on the other hand, she

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37 I categorized her as having a moderate disability. She had lost 4" of height, had a dowager's hump, had given up heavy household chores and had recently begun to use a cane occasionally on the days following her chemotherapy.
was concerned about becoming old and disabled. As with the woman discussed previously, this seemed related to people she saw in long term care facilities. However, it was also associated with her own apparent deterioration after treatment for cancer. This had undermined her feelings of confidence in her own abilities to overcome her chronic illnesses.

Women with contradictory selves strived to overcome feelings of poor self-esteem and to work toward improving their self-acceptance and self-respect as they attempted to align their extant and moral selves. They lacked the self-confidence and self-esteem to take control of their lives. Some of the women with contradictory selves had improved their self-esteem over time but they doubted themselves and lacked an enthusiastic view of themselves as worthwhile. For other women in this group, self-acceptance and self-respect still seemed elusive. While using Rosenberg’s principles of self-concept formation (as did women with competent selves), they seemed unable to think well of themselves over time. They judged their attributions based on their performance in situations over which they had little control. Interactions with others that provided some validation of positive extant selves seemed to provide only a short-term increase in self-esteem. They continued to judge themselves against their moral images which seemed unattainable. Individually, they held conflicting views of aging and of chronic illness which reinforced the contradictory nature of their self-concepts. While considering aging as part of living, as natural and attempting to adapt to their chronic illnesses, they were also concerned about deterioration and the loss of independence and the unpredictability of aging with a chronic illness. Ideas about chronological age and osteoporosis had not become fundamental to their self-concepts; more important were the symbolic meanings of being old and being disabled. These conceptions of aging and chronic illness seemed to reinforce selves that were contradictory.

The ineffectual self. Women with ineffectual selves described themselves in terms that would indicate that they lacked self-respect and considered themselves inadequate and incompetent. Generally these women described themselves as depressed during their interview as well as in their responses on their questionnaire. Rosenberg (1979) argued that there is a positive relationship between low self-esteem and depression. They seemed unable to narrow the gap between their extant and desired selves. Bringing their extant selves into alignment with their desired selves would require very dramatic changes in themselves. They were unable to manage challenges and take control over their lives. They talked about strained interpersonal relationships. They seemed to present selves to others that were negative and in keeping with their extant selves. They did not know how others would describe them and in some cases, seemed to fear what others thought. The isolated nature of their lives made validation of selves difficult because of the lack of feedback from others. Only recently had three of the women begun to engage in behaviours that might indicate some movement to enhance their self-concepts. While these changes might increase their self-esteem in the future, they continued to lack self-acceptance and self-respect at the time of their
interviews.

Women with ineffectual selves considered aging as negative, as a time of loneliness and uncertainty (7 of 8) and as a time of deterioration and loss of independence (6 of 8). Loneliness was often the result of the death of spouses, family and friends. Within this group, half of the women were widowed. This is a larger proportion than in the other two groups. This increased their reclusiveness and depression. It also raised concerns about who would care for them in the future. Uncertainty was related to general concerns about deteriorating health and continued participation in valued activities. Some women’s concerns were not related to their osteoporosis but to other diseases they feared (i.e., blindness, dementia or heart problems) but which they had not been diagnosed as having. Those who saw aging as a time of deterioration equated aging with chronic illness and disability. Some women described aging as “annoying” while others described it as “horrible”. They equated aging with the onset of physical deterioration and specifically with osteoporosis. This was reinforced by health professionals. Loss of independence was characterized by losses that ranged from losing one’s license to drive to being institutionalized as physical and mental changes occurred as a result of aging. The low self-esteem, lack of self-respect and depression of the women with ineffectual selves reinforced their views of aging as a time of loneliness and deterioration.

Women with ineffectual selves generally characterized chronic illness as unpredictable (7 of 8) and overwhelming (7 of 8) although some also saw it as a time of adaptation (4 of 8). Chronic illness as unpredictable was associated with the fear of fractures. This often resulted in a need for the women with ineffectual selves to change their lives in very significant ways. For some this meant the possibility of giving up paid employment or volunteering, activities which were valuable and meaningful for them. Other plans for the future were also difficult, given the unpredictable nature of their chronic illnesses. This resulted in some women living day to day. Some women considered chronic illness as overwhelming. They were devastated by their chronic illness. It had disrupted their lives completely. Previously active lives had become very restricted by osteoporosis. These women often felt lonely and isolated due to their inability to engage in previous activities and their inability to sustain relationships with others, due to the narrowed nature of their lives. Fear of institutionalization was also evident amongst women with ineffectual selves. They felt disheartened and fearful of a life dependent on the care of others. Living one’s life overwhelmed by chronic illness may be related to feelings of worthlessness and depression. As with the previous two groups, I will illustrate how women with ineffectual selves thought well of themselves by describing in depth three women’s stories.

Through increasing communication and compromise on her part, one woman thought she

38 They had mild (n = 2), moderate (n = 2) and severe (n = 4) disability.
could change her attributions or extant self with resultant positive changes in her relationships with her husband and children. Reciprocity\textsuperscript{39} was the ultimate goal of these changes. She wished to improve relationships with her husband so they would be able to care for each other as they aged. She had also rejected help for her chronic illnesses from her family in the past and she realized now that she may need their care in the future. She suggested that her own stubbornness and feelings of neglect, stemming from 10 years ago when one of her children was diagnosed with cancer, had contributed to poor relationships within the family. Now she contended that with extensive work she might be able to change her interactions with her husband and family. However, she was overwhelmed by the magnitude of the changes required. She saw herself as ineffectual, lacking in self-respect and self-acceptance. Throughout the interview, she cried. Change seems to be in the distant future.

I'm slowly changing .... I'm giving in more and (PAUSE) I'm communicating a bit more and I'm talking more and I'm not, while I still feel self-hurt a lot, but I think it's a lot in the way I approach [family interactions]. If I would approach it a little different, I would maybe communicate and maybe it would be a lot easier for that other person to try to communicate with me. But I don't. But slowly I realize now that what I am going through now that I can do it now. And I figure as my daughter says "Mom, life is too short so [you have to meet people] half way and see what dad can do and you can do". So this is what I am doing slowly (PAUSE). (P101, age 60)

This woman considered aging as a time of loneliness and uncertainty. She felt alone because of poor relationships she had with her family and she saw elderly people for whom she provided care in the community as having been abandoned by their families and society. Her attempts to change have the potential to provide an opportunity for reconciliation with her family and improvement in her self-esteem and care in the future but this will require a great deal of change to her extant and presenting selves.

This woman's discussions about chronic illness\textsuperscript{40} focused on a life overwhelmed by pain. She had been plagued by illness since her 40s when she fractured vertebrae and ribs and had been diagnosed as having rheumatoid arthritis and osteoporosis. She said "it's been downhill ever since" (P101, age 60). She complained of pain in most of her joints including both her upper and lower extremities. She did not have a drug plan and was unable to afford medications that might alleviate the pain. She seemed resigned to her life of discomfort and endeavoured to persevere despite the

\textsuperscript{39} Reciprocity has been defined by Antonucci (1990) as “symmetry of exchanges (the degree to which support is given and received)” (p. 206). Using the work of others, she argued that “friendship relationships are more satisfying and more positive if exchanges are equitable (Roberto, 1989), and that asymmetrical exchanges are associated with feelings of loneliness and dissatisfaction with social relationships (Rook, 1987, 1989)” (p. 212).

\textsuperscript{40} I classified her as having a severe disability. She had rheumatoid arthritis as well as osteoporosis. Pain limited her activities and she had given up obligatory and discretionary activities.
pain. While she seemed unable to take any control over her aging and chronic illness and she perceived herself as ineffectual, she compared herself with others as a strategy of maintaining a sense of herself as lucky. She said,

Some mornings I couldn’t get out of bed, it would ache so bad. I would put clothes on but I suffered each day because I figured there’s a lot worse off than me. I kept going because I thought walking was the best thing you could do. If you laid in bed day after day it would get worse .... I think the most important thing is when your day starts is to have a good attitude. Okay, you’re going to have some pain, that isn’t going to go away but just to keep going and try and think of other people and do things for other people than to think of yourself. And that’s what I do. Doesn’t matter how bad or how I feel, I try to keep going. (P101, age 60)

This woman’s life was overwhelmed by aging and chronic illness. Her poor self-esteem led to depression and a view of herself as inadequate to overcome her situation. While she attempted to make changes in her relationships with her family, these seemed onerous. Her ability to more closely align her desired and extant selves seemed to be inhibited by her depression. Social comparison, while providing some immediate relief from her poor self-esteem, did not seem to have any lasting effects on her self-concept.

Focusing on abilities rather than disabilities and on the positive aspects of aging rather than the negative aspects may allow one to think well of one’s self (self-attributions). One woman portrayed herself as having a poor self-image and as being depressed. She was overwhelmed by her aging and osteoporosis which she perceived to be closely linked. She had not thought of herself as old until she had been diagnosed with osteoporosis. She said,41 “Well, up until I got osteoporosis, I wasn’t old. And then suddenly I became very old and I became very old very fast I didn’t realize I had osteoporosis. I didn’t ease into it, it happened” (P208, age 70). The onset of osteoporosis had been an extraordinary event disrupting her life. However, she had recently attended a seminar given by a physiotherapist. She had received new information that she thought had the potential to change how she thought about herself. While in the past the information she had received from her doctors was very negative and focused on what she should not do, the physiotherapist was telling her what she could do and that anything that was “aged” was good and highly valued. Reflected appraisal (Rosenberg, 1979) or how particular others view us may have the potential to change this woman’s view of herself over time.

I went [to the seminar] and it’s the only time anybody ever ... gave me as much information about myself .... She told me how to sit and stand, that I wasn’t old, wear whatever you damn well please and enjoy yourself for as long as you can. First time, she made me feel good. I came home and I said to [my husband], “That woman’s charming”. She did more for me than any book I ever read .... I stand up against the wall now and try and straighten up, before I’d stand there like a lump .... she said, “Remember anything that’s aged, is good. Wine, art, architecture, books, whisky, if it’s old, it’s good .... When she said those things--

41 This quotation has been used in Chapter 6.
and I thought "this is the first time [anyone has been positive]" .... [the doctor] said, "Don’t bend over, be sure you get up properly. Don’t slip over the rug" .... I think that if there was someone who could just take a group of people and say, “Look, here you are, you are all sitting here like little old things, it’s madness, who gives a damn, get on with it”... Now some days you can’t. Some days you just can’t .... get on with what you have to do, but other days, this is the first time I’ve been at home all week because there’s been things for me to do and I’ve been well enough to do them. The week before, I couldn’t care whether I got my clothes on. Things hurt. (P208, age 70)

While focusing on abilities and the positive aspects of aging has the potential to change this woman’s self-concept over time, during the remainder of the interview, she persisted in portraying herself in very derogatory terms such as fat, old, ugly, angry, and hostile. She continued to describe herself as depressed and lacking in self-respect and self-acceptance. The magnitude of her depression and negative feelings about aging and osteoporosis will require considerable effort on her part to change her self-esteem.

The apparent devastating effects of the onset of osteoporosis seemed to have become central to her self-concept. Prior to the onset of osteoporosis, she had led a very active life engaged in meaningful and valued activities. But that changed drastically with the onset of osteoporosis. She now considered herself old and disabled and was depressed by the changes that she had to make in her life. She talked about how she viewed aging and chronic illness as overwhelming. These views of aging and chronic illness were related to her ideas about herself as ineffectual.

Social support may have the potential to enhance one’s self-esteem. How others view us has an influence on how we perceive ourselves (reflective appraisals). After discussing her troubled relationships with family members and with the people in her apartment complex, one woman talked about her social world apart from her family and co-residents. She had become involved in a local church which seemed to provide a quiet, peaceful retreat from the realities of her life. She was learning to meditate. The relationships she had with people at church were quite different from her interactions with her family. Her ineffectual self seemed to change once she was in this setting. For the time in which she was at church and interacting with people there, she seemed to view herself as more competent than when she was involved in family interactions.

[Going to church] gives me something to do and nobody talks about each other and that’s what I like .... I’ve never known how to relax and I’m learning by meditating you see .... It is a real little church and it is so nice and peaceful in there [describes where it is geographically located]. It’s nice in there .... I just started going again. I thought “I can’t just sit here all the time” and ... it’s the people I like. And they’re all nice and they’re all more or less young. I think I am the only old one there. But nobody minds. They’re really nice to me. I think that’s what I like--because they’re nice to me. And I don’t tell my children .... It’s nice, you know. Nobody talks about the other one and I like that. Such a change from here. But you daren’t tell anybody here you are going to meditation .... I told one lady here and she said "Oh, you’re joining the rest of the kooks". So I said "Oh, I’m just kidding" and thought just don’t say anything. They all wonder where I go on these nights but I wouldn’t dare tell them. I don’t feel I am doing any thing wrong. Everybody’s nice and we laugh and joke. (P111, age 75)
She continued by discussing the feedback she received from the young people there when she tried to help them with their problems. She talked in detail about her friendship with a young man who had been having marital problems. She described how he had appreciated her advice. These interactions with people outside her family helped her see herself in a more positive way, as a person of worth. However, at the time of the interview, when she was not in that setting, she reverted back to a view of herself as ineffectual.

I go to the [names the denomination] Church because I enjoy it. I have a lot of nice friends and we all hug each other. And it’s nice. And they pray to God .... And I’ve met this nice young fellow and he was very upset. Apparently, I don’t know if his wife had put him out or not. He’s 40 ... and I talked with him. I do this sometimes, I talk to people and try and lead them to the right path .... he was very agitated. And he went to talk with [his wife] and fortunately she has taken him back. And I said "How would you like to have an adoptive mother" because he was badly treated as a child and his mother apparently, used to when he was in bed at night she’d hit him over the head with a stick .... I thought I had it bad but I wasn’t abused like that. And he was so happy and he said "You don’t know how happy you’ve made me". So next weekend I am going to have dinner with them--with his wife and meet his three [children] ... that will be nice. (P111, age 75)

This woman viewed aging as loneliness, uncertainty, deterioration and loss. She described herself as weary and “tired in her bones” when asked about aging. She equated aging with deterioration of her physical abilities and the resultant inability to participate in discretionary activities. She characterized herself as unable to “do anything any more”; she could not write, read or knit, activities which she enjoyed in the past. She also considered chronic illness as part of aging and was overwhelmed by her osteoporosis. While she described herself as having mild osteoporosis,42 she had given up many obligatory and discretionary activities. She was “terrified” of falling and breaking her bones. She seemed resigned to her life as a woman aging with osteoporosis. She said, “I just do what I can do” (P111, age 75). In contrast to the woman described previously (P208), this woman’s poor self-concept seemed to be related to more than aging and chronic illness. Her interpersonal relationships, particularly with her family, seemed to have undermined her feelings of self-worth over time. New social support from friends at church had the potential to change her self-concept at least during the time she spent in that environment. However, her views of aging and chronic illness seemed to add to her lack of self-respect and self-acceptance.

Generally women with ineffectual selves did not think well of themselves. As with the previous two groups, they attempted to utilize Rosenberg’s principles of self-concept formation but they continued to display low self-esteem, lack self-respect and report that they were depressed. However, three women within this group related their recent understanding of the need to change their ineffectual selves and engage in activities to increase their feelings of self-worth. While in all

42 I classified her as having moderate disability. She had lost some height due to osteoporosis and had some back deformity. While she continued to manage her ADL, she was unable to do IADL such as heavy housework.
situations, these women would need to work very hard to change their self-esteem (and for some it may not be possible), they had some hope that they could overcome their feelings of worthlessness and self-contempt. They viewed aging as a time of loneliness and uncertainty and as a time of deterioration and loss. They were overwhelmed by their chronic illnesses. These negative meanings of aging and of chronic illness had become pivotal to their views of themselves as ineffectual. For some women, views of themselves as ineffectual seemed to be exacerbated by their negative conceptions of aging and chronic illness. For others, the onset of osteoporosis seemed to result in negative views of aging and chronic illness which, in turn, altered their sense of self. While prior to the onset of their osteoporosis, they had positive ideas about themselves, with the diagnosis of osteoporosis they had become old and disabled. For this latter sub-group, their views of their own aging and their own chronic illness created a sense of self as ineffectual.

In summary, while some of the women in the study thought well of themselves, others did not. Some seemed overwhelmed by their low self-esteem but others were actively striving to protect and enhance their self-worth. Rosenberg’s (1979) four principles or generalizations involved in self-concept formation were utilized in the maintenance of self-esteem across the three groups of women. Self-attributions were assessed and modified in attempts to more closely align the extant and desired selves. Mastery of past life events as well as focusing on abilities rather than disabilities often led to change and growth providing positive views of selves. Reflected appraisals provided feedback on how others viewed them. This feedback from family, friends, self-help group members and health care professionals provided reinforcement for both positive and negative aspects of the extant self. Social comparison was often used to augment their extant selves as they compared themselves favourably to others. It was also used to compare extant selves to moral images. The meanings of aging and of chronic illness and their influence on the self-concepts depended on the psychological centrality of these meanings to individuals. The importance attributed to aging and chronic illness varied across the three groups of women. For some, their ideas about aging and chronic illness had become central to their self-conceptions. For others, their conceptions of aging and chronic illness remained peripheral to their sense of self.

The conceptions of aging and chronic illness, while in some ways similar across the three groups of women, also varied across the three groups. The focus of this summary discussion will be on the differences among the relationships of the meanings of aging and of chronic illness and the self-concepts of the participants across the three groups, and the particular strategies used to maintain or enhance self-esteem. (See Table 7-2; themes which are different across groups have been highlighted.)

Women with competent selves seemed unconcerned about aging and chronic illness. Almost all of the women in this group considered aging as a natural process as did women with contradictory selves but, in contrast, some viewed aging as a time of increased wisdom and
forthrightness while others perceived it as a time of changing priorities and new found freedom. While some appraised chronic illness as mundane or unpredictable, as did women in the other two groups, others also considered it to be inconsequential. Chronic illness as inconsequential reflected their lack of concern about their osteoporosis and their ability to "get on with life". They were not particularly concerned about osteoporosis changing their lives to any great degree. Neither aging nor chronic illness was the focus of their lives despite the severity of some women’s osteoporosis. Ideas about aging and chronic illness had not become pivotal to their self-concepts. This lack of centrality of the meanings of aging and chronic illness allowed these women to consider themselves as competent despite changes that might result from aging and chronic illness. This confidence in their own abilities seemed to arise from their ideas about how they had dealt with adversity in the past. Some women survived particular life events; for example, half of the women in this group were divorced or separated. While they discussed how devastating these experiences had been, in retrospect they concluded that these events had led to increased growth and change. These opportunities for growth and change seemed to have a positive effect on their self-esteem in that they felt prepared to overcome subsequent challenges. Aging and chronic illness seemed insignificant compared to these other life events, and could be taken in stride. These other life events had led to an increased self-awareness—an awareness of an inner strength, of competence. This self-awareness had been gained through therapeutic relationships with health professionals as well as through self-help activities (e.g., meditation). The social support of family and friends also sustained them. Positive ideas about their selves were reinforced in these relationships. Engagement in valued activities (e.g., volunteering, paid employment) strengthened positive views of selves. When they considered aging and chronic illness, they believed that they had the ability to meet any challenges associated with aging and chronic illness. Past experiences and strong social support provided them with strategies to maintain and enhance their self-esteem over time. They were not preoccupied with aging and chronic illness. Rather, their high regard for their selves seemed to keep their ideas of aging and chronic illness from becoming pivotal as they continued to plan for the future.

Women with contradictory selves viewed aging as deterioration and loss, but also as part of life. Chronic illness was mundane or unpredictable as well as requiring adaptation. The contradictory nature of the meanings of aging and of chronic illness reinforced the inconsistent character of their self-concepts. While chronological age and osteoporosis were not fundamental to their sense of self, the symbolic meanings of being old and being disabled seemed to dominate their self-concepts. However, the ability to adapt to chronic illness may add strength to the self-concepts of these women with contradictory selves. They had given up some activities and changed the ways in which they performed other activities. The ability to adapt to changes brought on by aging and chronic
Table 7-2: Ideas about aging and chronic illness among three groups of women

<table>
<thead>
<tr>
<th></th>
<th>Competent selves (n = 12)</th>
<th>Contradictory selves (n = 8)</th>
<th>Ineffectual selves (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aging as ...</strong></td>
<td>* a natural process</td>
<td>* a natural process</td>
<td>* loneliness &amp; uncertainty</td>
</tr>
<tr>
<td></td>
<td>* increased wisdom</td>
<td>* deterioration &amp; loss of independence</td>
<td>* deterioration &amp; loss of independence</td>
</tr>
<tr>
<td></td>
<td>* changing priorities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chronic illness as ...</strong></td>
<td>* mundane</td>
<td>* mundane</td>
<td>* overwhelming</td>
</tr>
<tr>
<td></td>
<td>* inconsequential</td>
<td>* adaptation</td>
<td>* adaptation</td>
</tr>
<tr>
<td></td>
<td>* unpredictable</td>
<td>* unpredictable</td>
<td>* unpredictable</td>
</tr>
<tr>
<td><strong>Self-esteem motive</strong></td>
<td>* self-attributions</td>
<td>* self-attributions</td>
<td>* self-attributions</td>
</tr>
<tr>
<td></td>
<td>* reflective appraisals</td>
<td>* reflective appraisals</td>
<td>* reflective appraisals</td>
</tr>
<tr>
<td></td>
<td>* social comparisons</td>
<td>* social comparisons</td>
<td>* social comparisons</td>
</tr>
<tr>
<td></td>
<td>* psychological centrality</td>
<td>* psychological centrality</td>
<td>* psychological centrality</td>
</tr>
</tbody>
</table>

* highlights the themes that are different across the three groups
illness has the potential of being positive as individuals develop strategies for dealing with increasing age and disability. However, the contradictory nature of the self-concept of these women hampered their ability to actively take control over their lives. While some had experienced life events similar to women with competent selves, these had not provided opportunities for growth and change. Underlying doubts seemed to override any increases in self-esteem that might have resulted from these experiences. While some women with contradictory selves had sought help to increase their self-awareness and improve their mental health, they continued to question their abilities and to wait for the next episode of depression. Their mental health seemed very fragile. They had ambivalent relationships with family and friends. They felt exploited by family and friends rather than supported as women with competent selves did. Their lives seemed to be dominated by their moral obligations to others. They had little energy left to engage in activities that they valued or found meaningful. Moreover, when they engaged in these latter activities they felt guilty. Their conceptions of being old and being disabled seemed central to their sense of self. While their ability to adapt to aging and chronic illness held some promise for them viewing themselves as more competent, their views of being old and disabled threatened to push them toward becoming ineffectual.

Women with ineffectual selves considered aging as a time of loneliness and uncertainty and a time of deterioration and losses while viewing chronic illness as unpredictable and overwhelming. Their conceptions of aging and chronic illness seemed very interrelated, reinforcing the negative aspects of both. With age, they expected physical, mental and social losses. Chronic illness became very much a part of growing old for women with ineffectual selves. They were unable to discuss one without the other. These meanings of aging and chronic illness had become pivotal to their self-concepts. For some, their negative views of aging and chronic illness had become central to their sense of self, resulting in a self-picture as ineffectual, while for others, their conceptions of the self as ineffectual seemed to be reinforced by their despairing ideas about aging and chronic illness. These women were overwhelmed and depressed by their lives as aging women with chronic illness although for some life had been difficult for some time. They seemed unwilling or unable to reach out for help to change their situations. Poor interpersonal skills seemed to result in poor relationships with others, both family and friends. Half of the group were widowed and while some had lost friends to death, others took active steps to exclude friends from their lives. They seemed totally caught up in their own lives, unwilling or unable to reach out to others for social support. While some attended self-help groups, they seemed to do so because of an obligation to the group leader rather than because they found it helpful in their own lives. Also, they did not seek help from health care professionals but remained isolated. Depression and fear of falling kept them in their own homes. This isolation led to reclusiveness which had the potential to increase their depression, loneliness and uncertainty. They gave up valued activities because of their chronic illnesses but did not seem able to replace these with other activities that were within their abilities and that had the
potential to be meaningful and valued. They seemed immobilized by their fear and uncertainty, unable to plan for the future. They seemed on a downward spiral, at risk for further mental health problems. In contrast to women with competent selves, they lacked self-awareness and made few attempts to reach out to others and seek help for their depression. While they discussed past life events, that were similar to those experienced by women with competent selves, they seemed to attribute negative meanings to these events as opposed to opportunities for growth and change. They did not have strong social support networks nor did they actively seek help from others. They did not see themselves as active agents able to take control over things that happened to them. They did not plan for the future or attempt to engage in new activities to replace those they had been forced to give up as a result of their aging and chronic illnesses. They were overwhelmed by their aging and chronic illnesses. Their conceptions of aging and chronic illness and their sense of self as ineffectual put these women at high risk for mental health problems.

Regardless of what meanings are associated with aging and chronic illness, the ability to think favourably about one’s self seems related to the psychological centrality of these meanings to the sense of self. Women with competent selves were able to maintain high self-esteem by keeping negative views peripheral to their self-concepts while, in contrast, negative meanings of aging and chronic illness had become central to or invaded the sense of self of women with ineffectual selves, overwhelming them with fear and uncertainty. While keeping ideas of chronological age and osteoporosis marginal, the symbolic meanings of becoming old and disabled had become pivotal to the self-concepts of women with contradictory selves.

The Self-consistency Motive

The self-consistency motive is “the wish to protect the self-concept against change or to maintain one’s self-picture” (Rosenberg, 1979, p.53) and doing so “in the face of potentially challenging evidence” (Rosenberg, 1979, p. 57). This motive has been described in different ways in the literature: protection of the self, self-preservation, maintenance of the self and self-concept stability (Rosenberg, 1979). The self-concept is central to one’s ideas about one’s self. It is the “fundamental frame of reference, the foundation on which almost all [of one’s] actions are predicated” (Rosenberg, 1979, p. 59) and as such must be maintained and protected. The self-consistency motive suggests actions that are required to protect and maintain one’s self-concept. These actions may include cognitive and/or behavioural strategies or coping strategies (Bury, 1991; Pearlin & Schooler, 1978; Rosenberg, 1979). These behavioural or coping strategies will be referred to as strategies throughout the examination of the self-consistency motive. This section of the chapter will examine how women who are aging and have chronic illnesses manage to maintain positive self-pictures and what strategies they use to cope with changes brought on by aging with chronic illnesses. During the initial analysis, I identified five strategies the women used to maintain self-pictures: acceptance, discounting, acquiescence, resignation and denial. Careful review of these
strategies and the quotations to support them resulted in collapsing the five strategies into three: discounting and denial were combined into denial and acquiescence and resignation, into resignation due to the overlapping in the meanings of the words. The resulting three strategies were acceptance, resignation and denial. The women used a range of strategies across groups but there was a predominant strategy that emerged as useful for each group: acceptance was used by the women with competent selves, denial by women with contradictory selves and resignation by women with ineffectual selves. The self-consistency motive will be examined across the three groups of women. (See Table 7-3; the most commonly used strategy for maintaining self-consistency has been highlighted.)

Table 7-3: Self-consistency motives across three groups of women

<table>
<thead>
<tr>
<th>Self-consistency motive</th>
<th>Competent selves (n=12)</th>
<th>Contradictory selves (n=8)</th>
<th>Ineffectual selves (n=8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>* acceptance</td>
<td>* denial</td>
<td>* denial</td>
<td>* denial</td>
</tr>
<tr>
<td>*</td>
<td></td>
<td>* resignation</td>
<td>* resignation</td>
</tr>
</tbody>
</table>

* represents the most commonly used strategy for maintaining self-consistency

The competent self. The women with competent selves were generally very adept at maintaining their self-concepts despite the changes that occurred as a result of aging and osteoporosis. While acknowledging that changes had occurred, they seemed to accept (9 of 12) or deny (3 of 12) these changes and any resultant limitations.

Acceptance of their limitations and an active striving to maintain current levels of activity may explain how two women who were very disabled by their osteoporosis maintained their self-pictures as busy, strong and fortunate, as competent to participate in meaningful roles and activities despite significant limitations. This does not mean that they were not upset and concerned by the changes that altered their lives but rather that they had taken these in stride. Corbin and Strauss (1988) suggested that acceptance does not mean a state of happiness but rather means that an individual has found a way (through biographical work\(^43\)) of accommodating to illness through changed performance and, thus, give meaning to life despite ongoing body changes. This acceptance

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\(^{43}\) Corbin and Strauss (1988) defined biographical work as “the work involved in defining and maintaining an identity” (p. 10).
may go to a higher level of transcendence in which individuals “may find real joy in living ... although their performances may ... be severely limited .... life has taken on a new meaning and is in some ways better than before” (Corbin & Strauss, 1988, p. 78; also see Charmaz, 1991). Charmaz (1991) suggested that achieving transcendence requires making choices and taking action. It would also seem that acceptance and transcendence allow one to confidently take the actions required to protect and maintain one’s self-concept in the face of aging and chronic illness. Amongst the women in this group, with acceptance came the ability to take action to maintain their self-concepts as competent. One woman compared herself to others with osteoporosis and felt that she was much better off than them. While she used a cane most of the time and had altered her work, she viewed herself as competent, and in particular, as a competent worker. She described the action she had taken to maintain and enhance her physical status. Her physical limitations, while restrictive, did not seem to change her self-concept. She maintained a consistent self-picture as competent. She said,

And this again has put such a cramp in my style—the osteoporosis. Ah (PAUSE) but I thrive on [work], I work well under pressure for instance. I thrive on having something to look forward to all the time. I’m spontaneous .... I’m lucky because I have a zest for life, and I’m not going to let [osteoporosis get me down] .... I started going to ... [the Women Against Osteoporosis] support group .... and meeting people far worse than I and realizing I’ve got to do something because I don’t want to be like that [many of the woman attending the group have dowagers’ humps]. Ah I’m very serious about [my osteoporosis] now. And I’m very careful. I work out in a pool three days a week trying to get my muscles strong, and I do exercises in my home every day with weights. (P210, age 63)

Another woman also accepted the limitations of osteoporosis. She had fractured her hip, a few years ago and recently had a hip replacement. As a result of the problems with her hip, she had been unable to return to her job as a teacher and was receiving a disability pension. She had other chronic illnesses as well as osteoporosis, including rheumatoid arthritis, degenerated discs in her back, and hypoglycaemia. She considered herself “generally healthy” despite these illnesses. She was a Holocaust survivor and while she had never forgotten the loss of her family she had accepted what had happened and had adapted to her misfortune. She said,

I have never overcome [the loss of] my parents, the loss of my family. But you learn to live with it. And I think as I get older ... I don’t think a day passes that I don’t think one thing or another will remind me. A person walking similar or a person or somebody saying something or something on TV. But there isn’t a day but there were years were ... in my teens and I was (PAUSE) well I wouldn’t say depressed ... when I worked on the kibbutz ... they all liked to work with me because I was always singing. I was brought up to sing .... I guess it’s ... kind of cheering myself up as well as others .... I was 11 [when my parents were taken], old enough to understand, not to forget. Too young to do anything ... what can you do? That’s how it was and you learn to live with it, but it’s difficult, you can’t forget .... so basically I guess I just learned to live with whatever comes along and that’s it. (P202, age 64)

She believed that this experience had allowed her to manage subsequent life events including her aging and chronic illnesses. She maintained her self-consistency through a vision of herself as a competent teacher despite the fact that she would probably never return to work. When asked what
advice she would give to someone newly diagnosed with osteoporosis, she talked about the need to accept chronic illness and “keep going”.

I would say keep busy. Keep active if you’re capable (PAUSE) and forget about it. You know keep active .... Go to the doctor. Find the best available. See what he says. Have your tests. And then just go on doing what you’re doing. And if you’re going to keep on thinking about [osteoporosis] you might as well lie down and fall asleep. You can’t ‘live like that, you go on no matter what. (P203, age 64)

Forgetting about osteoporosis may indicate denial\(^{44}\) or a refusal to accept osteoporosis as a disease that will change one’s life. Also denial of the importance of changes brought on by osteoporosis was another way some women with competent selves maintained their self-pictures as healthy. They talked about the changes that they were experiencing as natural with aging. They were not concerned about their diagnosis of osteoporosis for the most part because they had not experienced any fractures or pain to date. Rather, osteoporosis was something to be expected with aging. If they have had to make changes, these have been quite minor and have allowed them to maintain a consistent view of themselves as competent. For the most part, they tried to put their osteoporosis out of their minds. One woman, when originally asked to describe herself, said: “I feel very lucky. I have no health problems that I know of” (P121, age 54). Despite a confirmed diagnosis of osteoporosis she did not think of osteoporosis as a health problem and certainly not something about which she needed to worry. Later in the interview, she said,

I’m not too concerned about it. To me, it’s almost, it’s very natural and I would assume that a lot of people I know have it and don’t even know they have it ... you know, it’s just a part of life. I don’t have many real big concerns about it. (P121, age 54)

Another woman also denied that her osteoporosis created any problems for her in order to maintain a consistent picture of herself as healthy. Prior to the interview she had suggested that she might not be a good participant because her life had not been affected very much by osteoporosis. Also during the interview she had portrayed herself as having no limitations associated with aging or osteoporosis. However, when asked if she had altered her day-to-day activities, she realized that she

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\(^{44}\) Charmaz (1991) suggested that denial is a label often based on judgements of individuals’ reactions to their illnesses by professionals. These judgements may be used to discuss patient management and compliance. She also argued that denial may be associated with an individual’s lack of knowledge or understanding of her illness. Some people may not know what their diagnosis means. This may also be related to the different progression of some diseases such as osteoporosis. The course may vary from one woman to another keeping it in the background for some and in the foreground for others. While “their stance looks like denial, … it derives from the reality of their experience” (Charmaz, 1991, p. 20). Finally, Charmaz stated that this explanation of denial does not negate the possibility of denial occurring. Some people may not wish to acknowledge their illness. This could also be described by using the concept of “role distance” (Goffman, 1961) which is the degree to which an individual separates herself from the role or roles she is in; in this case, the chronic illness role. In this thesis, I have used denial to mean a refusal to accept aging or chronic illness.
had made changes. She was annoyed that I had brought up these limitations and made her talk about them. In order to justify her lack of concern for these activities she discounted their importance to her. She considered her limitations insignificant when she compared them to those of others she saw with osteoporosis. Her denial of the limitations associated with her osteoporosis allowed her to maintain a consistent picture of herself as competent and maintain a sense of coherence in her life without taking any actions to deal directly with her osteoporosis.

I don’t down-hill ski. That’s the one thing that I don’t do any more. And even sitting playing the [piano], you have to sit upright .... I can’t play ... for very long ... I’m just too tired. You’re making [me say] things that I don’t want to say .... because I would never say them [out loud] .... I’m not going to get any sympathy [LAUGHS] .... And really I think to say "Well, I can’t play [the piano] as long as I did". I think that is frivolous. And I don’t think, if that’s all it interferes [with] or the fact that I can’t down-hill ski, those things are frivolous. They shouldn’t be important and so therefore that’s why I don’t consider that. If I’m crippled and I can’t get up in the morning or like I see people who are so bent over, their bones are so brittle and I haven’t had any fractures. What can I complain about? (P109, age 60)

Women with competent selves protected and maintained self-pictures that were not affected by changes brought on by aging or osteoporosis. They considered themselves competent despite the limitations of aging and chronic illness. Their acceptance of their aging and chronic illnesses allowed them to take positive action to maintain their self-concepts. Acceptance may reflect the biographical processes discussed by Corbin and Strauss (1988) and, in particular, their description of "coming to terms" with chronic illness (and aging). From their perspective, "coming to terms" involves "movement toward an understanding and acceptance of the irrevocable quality of chronic illness, of the performance limitations accompanying it, of death, and of the biographical consequences it brings about such as failed marriages, lost jobs, and dependency" (p. 76).

Other women in this group denied that their lives were affected in any way by osteoporosis. As discussed earlier, denial may be associated with a refusal to acknowledge or accept one’s aging or chronic illness, a lack of knowledge or understanding of one’s illness and its progression, or an attempt to distance oneself from the chronic illness role. These women who used denial as a strategy for maintaining views of themselves as competent regarded any changes associated with aging and chronic illness as normal and to be expected with aging. While they may have made modifications to the activities affected by their osteoporosis, they were not troubled by these. They discounted the importance of having to give up discretionary activities in order to maintain their self-consistency. Their denial required constant work on their part to maintain images of their selves as young and healthy.

Accepting or denying the changes and/or limitations were strategies used by these women as they protected and maintained the consistency of their selves as competent. They continued to feel competent despite aging and chronic illness.

The contradictory self. Women with contradictory selves had difficulty protecting and
maintaining their self-concepts in the face of the changes that they were experiencing as a result of aging with a chronic illnesses. Denial of changes associated with aging and chronic illnesses was a strategy used by the women with contradictory selves (5 of 8) to protect and maintain their self-concepts.

One woman discussed how she was able to forget about her osteoporosis because other things in her life were more important. Currently her major concern was related to what the future held for her daughter who had a developmental disability. She was concerned about how her daughter would manage once she and her husband died and were not there to care for her. Past life events (i.e., internment in a refugee camp, the death of her mother and sister, and the struggle to obtain schooling for her daughter) had given her strength that allowed her to accept current aspects of her life and to manage issues as they arose. By living one day at a time and not anticipating her future as a woman aging with osteoporosis, she maintained a view of herself as managing her chronic illness adequately right now. When asked about how past events might have shaped her ways of dealing with the changes brought on by osteoporosis, she said

Oh, yeh. You mean the past that affects the present. Oh by all means it does .... my personality, everything, I really don't know what's important, pretty much everything, the kind of person I am--I do live day to day and every day is important. So I think I mentioned that I've had a number of experiences in life that were kind of drastic .... The way I managed it was when you are young you get over difficulties much easier, okay. They do shape you, your character and everything else. They gave me strength in many ways, in many ways they gave me strength .... [osteoporosis is in] a secondary sort of place. I don't know. I didn't analyze myself .... I would prefer that I didn't go into that, I think it is just the way I am .... I just take things as they [come] and do the best that I can. (P114, age 66)

Later in the interview, when asked about what treatment she had been given for her osteoporosis and its effectiveness, she explained that she had been placed on a drug (she did not remember its name) but that she experienced side effects and had discontinued using it. At the time of the interview she was not taking any medication for her osteoporosis. She was able to put aside her concerns about osteoporosis and its treatment. She did not following a medical regimen for her osteoporosis. While she had made some changes in her life because of her osteoporosis, she denied that she had changed her life to any great extent. She wished to maintain her self-picture as strong and unconcerned about her own health. While she had other chronic illnesses, she maintained a consistent picture of herself as healthy. She said, “these things [medications for osteoporosis] I forget because I don't want to worry about them and ... somehow that is one of my abilities to simply put things out of my mind and I forget” (P114, age 66). Denial allowed her to put aside the need for any actions that might alter the course of her osteoporosis while she took action to put plans into place that would assure her daughter was cared for in the future.

Denial of limitations brought on by osteoporosis also led women with contradictory selves to engage in what their physicians might consider risk-taking behaviours, activities that might lead to
fractures. Because they were not experiencing any pain and had no deformities, they were able to maintain a consistent picture of themselves as healthy. They were able to ignore the fact that they had osteoporosis and continued living their lives as they had always done. For example, one woman talked at length about the extensive renovations she was completing on her house. She said,

I'm a pretty active person and I do do things that are weight bearing like I sawed down a big fir tree that was taller than my neighbour's two storey house .... you are using heavy saws and you’re pushing .... and just lugging dry wall around and I did my front all in patio stones that weighed more than me and I had the man who delivered them lean them all against the tree and I walked each one until I got it where I wanted it and let it down. And I did a whole path down the side of my house and a little [patio] at the back ... but mind you when these osteoporosis doctors hear about that—"you're going to [fracture something]" .... I'm not really finding [osteoporosis] any inconvenience because I don't have any crushed vertebrae therefore I'm not bent over or I don't have any pain anywhere with it .... I guess because I don't have any physical symptoms I forget that I have osteoporosis. (P103, age 59)

Resignation was another way some women with contradictory selves (3 of 8) tried to maintain a positive self-picture. They seemed to concede that certain things in life could not be controlled and that one must passively accept some things. One woman discussed changes that she was experiencing as a result of her aging. While she was happy about her retirement and had not found aging to be a burden, there were still some realities that she had noticed in her energy level. However, she recognized that, while these changes were real, it was a matter of changing her expectations of what she could accomplish in a particular time frame. She said,

I have never minded getting older. I've never minded for instance, telling people how old I am. It doesn’t phase me at all. But we're not quite the people we were .... healthwise, we do have more problems than we used to have. We're just not as energetic .... it's sort of all in what you expect of yourself I guess. (P123, age 67)

Women with contradictory selves had difficulty maintaining their self-concepts as positive in the face of aging and chronic illnesses. Some women struggled to protect their self-pictures by denying the importance of osteoporosis in their lives. Other life events took precedence over their chronic illnesses and some women continued to engage in risk-taking behaviours that might result in fractures. Denial required constant work on their part to maintain self-pictures of youth and health.

Denial might also be related to some aspects of acceptance as discussed by Charmaz (1991). In her discussion of accepting intrusive illness, she described four ways she found that people responded to chronic illness relative to acceptance: ignoring illness, struggling against it, reconciling themselves to it, and accepting it. I would suggest that ignoring illness and struggling against it may be similar to how I have interpreted denial among the participants in this study. From Charmaz's perspective, ignoring illness means overlooking or looking beyond chronic illness. This may be similar to my description of chronic illness as inconsequential. She described struggling

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45 This quotation has been used in Chapter 6.
against chronic illness as the need to confront, challenge and conquer it. This may reflect what women who engaged in risk-taking behaviours were doing at an unconscious level. Rather than considering these to be aspects of acceptance, they may more realistically be facets of non-acceptance or denial.

Other women with contradictory selves seemed to be resigned to the physical aspects of their aging and chronic illnesses and passively accepted these changes. Resignation did not require that they take action to change their situations as aging women with osteoporosis. Resignation will be discussed in more detail in the next section on women with ineffectual selves.

The ineffectual self. Women with ineffectual selves recounted their use of similar strategies to those used by women with contradictory selves (i.e., denial and resignation). Resignation seemed to be the most common strategy used by all of the women with ineffectual selves. Resignation suggests passivity, an inability to change the negative views they had of themselves. Charmaz (1991) discussed resignation and passivity as resulting from a loss of self. In order to take action to change one’s self, one must overcome this passivity. While women with ineffectual selves contended that they tried to keep going and to persevere despite the limitations imposed by aging and chronic illness, one can discern the constant struggle this created for them. They seemed to lack the will to plan for the future but rather lived day-to-day, a situation Charmaz (1991) argued helped people with chronic illness decrease their fear that the future would be worse than the present. Liebow (1995), in his book about homeless women, asserted that the idea of planning for the future assumes that the individual “has the power to control and influence the future. If one is truly powerless to influence events, planning makes very little sense. Even contingency planning requires a sense of options and outcomes and of one’s own ability to take effective action” (p. 186). The fear and uncertainty of aging with a chronic illness seemed to overshadow these women’s lives. They felt powerless to control the things that happened to them. One woman described herself as fortunate, stubborn and persevering. When she compared herself to others, she felt she was better off but she also seemed resigned to living one day at a time with the limitations imposed by aging with her chronic illnesses (osteoarthritis and osteoporosis). She constantly struggled to construct a positive sense of self. One of the ways she did this was by engaging in self-talk. But one can discern the resignation or passive acceptance of her situation in her comments.

I haven’t had a bad life. I’ve been pretty lucky. I’ve been a lot better off than a lot of other people. I look at a lot of elderly people and I see they’re alone .... growing old is just something you accept. You make the best of it. We all have to suffer .... Some days it’s worse, some days it’s not as bad so you take [it] day to day .... The pain was bad .... I said well you have to make a go ... I didn’t want to give in because as I said to you before you give in and it’s no good. You gotta keep fightin’ .... I keep going .... Sometimes I start to get depressed and that. And I shake it off and I say I can’t be like that. I got too much to [live] for .... I think the most important thing is when your day starts is to have a good attitude. Okay, you’re going to have some pain, that isn’t going to go away but just to keep going and try and think of other people and do things for other people than to think of yourself. And
that's what I do. Doesn't matter how bad or how I feel, I try to keep going. (P101, age 60).

Making a go of life seemed to reflect attempts to alleviate the passivity and her sense of herself as ineffectual. However, this seemed to be an overwhelming task for her. This theme was echoed by others. They also talked about "getting on with life" (P115, age 69; P208, age 70) despite the restrictions of aging with a chronic illness. Another woman, when asked what advice she would give to others with osteoporosis, said, "Well, I don't know. I didn't come to any conclusions about myself really and so I'm not in a position to give anybody advice except to say that well, I guess I just went ahead and lived my life" (P112, age 75).

Living day-to-day was a common strategy used by woman with ineffectual selves to manage their limitations and to protect positive aspects of their selves. One woman said, "I try to keep ... going day after day .... I feel that I'm happy. I'm alive. I'm not suffering bad. I suffer but what the heck. I'm just looking for the next day to come." (P101, age 60). While acknowledging that there might be good days and bad days (Charmaz, 1991), some women in this group had difficulty planning for the future. They seemed resigned to living their lives in the present. Living one’s life in the present does not require action for the future. Freund and McGuire (1995), in their discussions about the illness experience, suggested that "illness is especially damaging to the self when it is experienced as overwhelming, unpredictable, and uncontrollable because it paralyzes the person’s ability to manage life, to plan, and to act" (p. 145). This seemed particularly true with this group of women with ineffectual selves. Most had “no idea” what they would be doing in the future. One woman, however, said she expected to be dead. The onset of osteoporosis had disrupted her active life. She suddenly found herself unable to participate in many household management activities as well as discretionary activities such as travel. From her perspective, she had become old and frail with her diagnosis of osteoporosis. She seemed unable to maintain and protect her self-concept as active and engaged in meaningful activities. Rather she seemed overwhelmed by her conceptions of aging and osteoporosis and resigned to a life of disability. She said,46

Up until I got osteoporosis, I wasn’t old. And then suddenly I became very old and I became very old very fast I didn’t realize I had osteoporosis. I didn’t ease into it, it happened. I was skiing and skating and riding a bike and there wasn’t anything I didn’t do .... I’m not going in a nursing home and I’m not going to be housed in here, .... four or five years I doubt--I’ll be 75, I doubt very much that I’ll [be alive] .... no I don’t expect to be around in five years. (P208, age 70)

She also related her concerns about becoming a burden. While at the time of the interview her husband was very supportive and did many of the household tasks, she worried that at some time in the future he would perceive his role of caregiver as burdensome. She also seemed resigned to the fact that he might leave her. She seemed to feel powerless to do anything to change the situation.

46 Portions of this quotation have been included in Chapter 6.
I'm a burden to [my husband] in certain respects now because we can't do the things we had hoped .... If he wants to take off I can't hold him .... If he leaves me ... then I'd need somebody here all the time. I'm lucky I can afford it! (P208, age 70)

Fear and uncertainty of the effects of aging and chronic illness overshadowed the lives of women with ineffectual selves and made it difficult for them to enhance their self-pictures. The fear of falling when one has osteoporotic bones led some women in this group to give up activities they previously enjoyed. Fear created a paralysis, an inability to go out. This resulted in them living narrow, restricted lives in social isolation as described by Charmaz (1983). Fear and uncertainty seemed to result in feelings of resignation about their situation. Winter was a particularly difficult time for them because ice and snow brought an increased risk of falling and breaking their bones. One woman had fallen on some ice and fractured her ankle. While it had healed well, she was reluctant to go out in the winter because she had seen family members suffer from multiple fractures as the result of osteoporosis. She said

A year ago I broke my ankle. I fell on ice at the store. And I'm scared to go out in this weather now. I get that if I go out I'm watching everywhere I go. I'm so scared of falling especially since they tell me now I've got osteoporosis, you know. My mom ended up, she had 2 broken hips. (P129, age 64)

Another woman also expressed her apprehension about falling, but also that other usual activities, such as moving in bed, might result in fractures. Her use of words like “terrified”, “petrified” and “scared” illustrate the magnitude of this woman’s fear and uncertainty about what might happen because of her osteoporosis.

I have to be very careful walking in winter, [because] I fall. I am terrified to fall so I walk very carefully .... I can't get down and do the floors and I can't lift the vacuum. Every thing seems too heavy. And if I'm not careful, like in bed one night I thought I'd broken my back. Ohh, I was so petrified. I was too afraid to move ... terrible pain .... I didn't move for a long time and then I gradually pulled my knees up and it was okay but oh gosh, that was awful and I was scared. (P111, age 75).

Women with ineffectual selves seemed resigned to their lives of aging with chronic illnesses and became passive, living their lives day-to-day and not planning for the future. Passivity seemed to have overwhelmed their lives. Fear and uncertainty about aging and osteoporosis and their inability to overcome these fears hindered these women from changing their ineffectual selves. While I have argued earlier in this thesis that the women in this group had not succumbed to the loss of self, Corbin and Strauss (1988) provided a particularly vivid description of what chronic illness might be like for some people. “When a chronic illness comes crashing into someone’s life, it cannot help but separate the person of the present from the person of the past and affect or even shatter any images of the self held for the future” (p. 49). New self-conceptions of “who and what I am--past, present, and future--must arise out of what remains” (p.49). The complexity of this task seemed to result in resignation for women with ineffectual selves.
In summary, there was a range of strategies the women in this study used to protect and maintain their self-concepts against change. While all the strategies might be useful at different times for women across the three groups, predominant strategies for managing with aging and chronic illness were identified for each group of women. Women with competent selves accepted or denied the effects of aging and chronic illness and were able to take action in order to protect their self-concepts as competent. Women with contradictory selves used denial and resignation as strategies to maintain positive self-concepts. Denial required that they take action to maintain their self-concepts as healthy despite the changes brought about by aging and chronic illness while resignation created a passivity that limited the actions they could take to enhance or maintain their self-concepts. Women with ineffectual selves seemed resigned to their inability to change their views of themselves to be more positive. Rather, they were overwhelmed by their conceptions of aging and of chronic illness and seemed unable to mobilize the resources required to maintain everyday life (Bury, 1991; Locker, 1983).

Discussion

Self-concept and the meanings of aging and chronic illness are interrelated. The ways they are related varied across and among the three groups of women who participated in this study. There is evidence that there is a reciprocal relationship between self-concept and the meanings of aging and chronic illness. Self-concept influences the meanings of aging and chronic illness and the meanings of aging and chronic illness influence self-concept. Women with particular self-concepts held certain views of aging and chronic illness. For example, women with competent selves held predominantly positive views of aging and chronic illness but when they did hold negative views, these views were not central to their ideas of themselves as competent. They were able to keep these negative views from infiltrating their sense of self, thus maintaining their sense of competence despite the meanings of aging and chronic illness. For other women, particular meanings of aging and chronic illness seemed to influence their self-concepts. For example, the onset of aging and chronic illness for some women was a devastating event in their lives. While previously, they had considered themselves competent, their negative views of aging and chronic illness had undermined their self-concepts and now they considered themselves ineffectual.

The purpose of this discussion is to highlight how the sense of self relates to conceptions of aging and chronic illness and how women with competent, contradictory and ineffectual selves perceive aging and chronic illness. The focus will be on the differences across the three groups. (See Table 7-4 for a summary.)

For the most part, women with competent selves had positive views of their selves. They were self-confident. They felt that they could exert personal control over things that happened to them. They led balanced lives full of valued activities. Their mental health was good and they had
Table 7-4: Structural and processual aspects of self-concept in three groups of women

<table>
<thead>
<tr>
<th>Extent self</th>
<th>Competent selves (n = 12)</th>
<th>Contradictory selves (n = 8)</th>
<th>Ineffectual selves (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• positive views</td>
<td>• conflicting views</td>
<td>• negative views</td>
</tr>
<tr>
<td></td>
<td>• self-confident</td>
<td>• striving for self-confidence</td>
<td>• lack of confidence</td>
</tr>
<tr>
<td></td>
<td>• high self-esteem</td>
<td>• low self-esteem, self-worth</td>
<td>• low self-esteem</td>
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<td></td>
<td>• self-respect</td>
<td>• ambivalent sense of self</td>
<td>• lack self-respect</td>
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<tr>
<td></td>
<td>• personal control</td>
<td>• unable to control</td>
<td>• lack balance</td>
</tr>
<tr>
<td></td>
<td>• balanced life, valued activities</td>
<td>• struggle to balance</td>
<td>• poor relationships with others</td>
</tr>
<tr>
<td></td>
<td>• good relationships with others</td>
<td>• ambivalent relationships with others</td>
<td>• often lonely and depressed</td>
</tr>
<tr>
<td></td>
<td>• never lonely and depressed</td>
<td>• sometimes lonely and depressed</td>
<td>• Ryff scores = high to low</td>
</tr>
<tr>
<td></td>
<td>• Ryff scores = high</td>
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<tr>
<td>Desired self</td>
<td>• committed image</td>
<td>• moral image</td>
<td>• idealized image</td>
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<tr>
<td></td>
<td>• aligned with extent self</td>
<td>• discrepancy with extent self</td>
<td>• discrepancy with extent self</td>
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<tr>
<td></td>
<td>• doing same things (worker, etc)</td>
<td>• more control</td>
<td>• change in dramatic ways</td>
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<td></td>
<td>• healthy</td>
<td>• after role demands</td>
<td>• healthy</td>
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<td></td>
<td>• independent</td>
<td>• personal autonomy</td>
<td>• younger</td>
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<tr>
<td>Presenting self</td>
<td>• aligned with extent self</td>
<td>• presenting self in keeping with moral self, in contrast to extent self</td>
<td>• negative self presented to others</td>
</tr>
<tr>
<td></td>
<td>• others would describe them as they describe self</td>
<td>• difficulty knowing how others viewed them</td>
<td>• fear what others might think</td>
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<tr>
<td></td>
<td>• validation of extent self</td>
<td>• no validation of positive extent self</td>
<td>• validation of negative views</td>
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<tr>
<td></td>
<td>• comfortable, compatible with extent self</td>
<td>• need for social approval, conform to social norms</td>
<td>• lack of interaction with others</td>
</tr>
<tr>
<td>Aging as ...</td>
<td>• a natural process</td>
<td>• a natural process</td>
<td>• loneliness &amp; uncertainty</td>
</tr>
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<td></td>
<td>• increased wisdom</td>
<td>• deterioration &amp; loss of independence</td>
<td>• deterioration &amp; loss of independence</td>
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<td></td>
<td>• changing priorities</td>
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<td>Chronic illness as...</td>
<td>• mundane</td>
<td>• mundane</td>
<td>• overwhelming</td>
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<td></td>
<td>• inconsequential</td>
<td>• adaptation</td>
<td>• adaptation</td>
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<td></td>
<td>• unpredictable</td>
<td>• unpredictable</td>
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<tr>
<td>Self-esteem motive</td>
<td>• self-attributions</td>
<td>• self-attributions</td>
<td>• self-attributions</td>
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<td></td>
<td>• reflective appraisals</td>
<td>• reflective appraisals</td>
<td>• reflective appraisals</td>
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<td></td>
<td>• social comparisons</td>
<td>• social comparisons</td>
<td>• social comparisons</td>
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<td>• psychological centrality</td>
<td>• psychological centrality</td>
<td>• psychological centrality</td>
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<tr>
<td>Self-consistency motive</td>
<td>• acceptance</td>
<td>• denial</td>
<td>• denial</td>
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<td>• denial</td>
<td>• resignation</td>
<td>• resignation</td>
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</table>
good relationships with others. They wished to remain healthy and independent and actively planned for the future. They thought well of themselves, displaying self-respect and self-acceptance as women who were aging with osteoporosis. Although some women had negative views of aging and chronic illness, generally they considered aging as a natural process, as a time of increased wisdom and changing priorities and considered chronic illness as mundane, inconsequential and unpredictable. Their feelings of self-worth were not undermined by their negative conceptions of aging or chronic illness. These views of aging and chronic illness had not become pivotal to their views of themselves. Rather, they were able to maintain and protect the consistency of their self-concepts as competent through acceptance of aging and chronic illness. They described particular life events which had strengthened their self-concepts and prepared them to deal with subsequent life changes. They had mastered these life events and gained confidence in their ability to control things that happened to them in the future. Competence in the past and present resulted in them expecting continuity and consistency across future life events. They expected to be able to maintain a balance of valued activities despite the changes manifested by aging and chronic illness. They were able to consider their lives and selves in the past and make sense of things that had happened to them. A positive, strong sense of self allowed them to maintain a sense of coherence which they felt would facilitate their ability to control and master aging and chronic illness. Feedback from others provided them with support for their self-pictures as competent. When they compared themselves to others, they thought they were better off despite their own level of disability. The severity of osteoporosis was not related to their self-concepts. Women with mild, moderate and severe disability and competent selves displayed feelings of self-worth and maintained and protected their self-concepts in the face of their disabilities. Protection and maintenance of self-concepts were facilitated through the strategy of acceptance of the changes resulting from aging and chronic illness. Acceptance led to them taking active steps to increase their physical strength through exercise, to keep going despite changes and to learn to live with their limitations. Self as competent seemed related to ideas of aging and chronic illness as manageable. Conceptions of aging and chronic illness had not become central to the sense of self of women with competent selves. A strong, positive sense of self, reliable social support and mastery of past life events seemed to increase their confidence in their abilities to control their lives in the future, to control changes brought on by aging and chronic illness in the future.

Women with contradictory selves held conflicting views of their selves—both positive and negative views. This resulted in an ambivalent sense of self. They strived to gain control over their lives as they attempted to realize their moral image of what they should or ought to be. They struggled to balance their lives between doing things for others and doing things for themselves and to decrease their role demands. These struggles to gain balance often resulted in ambivalent
relationships with others. They attempted to increase their personal autonomy and acknowledge their own needs. They were sometimes lonely and depressed. They were not concerned with their chronological age or osteoporosis but were distressed by their ideas about becoming old and disabled. While they considered aging as part of living, they also thought of aging as a time of deterioration and losses. They viewed chronic illness as mundane but also as unpredictable and requiring adaptation. These conflicting notions reinforced the contradictory nature of their selves. Their experiences with older people who were living in long term care facilities reinforced their concerns about becoming old and disabled and being institutionalized and abandoned by their families. Their own ambivalence about providing care for others and their inability to fulfil their moral selves may have led to their concerns about how others might see caring for them in the future. They shared stereotypical ideas about aging and disability held by many people in our society. Their views of being old and being disabled became central to their self-conceptions. They struggled to think favourably about themselves. They strived to overcome feelings of poor self-esteem and endeavoured to improve their self-acceptance and self-respect. However, they continued to doubt themselves. While some of the women had improved their self-esteem over time in some situations, they seemed unable to transfer this to other situations. They often judged themselves based on their accomplishments in situations over which they had little or no control. They compared themselves to their moral images and found themselves wanting. Self-acceptance and self-respect remained elusive although some women had sought help to increase their self-awareness and improve their self-concepts. They seemed unable to maintain and protect positive self-concepts over time and in different contexts. They lacked the confidence to take action to control aspects of their lives impinged on by aging and chronic illness. Denial was one way in which they attempted to maintain their self-concepts as positive. They attempted to put aging and chronic illness out of their minds, to take things as they came. Other life events took precedence over their aging and chronic illnesses. They continued to participate in risky behaviours which could result in fractures of osteoporotic bones. This denial required ongoing work to keep aging and chronic illness in abeyance. They acknowledged the physical changes of aging and osteoporosis while trying to control their mental attitude toward life as women aging with osteoporosis. The severity of their osteoporosis did not seem related to their self-concepts. They had mild and moderate disability but none had severe disability. Having a contradictory self was related to views of aging and chronic illness as more negative than was having a competent self—as deterioration and loss of independence and as unpredictable and adaptation, as being old and disabled. Thinking well of one’s self seemed elusive. When compared to women with competent selves, while ideas about chronological age and osteoporosis had not become central to the self-concepts of women with contradictory selves, ideas about being old and being disabled had. When compared to women with ineffectual selves, it may be
that women with contradictory selves have the potential for changing self-conceptions given the
active striving to change that is evident among some of the women who were striving to increase
personal autonomy, to acknowledge their own needs, to increase personal control and to decrease
role demands. Changing self-conceptions to be more positive may, in turn, change the way they
think about aging and chronic illness. Taking control and mastering some aspects of their lives may
increase their confidence in their abilities to overcome their views of being old and being disabled.

Women with ineffectual selves held negative views of their selves. They lacked confidence
and self-respect. They had low self-esteem. They seemed unable to take control of their lives and
their lives lacked balance. They were depressed and had poor relationships with others. They wished
to be younger and healthy. Their lives were overwhelmed by aging and chronic illness. They
perceived aging to be synonymous with chronic illness and disability. It was a time of loneliness and
uncertainty. Chronic illness was viewed as overwhelming. Their negative views of both aging and
chronic illness had become central to their self-concepts. For some, their conceptions of themselves
as ineffectual seemed to reinforce their negative views of aging and chronic illness. For others, the
onset of osteoporosis had resulted in negative views of aging and chronic illness which had become
central to their perceptions of themselves as ineffectual. They did not think well of themselves. They
seemed caught up in their own lives, unable or unwilling to seek help from others. They became
isolated and reclusive. Their poor interpersonal skills seemed to reinforce their poor self-esteem, their
poor relationships with others and their depression. They were not able to maintain and protect
positive aspects of their self-concepts in the face of challenging evidence. Rather, they seemed
resigned to lives as aging women with osteoporosis. Their resignation seemed to result in a passivity
which engulfed their lives. They lived one day at a time, unable to plan for the future because of the
uncertainty of their osteoporosis. Fear of falling paralysed them and they led narrowed, isolated
lives. The severity of their disabilities was not related to their self-concepts. As with women with
competent selves, they had mild, moderate and severe disability. When compared with women with
competent and contradictory selves, women with ineffectual selves were more depressed. Their
negative conceptions of aging and chronic illness had become more pivotal to their sense of self.
They were less confident that they could overcome changes brought about by aging and chronic
illness, that they could exert personal control or master these changes. Rather, they seemed resigned
to their fate as aging women with osteoporosis. They did not seem to participate in valued activities.
They had succumbed to their negative views of aging and chronic illness. They were overwhelmed
by their lack of ability to control or master changes brought on by aging and chronic illness, by their
lack of social support and by their depression and feelings of powerlessness. They seemed unable to
make sense of their lives in the past or present in order to improve their self-conceptions in the
future. Without action to change their self-conceptions and their views of aging and chronic illness,
they seemed at risk of loss of self.

In summary, across the three groups of women, there is a spectrum of ways in which self-conceptions seemed related to perceptions of aging and chronic illness and vice versa. There is strong evidence of the reciprocal relationships between self-concept and the meanings of aging and chronic illness. While the women may move across groups over time, the three analytical groupings of women provide an opportunity to understand the complexities of the lives of older women living with chronic illnesses. Through the interview process and questionnaire analysis, I was able to gain an in-depth understanding of the self-concepts of the participants, of what meanings they ascribed to aging and chronic illness, of how these meanings of aging and chronic illness related to their self-concepts, and of what strategies they used to maintain, enhance and protect their self-concepts in the face of aging and chronic illness.

The analysis of the data provides a new level of understanding about the coalescence of aging and chronic illness for aging women with osteoporosis and the complex ways in which women maintain, protect and enhance their self-concepts despite changes brought on by aging and chronic illness. To date, little has been written about self-concept and the meanings of aging and chronic illness. Rather, there are two fairly distinct bodies of literature on self-concept and aging and self-concept and chronic illness. Early writings in aging often portrayed aging as a negative experience while more recent literature has stressed the more positive aspects and focused on what is needed to age successfully. This study suggests that aging holds both positive and negative aspects and that this may change over time and be related to self-concept and the meaning of aging for the individual.

The literature on chronic illness often focuses on younger adults and on the devastating losses associated with chronic illness. What little research has included older adults suggests that chronic illness is expected with aging and is, therefore, considered mundane. This study would suggest that this is not the case for all older adults. For some, the onset of chronic illness was an extraordinary event that left them overwhelmed by its implications. The bringing together of these two bodies of literature to inform this analysis facilitated the understanding of how aging with a chronic illness could be a devastating rather than a normative experience. This is an important finding given the increasing numbers of older adults in our population. As Minkler (1990) has argued, the focus on "successful aging" in the current literature on aging may reinforce prejudice against older women with chronic illnesses.

The final chapter will include a summary of the major findings, conclusions and the implications of this study for future research, policy and practice.
CHAPTER 8

CONCLUSIONS

This chapter presents an overview of the major findings of this study and gives consideration to these findings relative to the existing literature. Attention will be given to the limitations of this study as well as the implications of this study for current theory, research, policy and practice. Recommendations for further research in this area will also be discussed.

The increasing likelihood of chronic illness with aging requires that attention be given to the social aspects of aging and chronic illness. The focus on women’s aging and health is essential because in later years women outnumber men, women have higher rates of nonfatal chronic diseases and live longer with these conditions than men, and women have more chronic health problems than men. Thus, the overall purpose of this study was to consider the relationships among the meanings of aging and of chronic illness and the self-concepts of women. The basic assumption was that, while the meanings of either aging or chronic illness may be related to one’s self-concept, the coming together or coalescence of these two events may alter the relationships among the conceptions of aging and chronic illness and the sense of self. Using Rosenberg’s conceptualizations of self-concept (1979), an in-depth interview and a self-administered questionnaire were designed and data collected between September, 1993 and September, 1994 from participants with osteoporosis living in the greater metropolitan area of Toronto, Ontario, Canada. For the most part, the participants were able to talk explicitly about self-concept, although some were more comfortable with this task than others.

Most of the literature considers self-concept relative to aging and to chronic illness as two discrete areas of study. The exception is the work of Belgrave (1985, 1990) who did consider chronic illness in older women. Although she began her study considering chronic illness as a stigma, she concluded that stigma was inadequate to discuss the complexities of the ways in which the participants in her study thought about chronic illness. She suggested that one should consider the effect of the experience of chronic illness on everyday life and self-concept as varying with different illnesses. This was also supported by Corbin and Strauss (1988). I used these findings as a starting point, as well as the idea that the specific manifestations of chronic illness and its effects on valued activities in the everyday lives of elderly people would vary over time and, therefore, have varying consequences for their self-concepts. Because of my interest in the possible coalescence of the meanings of aging and chronic illness and their relationship to the self-concept, this latter idea was to be explored by concentrating on one chronic illness, osteoporosis. I also utilized theoretical sampling to include individuals at different stages of the illness and whose onset and/or outcome
varied in severity and timing. Although this approach may not have been methodologically as sound as a longitudinal study, I hoped that it might provide insight into the relationships between the meanings of aging and chronic illness and the self-concepts of women with osteoporosis.

**Major Findings**

The 28 women who participated in the study had a clinical diagnosis of osteoporosis. They ranged in age from 54-80 years and their mean age was 65.3. While the participants may not be considered “old” in terms of much of the research in aging, 55 has been identified in the literature as a marker by which time most women are menopausal and, thus, at risk for post-menopausal osteoporosis. Menopause and the diagnosis of osteoporosis may create a transition for women when they begin to think more about aging. These younger years (55-65) may be more important in women’s perceptions of age than the older years of 75 and older when women may clearly think of themselves as old. The self-reported health of the participants was generally good. Some were limited in activities at home and in leisure time pursuits. While some were free of pain or did not limit activities due to pain, others were prevented by pain from doing some activities. Three levels of disability were identified: mild, moderate and severe. These levels of disability were not related to the self-concepts of the participants.

The self-concepts of the women in the study were explored using Rosenberg’s structure of self-concept (extant, desired and presenting self) as well as self-concept processes (the self-esteem motive and the self-consistency motive). While the original research design included only the structural aspects of self-concept, during the analysis it became clear that the women were describing processes of the self-concept and the strategies they used to manage their aging with chronic illness. At that point, I went back to the writings of Rosenberg (1979) and re-analyzed the data using these self-concept processes.

From the analyses of data related to self-concept, three types of self-concepts emerged: the competent self, the contradictory self and the ineffectual self. The next step in the process of analysis was to consider the meanings of aging and chronic illness across all of the participants. There were five themes that emerged in each area. Aging was considered as a natural process, as a time of wisdom and forthrightness, as a time of changing priorities and new found freedom, as a time of loneliness and uncertainty and as a time of deterioration and loss of independence. Chronic illness was described as mundane, as inconsequential, as adaptation, as unpredictable and as overwhelming. Utilizing these meanings of aging and chronic illness, I then examined the relationships among the women’s ideas about aging, chronic illness and the self-concepts of the 28 participants through analysis of the self-concept motives of self-esteem and self-consistency across the three types of self-concept. These analyses resulted in a comprehensive description of the three
types of self-concept. A summary of the major findings across the three types will be discussed below.

I have utilized the term, the competent self to characterize those who have positive views of themselves and who perceive themselves as self-assured and self-confident. Extant, desired and presenting selves are closely aligned among those with competent selves. One source of confidence that is characteristic of those with competent selves is the sense of growth and mastery of previous life events. This results in confidence to master present and subsequent life events. Challenges can be overcome and control exerted over changes brought about by aging and chronic illness. Life is balanced through participation in valued activities and plans are made for the future. Work, both paid and unpaid, gives meaning to life. Views of the self are as a competent worker or volunteer, as healthy and as independent. Those with competent selves draw on and benefit from the support from others. They score high on measures of self-acceptance, environmental mastery and purpose in life. For the most part, aging is considered positively—as a natural process, a time of increased wisdom and forthrightness and a time of changing priorities and new found freedom. Chronic illness is perceived to be mundane, inconsequential and unpredictable. Self-esteem and self-consistency are maintained and protected primarily through acceptance of aging and chronic illness, acceptance of limitations and an active striving to maintain current levels of activity. When conceptions of aging and chronic illness are negative, these ideas are not psychologically central for those with competent selves. They maintain boundaries between self-concept and negative conceptions of aging and chronic illness. Denial is used to maintain a self-picture as healthy despite the severity of osteoporosis. Overall, those with competent selves characterize themselves as active agents confident that changes brought on by aging and chronic illness can be managed. A strong, positive sense of self increases confidence in abilities to keep ideas of aging and chronic illness from undermining the self-concept.

The contradictory self is used to describe a self that contains contradictory or discrepant elements, to describe those who perceive contradictory things about themselves. Ideas about the self are sometimes positive, sometimes negative. There is incongruity between the extant, desired and presenting selves. The discrepancy between extant and desired or moral selves results in a striving to change the extant self to more closely resemble the desired self and, in particular, the moral image. This may result in struggles between doing things for others and doing things for oneself. However, life remains dominated by obligations to others and those with contradictory selves are characterized by a lack of a sense of autonomy and a balanced life. This creates situations in which relationships with others are strained and ambivalent. There is little social support within these relationships. Those with contradictory selves endeavour to exert more control over life, to achieve personal autonomy, and to gain self-confidence. The need for social approval and to conform
to social norms leads those with contradictory selves to present selves to others that are in keeping with how they wish to be seen. Aging is considered to be a natural process but also as a time of deterioration and loss of independence. Chronic illness is viewed as mundane but also as unpredictable and as requiring adaptation. While chronological age and osteoporosis are not fundamental to the self-concept, those with contradictory selves are characterized by fears of growing old and becoming disabled. It is the symbolic meanings of being old and being disabled that has become central to the self-concept. This results in feelings of loneliness and depression. As with those with competent selves, denial is one strategy utilized in attempts to maintain a positive self-concept. Other life events take precedence over aging and chronic illnesses. Living one day at a time and not anticipating the future allows those with contradictory selves to maintain a self-picture as managing adequately. Denial of limitations leads them to engagement in behaviours that might be considered risky and which might result in fractures of osteoporotic bones while they maintain a consistent view of themselves as healthy. Those with contradictory selves also use resignation as a strategy for maintaining self-esteem and self-consistency. When certain things can not be controlled, they are passively accepted. While adaptation to chronic illness may provide some opportunities to overcome changes associated with aging and chronic illness, there is an inability to master particular situations and a lack of confidence to take control of and balance life. There is little consistency in how those with contradictory selves view the self across situations, reinforcing the sense of self as contradictory. An ambivalent sense of self is related to views of aging and chronic illness as meaning being old and being disabled, despite the lack of expressed concern for chronological age and osteoporosis. Conceptions of being old and being disabled have permeated the boundaries of self-concept and become central to those with contradictory selves while concerns about chronological age and osteoporosis remain more peripheral.

I have used the term, the ineffectual self to characterized those who describe themselves in disparaging ways which suggests a lack of self-respect and self-worth. There is a focus on weaknesses rather than strengths. There is incongruity between the extant and desired selves but the extant and presenting selves are similar. Those with ineffectual selves lack confidence to master situations which may arise as a result of aging and chronic illness. This is in keeping with past experiences which have not been mastered and which have been subsequently viewed as negative. The inability to take control of situations often leads to depression. Life becomes isolated and reclusive. Thus, there is an inability to access and benefit from support from others. Validation of negative self-pictures is reinforced through negative interactions with others. The desired or idealized self requires fundamental changes in the extant self. For the most part, the changes required are overwhelming. Valued activities have been given up and have not been replaced with new activities. Those with ineffectual selves are characterized by low self-acceptance, environmental mastery and
purpose in life. Aging is considered as a time of loneliness and uncertainty and as a time of
deterioration and loss of independence. Chronic illness is viewed as unpredictable and overwhelming.
Living one day at a time, unable to plan for the future because of the uncertainty of osteoporosis,
characterizes life. Fear of falling and sustaining fractures results in leading a narrowed, isolated life.
Both aging and chronic illness have become focal to the self-concept of those with ineffectual
selves. They engage in strategies of denial and resignation for the maintenance of self-esteem and
self-consistency. Resignation seems to result in a passivity which engulfed their lives. Overall, those
with ineffectual selves are characterized as overwhelmed by aging and chronic illness and at risk of
mental illness.

The analyses of the data in this study indicate that there is a reciprocal relationship between
self-concept and the meanings of aging and chronic illness. The competent self is associated with
positive views of aging and chronic illness. When there are negative ideas of aging and chronic
illness, these views are not related to self-esteem and self-consistency. These negative conceptions
are not central to the sense of self but are peripheral despite chronological age and/or chronic illness.
Even when severe disability requires daily attention to its management, those with competent selves
are able to keep negative ideas about chronic illness from infiltrating the sense of competence. The
lack of psychological centrality of negative views of aging and chronic illness allows for the
maintenance of self-esteem and self-consistency of the competent self. This reflects Rosenberg’s
(1979) discussions about psychological centrality in which he argued that the components of the
self “are of unequal centrality to the individual’s concerns and are hierarchically organized in a
system of self-values” (p. 18). At the other extreme, the negative meanings of aging and chronic
illness can become central to the sense of self. The ineffectual self is associated with being
overwhelmed by aging and chronic illness. Being old and being disabled undermines confidence and
may alter the sense of self. Also the sense of self as ineffectual may be reinforced by negative
meanings of aging and chronic illness and intensify self-pictures as ineffectual.

Implications for Theory

In this section, I will examine the major implications of this research for theory including the
self-concept in relation to aging and chronic illness, Rosenberg’s conceptualization of self-concept,
the life course perspective and the broader social context of aging and chronic illness.

When comparing the findings of this study with those reported in the literature, it is obvious
that while some women in this study perceived themselves in ways described in the literature on
aging and the literature on chronic illness, others did not. First I will discuss how the findings of this
study are consistent with previous literature.

Some of the women in this study described aging as predominantly positive as did
participants in studies by Kaufman (1986) and Keller et al. (1989). They characterized aging as a natural process, as a time of increased wisdom and forthrightness, and as a time of changing priorities and new found freedom to pursue other interests.

Some women described chronic illness as mundane, or something to be expected with aging, and as inconsequential or of little concern as did the women in Belgrave's (1990) study. Other women in this study described their experiences with chronic illness as unpredictable and overwhelming and in similar ways to those described in the chronic illness literature—the uncertainty and inability to control their lives; their restricted, often isolated, lives; their fear of falling; their inability to participate fully in valued activities such as work or leisure activities; their inability to plan for the future but rather living day to day concerned about becoming a burden and being unable to remain in their own homes; and their attempts to make sense of their chronic illnesses within the context of their lives. These findings are in keeping with the work of others (for examples see Bury, 1982; Charmaz, 1991; Williams, 1984).

In contrast, some of the findings of this study differ from those reported in previous research. Some women in this study described aging as predominantly negative. They described aging as a time of deterioration and loss of independence and as a time of loneliness and uncertainty. This finding is similar to early research in aging (for a discussion of this, see George, 1990) but more recent research has described older adults who consider aging to be more positive and something over which they can exert some control.

When compared to the women in Belgrave's study, some of the women in this study considered their chronic illnesses as overwhelming rather than mundane. They experienced dramatic changes in their lives. Some were able to overcome these changes through active striving. Others, for whom views of aging and chronic illness had become pivotal to self-concept, were not able to protect and maintain their self-concepts as competent.

When considering the similarities and differences of the findings of this study with previous research, it is important to remember that this study differs in several respects. Most of the previous research on aging and self-concept was not designed to consider chronic illness. While the work of Belgrave (1985, 1990) included older women with chronic illnesses, she did not explicitly study self-concept. Previous research on chronic illness has not focused on older adults. Charmaz (1991) gave only brief consideration to older adults in her work on chronic illness and self-concept. The impetus for this study was to address these gaps given the likelihood that women live longer and with more chronic illnesses than men. Thus, by combining self-concept, aging and chronic illness, this study contributes a unique perspective on self-concept to both aging and chronic illness research. It adds the chronic illness perspective to the aging and self-concept research and the aging perspective to the chronic illness and self-concept research. Both of these are important given changing
demographics. The qualitative nature of this study allowed me to examine how the participants understood their selves and the meanings they gave to aging and chronic illness. From the analysis, three types of selves were identified and described. These different ways of conceptualizing the self had implications for how individuals manage their aging and chronic illnesses. As well, their responses to aging and chronic illness shaped their perceptions of their selves. Thus, my findings demonstrate that there is a reciprocal relationship between the meanings of aging and chronic illness and the self-concept and that it is through consideration of these three concepts that we can understand the implications of aging and chronic illness for the lives of older adults. In order to understand the complexities of how people manage the changes brought about by aging and chronic illness, we must consider their sense of self. How they view themselves in the past and present has implications for how they manage change now and in the future, that is, what strategies they use to enhance, maintain and protect their self-concepts over time. The diversity of ways in which people view themselves and the meanings they attribute to aging and chronic illness dictates that we cannot assume that all people will react to aging and chronic illness in similar ways as is currently described in the literature. People’s reactions to aging and chronic illness are diverse and related to their views of themselves and to the meanings they give to aging and chronic illness.

Rosenberg’s (1979) theory of self-concept was valuable for use in this study of the self-concept of women with osteoporosis. While others (Bengtson et al., 1985; Ryff & Essex, 1991) have used some aspects of Rosenberg’s theory in studies of aging, it has not been used in studies of aging and chronic illness. His theory provides a framework for considering both the structure and process of self-concept. Both aspects were essential for an in-depth understanding of how the meanings of aging and chronic illness were related to self-conceptions. The structure provided information about what the self-concepts of the individuals were. It is critical to have a sense of how people see themselves in the present and past in order to explore the processes of self-concept. Without a clear picture of how people think about themselves, it would be difficult to understand how they protect and maintain their self-concepts. The structural aspects were essential to gain an understanding of the process aspects. Also Rosenberg’s theory allowed consideration of the sociological (reflective appraisals and social comparisons) and psychological aspects (self-attributions and psychological centrality) of the processes of the self. In this study, it was the analytical insight provided by the structure of the selves of the women that allowed me to then consider the processes of the self-esteem and self-consistency motives. The categorization of women having particular selves allowed me to consider the relationships between the meanings of aging and chronic illness and the self-concepts of the participants and how these differed depending on the centrality of these meanings to their sense of self.

However, there are limitations to Rosenberg’s framework. The most basic limitation is a need
to give more attention to the processes of the self-concept—the self-esteem and self-consistency motives. Demo (1992), in his recent review of the status of research on self-concept, critiqued Rosenberg’s work suggesting that Rosenberg’s framework is only structural and does not include a processual model. I would argue that this is not the case but I would suggest that this process aspect of his framework is not well described and leaves the reader of Rosenberg’s work with many questions regarding how these self-concept motives, including the principles of self-concept formation (i.e., reflected appraisals, social comparisons, self-attribution and psychological centrality), are conceptualized and can, thus, be utilized in research.47 Also, throughout his description of the self-concept, he did not clearly link the two aspects. This allows the reader to focus on one or the other. This lack of integration of the structure and process aspects of self-concept has resulted in researchers utilizing only the structural or processual aspects of Rosenberg’s framework (see for example Bengtson et al., 1985; Ryff, 1989). In this research, initially I focused totally on the structure while excluding processes in the development of the project. It was only during the analysis of the data that I realized the limitations of this focus and re-read Rosenberg’s work and re-formulated my analysis based on the addition of the processes of the self. This oversight resulted in no data being collected on self-concept processes directly but only indirectly through discussions about aging and chronic illness.

Other researchers have provided clearer and more straightforward conceptualizations of the processes of self-concept than Rosenberg. Demo (1992) outlined some of these in a recent review of the status of research in the area of self-concept (Burke, 1980; Markus & Wurf, 1987; Turner, 1968). The “working self-concept” or the “dynamic self concept” (Markus & Herzog, 1991; Markus & Wurf, 1987) includes both the structure and processes of the self-concept. In this conceptualization, as well as knowledge about the roles and characteristic behaviours, adults have “knowledge of their preferences and values, their hopes and fears, their goals and motives, and their strategies, plans, and rules for regulating behavior. This knowledge, along with the processes that construct, maintain, and defend it, comprise the dynamic self-concept” (Markus & Herzog, 1991, p. 112). One of the limitations of this work by Markus and Herzog, however, is the focus on the psychological aspects of the self-concept processes and the exclusion of the more sociological aspects (e.g., reflected appraisals). Despite this oversight, the focus on the dynamic nature of the self-concept strengthens the conceptualization of the self-concept as structure and process—a strength that is missing from Rosenberg’s work. Thus, I would argue that Rosenberg’s conceptualizations have the potential to mislead researchers because of his failure to strongly link

47 Rosenberg dedicated twice as many pages in his text to the structure (50 pages) of the self in contrast to the process aspects (25 pages).
the structural and processual aspects of self-concept. It is only with the inclusion of both aspects that the researcher can gain an understanding of how individuals see themselves in the past, present and future and the processes utilized to maintain self-esteem and self-consistency over time.

Another limitation is the cumbersome terminology he utilized to describe the different aspects of the self. The extant self is the most obvious example of this. In more recent literature on self-concept, other authors have used everyday language when describing how one sees one's self—the "current self" or the "present self" (Markus & Herzog, 1991). With reference to the desired self or how one would like to see one's self, Markus and Herzog (1991) have used the term "possible self". They have expanded this to included "possible feared self" when describing selves that older adults may want to avoid (the examples they gave were of the depressed self or the bag lady self). Possible selves are "future-oriented components of the self schema" (Markus & Herzog, 1991, p. 116) and, thus, may also be referred to as "future possible selves". The other component of self-concept not focused on by Rosenberg (1979) is the "past self". This aspect is included in the work of Markus and Herzog (1991) and is an addition that augments the conceptualization of self. It allows the researcher to address the importance of the past in giving meaning to the present and the future. The past self has been an important element in the aging literature in the consideration of life review (Butler, 1963; Marshall, 1980). The structural aspects of the self-concept would be enhanced and made more comprehensive by including the present self, the possible self, the presenting self and the past self. Therefore, Rosenberg's conceptualization of self would be improved by stronger links between the structural and processual aspects of the self as well as by the inclusion of the past self.

Demo also suggested that using a life course perspective to frame research in self-concept would enable researchers "to examine the social pathways and life trajectories that facilitate a stable self-concept and the life events and experiences that seem to disrupt self-concept" (p. 319). The life course approach "concentrates on age-related transitions that are socially created, socially recognized, and shared" (Hagestad & Neugarten, 1985, p. 35). This perspective also considers the social, psychological and biological processes from birth to death (Passuth & Bengtson, 1988). Within this study, the life course perspective would have allowed clearer consideration of the transitions to old age and poor health (i.e., to becoming old and to becoming chronically ill) while recognizing the historical time within which the participants lived. For example, a small number of women talked about their experiences during times of war and political unrest in which they had experienced the loss of family members and their home land. They described how these past events, in turn, influenced who they were in the present and how they would approach life events in the future. The life course perspective would have provided a focus on the self-concept over time--past, present and future--more explicitly. It was only during the first few interviews when I realized that,
without asking specifically about their lives in the past, I lacked a context within which to understand their lives in the present and how they might see themselves in the future. While I did acquire data on these selves, a life course perspective would have more clearly dictated the inclusion of an historical perspective and the inclusion of biography with a focus on past events and past selves and the personal meaning of these life course changes which would have clarified the importance of these events to present and future selves. The lack of inclusion of the past self in Rosenberg’s conceptualization of the self may have contributed to this oversight in the initial formulation of the proposal for this thesis.

Consideration must also be given to the context within which individuals live and manage their self-concepts. The findings of this study focus on the self-concept as varying with the meanings aging and chronic illness have for individuals. But the meaning of aging and the meaning of chronic illness held by individuals are embedded in the context within which the individuals live. For the women in this study, the meaning of aging arises from societal views of aging as both positive and negative. How one sees oneself as an object, or one’s self-concept, is formed based on interactions with others. The ability to maintain stability or self-consistency despite the changes of aging are required if one is to take action to maintain a positive self-concept. Similarly, the meaning of chronic illness for the women in this study is located in societal views of menopause as a natural occurrence or as a symbolic milestone on the way to old age. In this latter view, MacPherson (1985) has argued that osteoporosis and menopause are situated in a social and cultural context that devalues women older than 45. The experience of some of the women in this study would suggest that osteoporosis is viewed by some significant others in our society (i.e., health providers) as an indicator of old age.

Before beginning my research, I acknowledged the importance of context and, over the course of the project, I continued to collect and read the non-technical literature on menopause and osteoporosis as discussed in Chapter 2. However, this non-technical literature represents only a small portion of the information available to the participants and thus, only addresses a very limited aspect of the context. It does not consider the role of family and friends, health care and social systems or the social values and expectations held more generally by others in our society. Although I did ask the participants how they learned about osteoporosis with probes that included reading books and magazines, I did not ask them how they might have been influenced by the broader aspects of the context within which they lived. Other than indicating the increasing availability of information in the popular press, they did not discuss their impressions of the information or how it influenced their ideas about aging and osteoporosis. Without asking them directly, I can only speculate on how the social context may have influenced their ideas. Discussions of their perceptions of societal views of aging and osteoporosis may have enhanced my understanding of the
meanings of aging and osteoporosis they held.

In summary, while Demo has argued that the theoretical groundwork for the study of self-concept has been laid, there is a need to consider the structure and processes of the self-concept. The aspects of self-concept, described by Rosenberg (1979) and used in this study, could be enhanced by changing the language of extant and desired selves to present and possible selves, by maintaining the presenting self and adding the past self. The inclusion and integration of self-concept processes (both psychological and sociological) as well as utilizing a life course perspective would facilitate consideration of the dynamic self-concept. Finally, the incorporation of the context within which individuals live their lives would enhance our understanding of how they manage their self-concept. The inclusion of these aspects using various research methods and considered over time would strengthen research focusing on self-concept.

Limitations of the Study and Implications for Future Research

In order to understand the impact of aging and chronic illness on the self-concepts of women, it is important to consider individuals' lives. The qualitative methods used in this study allowed me to explore in depth the self-concept of women who were aging and had acquired a chronic illness. Self-concept develops over time and thus, any changes in self-concept originating in either the views of aging or chronic illness must be considered against the backdrop of the history and experiences of the individual. The in-depth nature of this study provides rich, thick descriptions. Questions about how the women in this study have changed over time bring a retrospective consideration of change but use of retrospective questions does not replace the need for longitudinal study.

While interviews provide rich data, Dreher (1994) has warned that relying solely on verbal reports may weaken the quality of the research. This method depends on the participants’ ability to conceptualize and articulate their ideas. She argued that the researcher must “take precautions to ensure that the interpretation is truly a reflection of differences in experiences and not simply differences in capacity to use language and discourse” (p. 292). Similarly, the use of a questionnaire requires a certain level of literacy which may or may not be present. It may also be possible that women who refused to participate in the study may have done so because of discomfort with talking about themselves or because of literacy concerns, leading to the lack of inclusion of women who might have had different perspectives on aging and chronic illness than the women in this study.

The lack of focus on the processual aspects of self-concept in the original design of the study is an important limitation. This resulted in the exclusion of any questions related to changes in self-concept over time that were not associated with aging and chronic illness. Any more general questions of self-concept may have been overshadowed by the knowledge of the women about the
focus of the research project. When I contacted them to participate, I outlined my interests in their experiences with osteoporosis. In some cases, this created a clear context for some women and they responded to most questions relative to their osteoporosis despite my attempts at the beginning of the interview to discuss self-concept more generally. However, with the realization of the focus of the interviews on how the participants were able to maintain and protect their self-concepts relative to aging and chronic illness, I was able to go back to Rosenberg's work on the self-concept motives. This review of the self-concept motives resulted in the inclusion of the processes as these related to aging and chronic illness.

The inclusion of both qualitative and quantitative data strengthened this research through the confirmation of results across different methods (Morgan, 1998). As noted by Demo, most frequently questionnaires are utilized but the addition of descriptions of self, in-depth interviews, case histories, and extended observation would provide rich data to compliment the quantitative data that are commonly examined. The focus on qualitative methods as the primary method of collecting data may have resulted in less attention to the questionnaire. Originally the inclusion of a questionnaire was to give more time during the interview for in-depth, more open-ended questions rather than having to deal with factual information including demographics and information about ADL and IADL. Some questions from Ryff's scale of well-being were added with the idea that these may lend support to the qualitative data. In retrospect, given the overall similarities in the data from the in-depth interviews and Ryff's scale, it may have be useful to have included the complete scale rather than just the questions about self-acceptance, environmental mastery and purpose in life. The inclusion of questions related to autonomy, personal growth and positive relations with others would have enhanced the study by providing another source of data to support the findings.

The restricted sample and qualitative nature of this research do not allow for generalization of the findings to women with other chronic illnesses or to men's reactions to aging and chronic illnesses. Rather, this study provides particular concepts (i.e., the three types of self-concepts, meaning of aging, meaning of chronic illness, valued activities, coalescence of aging and chronic illness) which may be of more general use and should be further explored in research with participants with other chronic illnesses and with men with chronic illnesses.

The lack of impact of marital status and socioeconomic status on the self-concept of the women in this study may be related to the size of the sample. The literature on stress and women's health indicates that these are important variables in predicting good health. Also the participants in this study were predominantly of British ancestry; the inclusion of other cultural groups may alter the findings. A larger sample may yield more evidence of the importance of these variables in a group of older women with osteoporosis.

The findings of this study suggest the need for further research. Some questions which could
add to the body of knowledge in the area of aging and chronic illness are:

- How does the self-concept of the women vary over time? Does it vary across the three types of self-concept (i.e., the competent self, the contradictory self, the ineffectual self) over time? Does it vary over time relative to the changes in physical and functional health (i.e., level of disability)?
- Does marital status, socioeconomic status or cultural membership make a difference in the relationships between the meanings of aging and chronic illness and self-concept?
- With women being diagnosed with osteoporosis at younger ages, what is the relationship between the meaning of chronic illness (i.e., osteoporosis) and the self-concept of these younger women (i.e., women younger than 55)?
- How does the self-concept of older women with chronic illnesses differ from the self-concept of older men with chronic illnesses? Do the meanings of aging and chronic illness differ by gender?
- How do particular strategies for maintaining and protecting self-esteem and self-consistency affect self-concept, for example, spirituality, self-help groups?
- Do other chronic illnesses which are associated with aging (for example, osteoarthritis) create similar meanings of aging and chronic illness? What are the relationships between these meanings and self-concept?

Implications for Practice

The findings of this research suggest a number of implications for practice for health and social service professionals. These professionals need information about the relationship between the meanings of aging and chronic illness and self-concept. Present and future selves of individuals aging with chronic illnesses may be of particular interest. How one thinks about one’s self in the present has implications for one’s plans for the future. Plans for the future as well as feelings of competence are important to the maintenance of self-esteem and self-consistency despite the changes which might be brought on by aging and chronic illness. There are a variety of ways in which the individuals’ views of aging and chronic illness are related to their self-conceptions. Health professionals need to be aware of the diversity of meanings individuals may give to their aging and to their chronic illnesses and how these meanings might be related to self-conceptions. While some may take their aging and chronic illness in stride and maintain views of themselves as competent, others (possibly as part of their denial) may participate in risk taking behaviours and still others may

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48 Throughout the remainder of this thesis, I will use the term “health professional” to include all service workers who may come in contact with individuals as they age with a chronic illness.
be totally overwhelmed by aging and chronic illness. These may be important factors in women’s decisions to seek care from health professionals.

How health professionals elicit information about self-concept and the meanings of aging and chronic illness for their individual clients may be a more difficult task than acknowledging its importance. While it would seem that asking these kinds of questions would require the establishment of rapport between the professional and the individual, it may be that there are questions that might get at this information in a different way. Questions about current activity levels might elicit information about valued activities which have been given up and retained. Particular questions about self-care (ADL and IADL), productivity (work or volunteering) and leisure might give more detailed information about changes in activity levels. Individuals may require assistance in changing the way they do some of their activities or they may need aids or assistive devices to accomplish some tasks. In addition to activities of daily living, it is also important to give attention to the total environment in which individuals who are aging and have chronic illnesses are living. This may require consideration of economic situations including consideration of disability pensions; living arrangements including whether or not home care services are required and whether the individual is isolated; and housing and economic concerns for the future.

Women in this study stressed the importance of learning what they could do as opposed to what they could not do—the importance of a positive slant on what otherwise might be very negative news. The need for education about chronic illness varies across individuals. Earlier in this thesis, I discussed Charmaz’s ideas about denial as resulting from individuals’ lack of information about their chronic illness rather than their failure to acknowledge their chronic illness. However, the giving of information about one’s chronic illness needs to be appraised carefully by the health professional. The detail and timing of information required needs to be discussed openly with the individual with a chronic illness. Women in this study varied in the amount of information they wanted. While some felt that they needed more information, others felt they had just enough. Some actively sought more information by reading newspaper and magazine articles. One woman routinely read medical articles on osteoporosis. Family members may also need more information in order to provide support for the individual with osteoporosis. Provision of information must occur within a framework of client-centred care. Listening to what the individual is saying and providing an opportunity for the development of a partnership between the individual and health professional will facilitate the sharing of appropriate levels of information.

The importance of social support in maintaining views of one’s self as competent suggests the need for inclusion of questions about social network and support. Screening for mental health problems and in particular, depression, would identify the need for referral to mental health professionals, support and/or self-help groups. While some women in this study felt they benefitted
from self-help groups for women with osteoporosis, others found specific one-on-one counselling from a mental health professional a necessary step in improving their self-concepts and helping them identify specific strategies that would allow them to deal with their chronic illnesses.

Some of the women in this study identified the need for health professionals to acknowledge and address the importance of the social and psychological implications of chronic illness rather than focus solely on the physical aspects. A focus on client-centred care may help to redress this issue. While client-centred care is the latest paradigm being promoted in the health care system, there are many contextual issues that may limit its utilization. It is based on the assumption that both the person requiring care and the person providing care are able to become equal partners in care rather than remain in an unequal client-provider relationship which is perpetuated in our current health care system.

Also as indicated in this study, there are various ways in which women with osteoporosis may manage their day-to-day lives with varying manifestations of osteoporosis. The importance of a positive self-concept in motivating the individual to action cannot be overstated. Only with a positive self-concept will the individual be able to strive to manage his or her self-concept despite the changes brought on by aging and chronic illness. Client-centred care will require flexible health professionals who can respond to different needs as well as different approaches to managing self-concept.

**Implications for Policy**

Several issues were raised during this research that warrant further discussion and consideration for policy development and change. Aging and chronic illness do present problems for people who wish to stay in their own homes. Many of the women in this study had other disabling conditions in addition to osteoporosis. Management of multiple problems requires a comprehensive approach to care. Some of the women in this study discussed their inability to access appropriate services in their communities. The recent focus by government on long-term care reform moves more care from institutions to the community. If this reform is to be successful, adequate services must be available to older people who have recently acquired a chronic illness but who will continue to need services over time as their health deteriorates. While the findings of this study suggest that women with competent selves may have the ability to access resources and services personally or through supportive networks, women with ineffectual selves may need assistance with these tasks from health care professionals.

Some of the women also discussed the lack of training of health professionals to deal with the special needs of people with chronic illnesses. Rehabilitative and palliative approaches to care may be more appropriate than curative approaches when dealing with older people with chronic
illnesses. Considering the aging population and the increasing prevalence of chronic illnesses among older people, research initiatives that focus on the application of theory to practice in aging and chronic illness should be fostered to inform policy development and change.

The meanings of aging and chronic illness vary among people and a client-centred approach in which the older person with the chronic illness defines priorities for care may be appropriate (Havens, 1995). The involvement of families in care may also address the lack of understanding some have of the implications of osteoporosis to the long-term care of family members.

The social and psychological aspects of aging and chronic illness, in addition to the focus on medical care, needs attention from health professionals. Some women in this study identified this need for a more inclusive approach—for the addition of social and psychological aspects to the physical aspects of chronic illness. Bury (1988) has argued that the experience of illness should be at the centre of care of chronic illness. It is only by understanding the experience of people with particular chronic illnesses that care will change. This will require a shift from a strictly biomedical model of research and care to a collaborative biomedical and psychosocial model.

\[ An\ example\ of\ the\ continued\ focus\ of\ the\ Ontario\ government\ in\ the\ care\ of\ older\ adults\ has\ been\ evident\ in\ the\ initial\ report\ of\ the\ Hospital\ Services\ Restructuring\ Commission\ with\ regard\ to\ the\ restructuring\ of\ hospitals\ in\ Hamilton,\ Ontario,\ Canada.\ The\ initial\ report\ called\ for\ the\ closing\ of\ St.\ Peter’s\ Hospital\ which\ provides\ rehabilitation\ and\ chronic\ care\ for\ older\ adults\ in\ Hamilton-Wentworth\ and\ the\ relocation\ of\ long-term\ care\ beds\ for\ older\ adults\ to\ the\ acute\ care\ hospitals\ in\ the\ region.\]
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Appendix 1

Self-administered Questionnaire Package

Letter to Participants

On Departmental Letterhead

Dear ,

I am writing to you about a study I am doing as part of my PhD program in Behavioural Science, Graduate Department of Community Health, Faculty of Medicine, University of Toronto.

The purpose of this study is to find out how osteoporosis affects the everyday lives of women. Your name was selected at random and given to me by the Coordinator of the Metabolic Bone Clinic at St. Michael's Hospital. While research has been conducted on the medical aspects and clinical management of osteoporosis, little is known about the social and psychological effects of osteoporosis for women. This study of women with post-menopausal osteoporosis explores how osteoporosis affects their personal experiences of day-to-day life.

The study is conducted in two phases. The first phase includes the completion and return of the enclosed questionnaire which can be completed in about one hour. The second phase involves an interview of about 2 hours with me.

No risks or discomfort will arise for participants during this study. Although there may not be direct benefits of this research to you, I hope that you will enjoy the interview and the opportunity to talk about your experiences. It is anticipated that the findings from this research will result in knowledge about the social psychological aspects of osteoporosis and coping methods will be made available to women with osteoporosis in the future.

I would like to invite you to participate in this study. Please complete the enclosed questionnaire and return it to me in the self-addressed stamped envelope provided. Once the questionnaire is returned, I will telephone you to answer further questions and set up a time for an interview. All the information you provide in the questionnaire and interview will be confidential and your identity protected. No names will appear on the questionnaire or interview materials. Dr. Murray and/or your Clinic physician will not know if you are participating in the study or not. If you decide not to participate or wish to withdraw at any time, your medical care will not be jeopardized.

I am excited about this research project and hope that you will participate. I look forward to talking to you in the near future.

Sincerely,

Seanne Wilkins
THE EFFECTS OF OSTEOPOROSIS ON THE LIVES OF WOMEN

SELF-ADMINISTERED QUESTIONNAIRE

Consent Statement

By returning this questionnaire, I imply consent to use the information I have included in my responses for the purposes of the study of the effects of osteoporosis on the everyday lives of women. I am aware that my participation in this study is completely voluntary and that I may withdraw from the study at any time without affecting my future medical care for osteoporosis.

This study is being conducted by Seanne Wilkins as part of her PhD program in Behavioural Science, Graduate Department of Community Health, Faculty of Medicine, University of Toronto. Ms. Wilkins is under the supervision of Dr. Carolyn Rosenthal, Behavioural Science and Occupational Therapy, University of Toronto.

The purpose of this study is to find out how osteoporosis affects everyday life. It will be conducted in two phases. The first phase includes the completion and return of the enclosed questionnaire which can be completed in about one hour. The second phase includes an interview of approximately 2 hours with Seanne Wilkins. A separate consent form will be required for phase 2.

I understand that the information provided in this questionnaire and the interview will be treated with the utmost confidentiality. No names will be used on the questionnaire or interview materials. An identification number will be used instead of my name. This identification number appears on the enclosed questionnaire and will be the only means of identification except for a master list securely held by Seanne Wilkins for the purposes of managing the project. No one but Ms. Wilkins will see my name.

In addition to Dr. Rosenthal, Ms Wilkins' thesis committee includes Dr. Joan Eakin (Behavioural Science, University of Toronto), Dr. Victor Marshall (Behavioural Science and the Centre for Studies of Aging, University of Toronto) and Dr. Timothy Murray (St. Michael's Hospital and Faculty of Medicine, University of Toronto). While the thesis committee will have access to information from the study, my name will not appear on the questionnaire or interview materials. Dr. Murray and/or my Clinic physician will not know whether I take part in the study or not.

I understand that the results of this study will be part of Ms. Wilkins' PhD thesis and will be reported in academic journals and at conferences and that my name will not be used in any of these papers or presentations.

DO NOT SIGN
INSTRUCTIONS

Please fill in the space provided or circle the most appropriate response to the questions below. When asked to "specify", please print your answer on the line provided.

The first questions are about you.

SECTION A: DEMOGRAPHICS

1. In what year were you born? ____

2. What is your present marital status?
   1 never married
   2 married 2a. How long? ____ years
   3 living in a marriage like state (i.e. common-law)
   4 divorced/separated
   5 widowed
   6 other (specify: ________________)

3. Do you own or rent your home?
   1 own 2 rent 3 live in someone else’s home

4. In addition to being Canadian or living in Canada what is your main ancestry or ethnic group?
   1 British (including England, Scotland, Wales)
   2 French
   3 German
   4 Irish
   5 Italian
   6 Other (Specify: ________________)

5. What is/was your major occupation in life? ________________

6. What is/was the major occupation of your partner? ________________
7. **What is the highest level of education that you have completed?**

1. no formal schooling  
2. some elementary or public school  
3. some high school  
4. completed high school  
5. vocational or technical college (other certificate)  
6. special diplomas, e.g. teaching, nursing  
7. some university  
8. graduated university  
9. post-graduate education, e.g. Master's, PhD

The next questions are about your health.

**SECTION B: HEALTH STATUS**

8. **How would you describe your state of health?** Please circle the number that best indicates your response. Compared to other people your age, would you say it was

1. excellent  
2. good  
3. fair or  
4. poor?

9. During the last two weeks were there any days when you were not able to carry on your normal daily activities because of illness?

1. NO  
2. YES

   a. how many different days altogether in the last two weeks?

      ___________ days

10. How many days during the last two weeks did you stay in bed for all or part of the day?

    ___________ days

11. During the last 12 months, how many times did you see or talk to a medical doctor (general practitioner and/or medical specialist) about your health?

    None  

    ___________ number of times
12. **Below are some common conditions for which people require regular medicine or treatment. For each condition, please indicate whether or not you currently have it, and whether or not you are being treated for it. DO NOT INCLUDE OSTEOPOROSIS.**

<table>
<thead>
<tr>
<th>Condition</th>
<th>NO</th>
<th>YES, NOT RECEIVING TREATMENT</th>
<th>YES, RECEIVING TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. arthritis &amp; rheumatism</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. high blood pressure</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. limb or joint problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. heart disease</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. hearing problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. vision or sight problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. &quot;nerve&quot;, emotional or mental health problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. cancer</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. digestive problems, e.g., diverticulosis, irritable bowel syndrome, peptic ulcers, hiatus hernia</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>j. dental problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>k. diabetes</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>l. bronchitis, emphysema, or asthma</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>m. other (specify: ___________________________ )</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. **In the last six months ....**

<table>
<thead>
<tr>
<th>Condition</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. have you had a fall?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b. have you had feelings of dizziness?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c. do you get short of breath when walking with other people of your own age?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d. do you get chest pains when walking with other people of your own age?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e. have you been troubled by constant tiredness?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f. have you experienced frequent headaches?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>g. have you had any rashes or itching?</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
h. do you have difficulty controlling your bladder? i.e., wetting pants. DO NOT INCLUDE ACCIDENTS WHEN COUGHING, ETC. OR GETTING UP TO THE TOILET AT NIGHT.

i. have you had difficulty controlling your bowel movements?

j. do you have difficulty sleeping at night?

k. have you lost your appetite or been revolted by food?

l. do you have stomach upsets or indigestion?

m. have you been unhappy and depressed more than usual for a considerable length of time (two weeks or more)?

n. other (specify: ____________________________ )

14. Which one of the following sentences best describes the effect of pain or discomfort you usually experience? Circle the appropriate number.

1. Free of pain and discomfort
2. Pain or discomfort that does not prevent any activities
3. Pain or discomfort that prevents a few activities
4. Pain or discomfort that prevents some activities
5. Pain or discomfort that prevents most activities

15. Relative to this pain and discomfort are your activities limited

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. at home?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b. at work or school?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c. in other activities, such as, leisure time pursuits or transportation?</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

16. How well do you feel you are coping with this pain or discomfort? Circle the number that best indicates your response. Would you say ...

1. very well?
2. fairly well?
3. not very well?
4. not at all well?
Here is a list that describes some of the ways people feel at different times. During the past few weeks, how often have you felt ...

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Often</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>on top of the world?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>very lonely or remote from other people?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>particularly excited or interested in something?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>depressed or very unhappy?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>pleased about having accomplished something?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>bored?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>proud because someone complimented you on something you had done?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>so restless you couldn’t sit long in a chair?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>that things were going your way?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>upset because someone criticized you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

The next questions are about what you can do on an average day with any aids that you usually use.

SECTION C: ACTIVITIES OF DAILY LIVING

For each of the following activities, indicate if you can do it yourself with no difficulty, if you can do it yourself but it is difficult or takes a long time, if you need assistance or if you are totally unable to do it.

<table>
<thead>
<tr>
<th>Activity</th>
<th>No Difficulty</th>
<th>Can manage but with difficulty</th>
<th>Need assistance</th>
<th>Unable to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>walk 3 city blocks without resting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>walk up and down a flight of stairs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>carry a heavy object like carrying a 12 pound bag of groceries about 30 feet (that’s 5 kilograms for 10 metres)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>stand for long periods of time, e.g., waiting in line for 20 minutes or more</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>bend at the waist</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>cut your own toenails</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>use your fingers to grasp and handle</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Activity</td>
<td>No Difficulty</td>
<td>Can manage but with difficulty</td>
<td>Need assistance</td>
<td>Unable to do</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------------</td>
<td>---------------------------------</td>
<td>-----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>h. reach above your head</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i. see well enough to read a newspaper with glasses (if you usually wear them)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>j. hear what is said in a normal conversation (with a hearing aid if usually worn)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>k. leave your house or apartment on your own</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>l. get in and out of bed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>m. get in and out of a chair</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>n. dress and undress yourself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>o. wash your hands and face</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>p. feed yourself including cutting food</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>q. use the toilet</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

The next section is about things you do around the house and in the community.

**SECTION D: INSTRUMENTAL ACTIVITIES OF DAILY LIVING**

19. For each of the following activities, indicate if you can do it yourself with no difficulty, if you can do it yourself but it is difficult or takes a long time, if you need assistance or if you are totally unable to do it.

<table>
<thead>
<tr>
<th>Activity</th>
<th>No difficulty</th>
<th>Can manage but with difficulty</th>
<th>Need assistance</th>
<th>Unable to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. do light household chores, e.g., washing dishes, dusting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. do heavy household chores, e.g., vacuuming, washing floors</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. do house maintenance and yardwork, e.g., cleaning windows, cutting the lawn, shovelling snow</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. drive a car</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e. use public transit, i.e., subway system</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>f. get on and off a bus</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>g. do shopping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
20. The next questions are about how you feel generally about things in your everyday life. For each of the following statements indicate how strongly you agree or disagree with each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>No difficulty</th>
<th>Can manage but with difficulty</th>
<th>Need assistance</th>
<th>Unable to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>h. make your meals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i. use the telephone</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>j. take medication</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

1. strongly disagree
2. disagree
3. slightly disagree
4. slightly agree
5. agree
6. strongly agree

a. In general, I feel I am in charge of the situation in which I live. 1 2 3 4 5 6
b. I feel good when I think of what I've done in the past and what I hope to do in the future. 1 2 3 4 5 6
c. When I look at the story of my life, I am pleased with how things have turned out. 1 2 3 4 5 6
d. The demands of everyday life often get me down. 1 2 3 4 5 6
e. I live life one day at a time and don't really think about the future. 1 2 3 4 5 6
f. In general, I feel confident and positive about myself. 1 2 3 4 5 6
g. I do not fit very well with the people and the community around me. 1 2 3 4 5 6
h. I tend to focus on the present, because the future nearly always brings me problems. 1 2 3 4 5 6
i. I feel like many of the people I know have gotten more out of life than I have. 1 2 3 4 5 6
j. I am quite good at managing the many responsibilities of my daily life. 1 2 3 4 5 6
k. I have a sense of direction and purpose in life. 1 2 3 4 5 6
l. Given the opportunity, there are many things about myself that I would change. 1 2 3 4 5 6
m. I often feel overwhelmed by my responsibilities. 1 2 3 4 5 6
n. My daily activities often seem trivial and unimportant to me. 1 2 3 4 5 6
The next questions are about how you feel about areas of your life and living conditions in general.

SECTION E: GENERAL FEELINGS

21. Please indicate by circling the appropriate number how much you agree or disagree with each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Somewhat Agree</th>
<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I feel useless at times.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. I have little control over the things that happen to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. I feel that I have a number of good qualities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. At times I think I am no good at all.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e. There is no way I can solve some of the problems I have.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>f. I feel that I'm a person of worth, at least on an equal plane with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>g. I am able to do things as well as most people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>h. All in all, I am inclined to feel that I'm a failure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i. There is little I can do to change many of the important things in my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>j. I enjoy living now as much as I used to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>k. I do not feel I have the energy to do the things I would like.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>l. I worry about physical pain and suffering.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

22. The next questions ask you to rate your feelings about areas of your life and living conditions, whether you are very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied. How would you rate your feelings about each of the following?

<table>
<thead>
<tr>
<th>Area</th>
<th>Very Satisfied</th>
<th>Somewhat Satisfied</th>
<th>Somewhat Dissatisfied</th>
<th>Very Dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Your health</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. Your job or major activity</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. Your finances</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. Your housing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Very Satisfied  Somewhat Satisfied  Somewhat Dissatisfied  Very Dissatisfied

e. Family relations  1  2  3  4
f  Friendships  1  2  3  4

23. In this question indicate how strongly you agree or disagree with each statement.

   1. strongly disagree
   2. disagree
   3. slightly disagree
   4. slightly agree
   5. agree
   6. strongly agree

a. I like most aspects of my personality.  1  2  3  4  5  6
b. If I were unhappy with my living situation, I would take effective steps to change it.  1  2  3  4  5  6
c. I don't have a good sense of what it is I'm trying to accomplish in life.  1  2  3  4  5  6
d. I made some mistakes in my past, but I feel that all in all everything has worked out for the best.  1  2  3  4  5  6
e. I generally do a good job of taking care of my personal finances and affairs.  1  2  3  4  5  6
f. I used to set goals for myself, but that now seems like a waste of time.  1  2  3  4  5  6
g. In many ways, I feel disappointed with my achievements in life.  1  2  3  4  5  6
h. I find it stressful that I can't keep up with all of the things I have to do each day.  1  2  3  4  5  6
i. I enjoy making plans for the future and working to make them a reality.  1  2  3  4  5  6
j. For the most part, I am proud of who I am and the life I lead.  1  2  3  4  5  6
k. I am good at juggling my time so that I can fit everything in that needs to be done.  1  2  3  4  5  6
l. I am an active person in carrying out the plans I set for myself.  1  2  3  4  5  6
m. I envy many people for the lives they lead.  1  2  3  4  5  6
n. My daily life is busy, but I derive a sense of satisfaction from keeping up with everything.  1  2  3  4  5  6
24. How do you feel about your life as a whole ...
   1. Very satisfied
   2. Somewhat satisfied
   3. Somewhat dissatisfied
   4. Very dissatisfied?

25. Would you describe yourself as ...
   1. Very happy
   2. Somewhat happy
   3. Somewhat unhappy
   4. Very unhappy?

26. In this question indicate how strongly you agree or disagree with each statement.

   1. strongly disagree
   2. disagree
   3. slightly disagree
   4. slightly agree
   5. agree
   6. strongly agree

   a. Some people wander aimlessly through life, but I am not one of them.
   b. My attitude about myself is probably not as positive as most people feel about themselves.
   c. I get frustrated when trying to plan my daily activities because I never accomplish the things I set out to do.
   d. I sometimes feel as if I’ve done all there is to do in life.
   e. Many days I wake up feeling discouraged about how I have lived my life.
   f. My efforts to find the kinds of activities and relationships that I need have been quite successful.
   g. My aims in life have been more a source of satisfaction than frustration to me.
   h. The past had its ups and downs, but in general, I wouldn’t want to change it.
1. strongly disagree
2. disagree
3. slightly disagree
4. slightly agree
5. agree
6. strongly agree

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>i.</td>
<td>I have difficulty arranging my life in a way that is satisfying to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>j.</td>
<td>I find it satisfying to think about what I have accomplished in life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
k. | When I compare myself to friends and acquaintances, it makes me feel good about who I am. | 1 | 2 | 3 | 4 | 5 | 6 |
l. | I have been able to build a home and a lifestyle for myself that is much to my liking. | 1 | 2 | 3 | 4 | 5 | 6 |
m. | In the final analysis, I'm not sure that my life adds up to much. | 1 | 2 | 3 | 4 | 5 | 6 |
n. | Everyone has their weaknesses, but I seem to have more than my share. | 1 | 2 | 3 | 4 | 5 | 6 |

The next questions are about your family and friends.

SECTION F: SOCIAL NETWORK

27. How many brothers and sisters do you have still living? Include step, adopted, and half brothers and sisters.

   _______ sister(s)

   _______ brother(s)


   _______ daughter(s)

   _______ son(s)

29. Thinking now about your family (including spouse or partner, children and other relatives), do you have any family members you feel close to? That is, family members you feel at ease with, can talk to about private matters, or can call on for help?

   1 Yes  How many? ______

   2 No
30. Thinking about the family member you feel closest to, does this person live ...
   1 in the same household as yourself?
   2 within your neighbourhood?
   3 within the same city?
   4 in another city or town?

31. Are you satisfied or dissatisfied with the kind and frequency of contact you have with family, including personal contact, phone calls and letters?
   1 Very satisfied
   2 Somewhat satisfied
   3 Somewhat dissatisfied
   4 Very dissatisfied?

32. Not counting family members, do you have any close friends? That is, close friends you feel at ease with, can talk to about private matters, or can call on for help?
   1 Yes How many? _____
   2 No

33. Thinking about the friend you feel closest to, does this person live ...
   1 in the same household as yourself?
   2 within your neighbourhood?
   3 within the same city?
   4 in another city or town?

34. Are you satisfied or dissatisfied with the kind and frequency of contact you have with friends, including personal contact, phone calls and letters?
   1 Very satisfied
   2 Somewhat satisfied
   3 Somewhat dissatisfied
   4 Very dissatisfied?
The next questions concern your personal income. This information will be kept confidential.

SECTION G: FINANCIAL SITUATION

35. Are you currently receiving income from any of the following sources? Are you receiving income from...

<table>
<thead>
<tr>
<th>Source</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. work (self-employment, salaries, wages, commissions, tips)?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b. a retirement pension (include superannuation &amp; annuities)?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c. government pension?</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

If yes to government pension, are you receiving income from...

<table>
<thead>
<tr>
<th>Source</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Old Age Security Pension?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Guaranteed Income Supplement (GIS, Federal)?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Spouse's Allowance?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Guaranteed Annual Income Supplement (GAINS, Provincial)?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Canada Pension Plan?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. Other (specify:_________)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

36. Thinking about your financial situation, would you say that you are...

1 having difficulty making ends meet?
2 have just enough to get along? OR
3 are you comfortable?
37. Taking all sources of income into consideration (including pensions, bank interests, investments, etc.), please estimate the total family income of you (and your spouse). Circle the most appropriate category.

1. less than $9,999
2. $10,000 to 19,999
3. $20,000 to 39,999
4. $40,000 to 59,999
5. $60,000 to 99,999
6. 100,000 or more.

THAT COMPLETES THE QUESTIONNAIRE. PLEASE CHECK TO SEE THAT YOU HAVE NOT SKIPPED OVER A PAGE AND THAT YOU HAVE ANSWERED BOTH FRONT AND BACK OF EACH PAGE. THANK YOU FOR COMPLETING THE QUESTIONNAIRE. PLEASE PLACE THE QUESTIONNAIRE IN THE STAMPED RETURN ENVELOPE AND MAIL IT BACK TO ME. I WILL BE IN TOUCH WITH YOU BY TELEPHONE WITHIN THE NEXT TWO WEEKS.
THE EFFECTS OF OSTEOPOROSIS ON THE LIVES OF WOMEN

INTERVIEW

Information Sheet for Participants

The purpose of this study is to find out how osteoporosis affects the everyday lives of women. While research has been conducted on the medical aspects and clinical management of osteoporosis, little is known about the social and psychological effects of osteoporosis for women. This study will focus on women with post-menopausal osteoporosis and explore the personal experiences of day-to-day life. Seanne Wilkins is conducting this study as part of her PhD program in Behavioural Science, Graduate Department of Community Health, Faculty of Medicine, University of Toronto under the supervision of Dr. Carolyn Rosenthal, Behavioural Science and Occupational Therapy, University of Toronto.

This second phase of the study involves an interview of about 2 hours with Seanne Wilkins. The interview is to determine how osteoporosis has affected your life including the methods that you have used to cope with osteoporosis. Because this study is of post-menopausal osteoporosis, there will be questions about your ideas on aging and its effect on living with osteoporosis.

No risks or discomfort will arise during the interview. Although there may not be direct benefits of this research to you, it is anticipated that the findings from this research will result in knowledge about the social psychological aspects of osteoporosis and coping methods will be made available to women with osteoporosis in the future.

The information from the interview will be treated with the utmost confidentiality. Your name will not appear on the questionnaire or interview materials. An identification number will be used in place of your name. A master listing of identification numbers and names as well as questionnaires and interview materials will be secured in storage only accessed by Seanne Wilkins. Your name will not be used in any publications about the findings of this study. The audiotapes of the interview will be erased at the end of the study.

You may refuse to answer any questions or withdraw from the study at any time without affecting your future medical care.

If you have additional questions after the interview, you can contact Seanne Wilkins at 905-319-3843.
Consent Forms for Participants

I acknowledge that the study described on the Information Sheet for Participants has been explained to me. I have been given a copy of the information sheet and consent form. Any questions I have asked have been answered to my satisfaction.

I understand no risks or discomfort will occur during this interview. Although there may not be direct benefits of this research to me, it is anticipated that the findings from this research will result in knowledge about the social psychological aspects of osteoporosis and coping methods will be made available to women with osteoporosis in the future. I know that at any time I may ask any questions about the study.

I understand that I will be participating in an audiotaped interview and that the information that I provide will be kept in the strictest confidence. My name will not appear on interview materials; it will be replaced with an identification number. I understand that my name will not be used in any publications or presentations about the findings of this study. The audiotapes will be erased at the end of the study.

I understand that I may refuse to answer any question or withdraw from the study at any time. I further understand that if I do not participate in the study, or if I withdraw at any time, my future medical care will not be affected in any way.

I hereby consent to participate in the above study.

__________________________________________
Participant’s Name (print)

__________________________________________  _____________
Participant’s Signature  Date

__________________________________________  _____________
Researcher’s Signature  Date
THE EFFECTS OF OSTEOPOROSIS ON THE LIVES OF WOMEN

Interview Schedule

Self-concept

First, I am interested in how you think about yourself.

1. a) How would you describe yourself?
   (PROBES: How do you think of yourself? What are you like as a person? What sort of person would you say you are? Can you think of anything else?)
   
   b) What are your strong points? your weaknesses?
   
   c) How would you describe yourself in the past?
   
   d) How have you changed or stayed the same over your life?
   (PROBES: In what ways have you changed? In what ways have you stayed the same?)

2. How would others describe you now? in the past?

3. If you could live your whole life over, what would you do differently?
   (PROBES: What would you change? What would you leave the same?)

4. What is your best quality? your worst quality?

The Experience of Aging

Everyone is growing older. I am interested in what you think about aging/getting older.

5. How do you feel about growing old?

6. a) Thinking about your own life, what is the hardest thing about growing old?
   b) What is the best thing about growing old?

7. a) What are the advantages of getting older?
   
   b) What are the disadvantages of getting older?

8. a) What do you think you will be doing three years from now?
   (PROBES: What sorts of plans have you made? What keeps you from planning?)
   
   b) What are your concerns for the future?
   (PROBES: generally? relative to osteoporosis?)

9. What do you look forward to now?

10. If you could stay the same age all your life, which age would you choose? Why?
11. a) Generally how do you think you have made out in your life?

b) How do you think you have made out in your life compared to what you hoped when you started out?
   (PROBES: better, as well as, worse)

Why?

FOR THOSE PARTICIPANTS WHO SEEM FATIGUED:
We are about half way through the interview. The next set of questions are about your osteoporosis. Do you wish to continue today or should we meet again another day?

Chronic Illness Experience

I am interested in knowing about your experiences with osteoporosis - what it's like and how it has affected your life.

12. How did you know that you had osteoporosis?
   (PROBES: symptoms? routine physical check-up? treatment for another condition?)

14. a) What is osteoporosis? How was your osteoporosis diagnosed?

b) How did you feel about the diagnosis?
   (PROBES: second opinion? potential course? body failure?)

c) What do you think caused your osteoporosis?

d) How have you learned about osteoporosis?
   (PROBE: Where have you got information about osteoporosis from? physician, reading books, magazines)

15. a) Since diagnosis of your osteoporosis, has it progressed or stayed the same? How has it progressed?
   (PROBES: hospitalizations, fractures, pain, deformities)

b) What treatment has been recommended? have you used?
   (PROBES: diet, exercise, HRT, calcium, fluoride, vitamin D, medications, e.g. calcitonin, etidronate)

16. a) Could you describe what you do on a typical day?
   (PROBES: yesterday [if not the weekend] or Friday; self-care, household, social and recreational activities)

b) Did your osteoporosis cause any problem(s) for you?
   If YES, would you tell me about the problem(s)?
   (PROBE to connect osteoporosis to problems)

c) What did you do to take care of your problem(s)?
17. How have things changed in your day-to-day life since you developed osteoporosis?
   (PROBE for details of what has changed, do you do things differently, do you see the
   same people, e.g., friends, acquaintances, family members)

18. a) How would you compare the person you were ___ years ago with the person you are now?
   (PROBES: Has osteoporosis had an effect on your life? How? What was going on in your
   life before you were diagnosed as having osteoporosis? Were any plans changed or
   interrupted because of your osteoporosis? If so, describe)

   b) What have you learned about yourself over the past ____ years?

19. What things have you done to manage your osteoporosis?

20. Thinking back over your life, what past experiences or events have influenced how you
    manage your life with osteoporosis?

21. How do you feel about being chronically ill?
    (PROBE: particularly about having osteoporosis?)

22. What advice would you give to another woman with osteoporosis?

23. Is there anything else that I have not asked that you think is important?

Thank you for taking the time to participate in this study. Can I contact you at a later date for a
second interview or clarification of interview material?

   Yes                   No

Do you wish to receive a summary of the findings of this research upon completion of the project?

   Yes                   No
Appendix 3

(Departmental Letterhead)

THE EFFECTS OF OSTEOPOROSIS ON THE LIVES OF WOMEN

Information Sheet for Clinic Coordinator

I would like to tell you about a study being conducted by Seanne Wilkins. She is completing her PhD at the University of Toronto in the Department of Community Health under the supervision of Dr. Carolyn Rosenthal. She is interested in studying how your life is affected on a day-to-day basis having osteoporosis. She would like you to fill out a questionnaire and be interviewed.

None of the staff at the Clinic will be involved in conducting the research project. Participation is voluntary and your information will be kept confidential. You may refuse to answer any questions or withdraw from the study at any time. The Clinic doctors will not be aware of whether you take part in the study or not. If you do not participate your future medical care will not be affected.

Are you interested in taking part in the study?

(IF YES)
Can I give your name, address and telephone number to Seanne Wilkins? She will contact you and explain the study in more detail.

(IF HESITANT OR UNSURE)
If you would like more information about the study before deciding whether you will take part or not, please call Seanne Wilkins directly at 231-3113 (PLEASE GIVE HER A BUSINESS CARD). If she is not there, you can leave a message on her answering machine.

(IF NO)
Thank you for considering this request.
Appendix 4
Coding Sheets

A. Self-concept

1. extant self: how one sees oneself
   a. social identity - gender, age, social status, social situation
   b. personal qualities - attitudes, abilities, values, habits, preferences
   c. physical characteristics
   d. dimensions: strengths, weaknesses
   e. structure, ego-dimensions: meaning of life (work, family)

3. desired self: idealized self; how one would like to see oneself: idealized (or ultimate) image, committed image (self-picture we take seriously), moral image (what we feel we must, ought or should be); active, striving, behaviour-oriented factor for self change, allows for change of current or extant self toward desired or idealized self, adds historical and biographical dimension
   a. coping: cognitive processes involved in maintaining feelings of worth and sense of coherence in spite of age or chronic illness
   b. religion, spirituality
   c. change versus continuity
   d. control, autonomy

4. presenting self: self we display to others; private versus public self; fulfillment of goals, self-esteem, self-consistency, conformity to norms

5. context: family relations, friends, religion, spirituality, family life, caregiving, lack of choices re life, career; work, retirement; social network, support network

6. biography including children; biographical time, life course (C & S, p.50): life stretching over years and life evolving around a continual stream of experiences that result in a unique identity; context

7. body: appearance, demeanour, sensuality, regimes

B. Aging

1. meaning age: significance, i.e., what being old denotes in a given culture

2. meaning age: consequences, i.e., problems, repercussions and costs to individual; concerns, future, financial concerns, uncertainty, physical problems, mental problems, lonely, fear, early retirement, work

3. biography: future
4. coping: cognitive processes involved in maintaining feelings of worth and sense of coherence in spite of age

5. strategies: actions people take or what they do in the face of aging; actions taken to mobilize resources and maximize favourable outcomes

6. context: encounters with the health professions, living in seniors' housing, financial concerns, concerns about crime, violence, caregiving, work, retirement

7. continuity versus change

C. Chronic Illness (CI)

1. history of chronic illness med hist
   a. initial disruption
   b. diagnosis: uncertainty, anxiety, fear, shock
   c. legitimation: family history, predisposing factors, ideas about cause of osteoporosis, reluctance to seek help for problems
   d. disruption: limitations, fractures, deformities, pain, explanation (explanatory models, narrative reconstruction attempt to decrease biographical disruption), fear, wasted time, mental health (depression, suicidal)

2. context: conflict, encounters with health professions, additional chronic illnesses (cancer, arthritis), others worse off, perceptions of health, how learned about osteoporosis, family life, clinic, friends, education (changed with P111), caregiving, understanding about O/P (added with P114), social network, support network

3. illness trajectory
   a. course, symptoms: menopause, crushed vertebrae, fractures, pain, ongoing follow-up (i.e., bone density tests, dual photon, etc), loss of height, inability to stand for long periods
   b. treatment (Rx.): complications, risks, calcium, HRT, vitamin D, exercise, walking, diet, didronel, sodium fluoride, help seeking, side-effects, doubt about the value of, conflicts about taking HRT, importance, alternative health services (e.g., PT, health food, chiropractor), uncertainty, fear, anxiety, optimism, regimes, prevention, value HRT, pain management, quality of life, home care (added with P201)
   c. adaptation: risk-taking, day's activities (ADL, IADL, discretionary activities), canes, water beds, limitations, self-education, reading, compliance, non-compliance, clothing
   d. prognosis, future

4. biography/biographical time: past experiences influence who one is in the present and present influences who one is in the future; biographical context (C & S, p. 50)
5. **meaning**: significance, i.e., what being chronically ill denotes in a given culture

6. **meaning**: consequences, i.e., uncertainty, problems, repercussions and costs to individual, fear, helpless, anxiety, lonely, activity restrictions, social disadvantage, personal care problems, employment & financial problems

7. **coping**: cognitive processes involved in maintaining feelings of worth and sense of coherence in spite of chronic illness, denial, others worse off (P. 111)

8. **strategies**: actions people take or what they do in the face of chronic illness; actions taken to mobilize resources and maximize favourable outcomes; avoidance, self-help group, available resources, compliance/non-compliance, control, autonomy, educational sessions

9. **body**: performance, appearance
Appendix 5

Other Self-reported Chronic Illnesses in Addition to Osteoporosis

<table>
<thead>
<tr>
<th>Code</th>
<th>Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>P101</td>
<td>rheumatoid arthritis</td>
</tr>
<tr>
<td>P107</td>
<td>cancer</td>
</tr>
<tr>
<td>P111</td>
<td>osteoarthritis, hiatus hernia</td>
</tr>
<tr>
<td>P112</td>
<td>diverticulosis</td>
</tr>
<tr>
<td>P114</td>
<td>angina, asthma, osteoarthritis</td>
</tr>
<tr>
<td>P115</td>
<td>osteoarthritis</td>
</tr>
<tr>
<td>P119</td>
<td>fibrocystic breast disease</td>
</tr>
<tr>
<td>P120</td>
<td>cancer</td>
</tr>
<tr>
<td>P122</td>
<td>osteoarthritis</td>
</tr>
<tr>
<td>P127</td>
<td>osteoarthritis</td>
</tr>
<tr>
<td>P128</td>
<td>osteoarthritis</td>
</tr>
<tr>
<td>P202</td>
<td>temporal arteritis</td>
</tr>
<tr>
<td>P203</td>
<td>fibromyalgia, osteoarthritis</td>
</tr>
<tr>
<td>P206</td>
<td>asthma, osteoarthritis</td>
</tr>
<tr>
<td>P209</td>
<td>epilepsy</td>
</tr>
<tr>
<td>P210</td>
<td>osteoarthritis</td>
</tr>
<tr>
<td>P213</td>
<td>chronic obstructive lung disease</td>
</tr>
</tbody>
</table>
### Appendix 6

**Summary Table of Components of Self-concept**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Extant Self</th>
<th>Desired Self</th>
<th>Presenting Self</th>
</tr>
</thead>
<tbody>
<tr>
<td>P101</td>
<td>fighter, stubborn, hard worker; lucky; better off than lots; helps others, giving; good attitude to life; keep going;</td>
<td>would like to change attitude, disposition; communicate better; make things work out; stop pushing people away; give in more;</td>
<td>stubborn; won’t let others help her; better with others; critical of family;</td>
</tr>
<tr>
<td>age 60</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>also has RA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P103</td>
<td>perfectionist; low opinion of self; keeps things inside; hangs in; perseveres; strong; high pain threshold; impatient busy, little free time; volunteer do-it-yourselfer</td>
<td>more time for self; accept that perfection not always necessary; more realistic; learn to say no;</td>
<td>friendly, available to help others; always rushing; younger; very energetic; limitless energy; expect her to do for others;</td>
</tr>
<tr>
<td>age 58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P107</td>
<td>recluse, content to some degree; doesn’t project self; enjoys privacy; worrier (finances); strong-willed; motivated; sense of humour; concern for others; determined; interested in others; self-sufficient; deep spiritual life;</td>
<td>wants friendship; more dynamic; travel more; past life before divorce; make financial decisions better; need to be forgiving; not resentful;</td>
<td>doesn’t complain; manages well on her own; going ahead with treatment, doing what has to be done; determined; doesn’t mix well; quiet; self-sufficient? unfriendly?</td>
</tr>
<tr>
<td>age 78</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>cancer</td>
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</table>
### Appendix 7

#### Summary Tables of the Meaning of Aging and the Meaning of Chronic Illness

<table>
<thead>
<tr>
<th>Participant</th>
<th>Meaning of Aging</th>
<th>Meaning of Chronic Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>P101</td>
<td>old people want attention &amp; love; alone, lonely but with attention happy &amp; talkative; institutions vs home need for compassion and caring; respect &amp; love; age doesn't mean anything.</td>
<td>disability pension, not able to work, less money; unable to walk much; suffering, pain, tired; related to getting old; cost of medication prohibitive; import of attitude; can pull through, more worse off; despite pain get on with life</td>
</tr>
<tr>
<td>P103</td>
<td>difficulty realizing how old she is; others see her as younger; everyone else is aging, she isn't; needs to mentally prepare herself; where did life go; old people are alone and need help</td>
<td>crippled, who will visit when she is disabled; people with fractured hips left with no active treatment; lonely, imposing; hospital, institution; helpless, incontinent</td>
</tr>
<tr>
<td>P107</td>
<td>lost friends; small pension, things are tight; fear of getting old and being disabled; dreads giving up her car, it is freedom;</td>
<td>came to terms with cancer; lonely; embarrassed by osteoporosis; too weak to stand tall; chemotherapy also affects her comprehension and communication;</td>
</tr>
</tbody>
</table>