LOOKING AT FRAILTY THROUGH THE LENS OF ETHNICITY:
A PHENOMENOLOGICAL STUDY OF ELDERLY WOMEN
LIVING ALONE IN THE COMMUNITY

by

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A thesis submitted in conformity with the requirements for the degree of Master of Science
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“We grow neither better or worse as we get old, but more like ourselves”.

Anonymous quote
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OF ETHNICITY: A PHENOMENOLOGICAL STUDY
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ABSTRACT

The purpose of this thesis is to understand how ethnic background frames the experience of frailty for elderly women living alone in the community using a phenomenological approach. Twelve semi-structured interviews were conducted with women who were seventy-five years of age and older from Polish-Catholic, Anglo-Saxon, and African-Caribbean ethnic backgrounds. All of the women lived in the greater Metropolitan Toronto area and received home care assistance for three to twelve hours each week.

The major finding of this study was that the onset of frailty was experienced as an affront to established identity, and in order to maintain a sense of continuity with respect to this established identity, the women engaged in various strategies. These strategies involved affirming a sense of personal competence through adhering to a predictable daily routine and reframing abilities, and incorporating new aspects of the self through restructuring roles, negotiating shifting relationships, and altering expectations.
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# TABLE OF CONTENTS

Abstract ...................................................................................................................... iii  

Acknowledgments ...................................................................................................... iv  

CHAPTER ONE ........................................................................................................... 1  
Introduction And Overview ...................................................................................... 1  

CHAPTER TWO ........................................................................................................... 6  
A Review Of The Literature Pertaining To Frailty, Aging, And Ethnicity ..................... 6  
What Is Frailty? ........................................................................................................ 6  
The Social Construction Of Frailty ........................................................................ 10  
A Review Of Phenomenological Research Exploring Frailty .................................... 12  
The Interplay Between Aging And Ethnicity .......................................................... 13  
The Conceptualization Of Ethnicity ..................................................................... 15  
A Discussion Of The Prevalent Theories Of Aging And Ethnicity .............................. 18  
Multiple Jeopardy Theory ..................................................................................... 18  
Levelling Theory .................................................................................................. 21  
Buffer Theory ....................................................................................................... 24  
Summary .................................................................................................................. 27
CHAPTER THREE .......................................................................................................................................................... 29

Theoretical Framework: A Discussion Of Symbolic Interactionism

And Its Contribution To An Understanding Of Frailty ................................................................. 29

Introduction .................................................................................................................................................. 29

An Overview Of Symbolic Interactionism ......................................................................................... 32

The Tools Of Symbolic Interactionism ............................................................................................... 33

The Symbol ............................................................................................................................................. 33

The Self ..................................................................................................................................................... 35

Self And Identity .................................................................................................................................... 39

Self, Identity, And Stigma ..................................................................................................................... 40

Supernormal Identity ......................................................................................................................... 40

Preferred Identity ............................................................................................................................... 40

Identity Salience .................................................................................................................................. 41

Self, Identity, Stigma, And Old Age .................................................................................................. 43

Summary ............................................................................................................................................... 49
<table>
<thead>
<tr>
<th>CHAPTER FOUR</th>
<th>51</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodology</td>
<td>51</td>
</tr>
<tr>
<td>Research Objectives</td>
<td>51</td>
</tr>
<tr>
<td>Methodological Orientation</td>
<td>52</td>
</tr>
<tr>
<td>Researcher's Assumptions Guiding The Examination Of The Social Construction Of Frailty</td>
<td>58</td>
</tr>
<tr>
<td>Methods</td>
<td>62</td>
</tr>
<tr>
<td>Sample Selection</td>
<td>62</td>
</tr>
<tr>
<td>Site</td>
<td>65</td>
</tr>
<tr>
<td>Data Collection</td>
<td>67</td>
</tr>
<tr>
<td>Ethical Considerations</td>
<td>69</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>70</td>
</tr>
<tr>
<td>CHAPTER FIVE</td>
<td>75</td>
</tr>
<tr>
<td>Results And Analysis</td>
<td>75</td>
</tr>
<tr>
<td>Part 1 - Descriptive Data</td>
<td>75</td>
</tr>
<tr>
<td>How Respondents Spend A Usual Day</td>
<td>76</td>
</tr>
<tr>
<td>Important Activities And Interests</td>
<td>78</td>
</tr>
<tr>
<td>Experiencing Changes In The Ability To Do Things As One Ages</td>
<td>80</td>
</tr>
<tr>
<td>Who Respondents Spent Time With, Where Do They Go, and What Do They Do</td>
<td>82</td>
</tr>
<tr>
<td>Respondents' Perception Of Their Most Important Attributes</td>
<td>85</td>
</tr>
</tbody>
</table>
Part II - Theoretical Analysis Of Data ................................................................. 89

Adhering To A Predictable Daily Routine....................................................... 89
Experiencing Boredom .................................................................................. 91
Experiencing Loneliness ................................................................................ 94
Altering Expectations .................................................................................. 97
Reframing Abilities ...................................................................................... 100
Restructuring Roles ..................................................................................... 103
Negotiating Shifting Relationships ............................................................ 106
Summary ...................................................................................................... 112

CHAPTER SIX ................................................................................................. 114
Discussion .................................................................................................... 114
Maintaining Identity .................................................................................... 114
Affirming A Personal Sense Of Competence .............................................. 115
Incorporating New Aspects Of The Self ...................................................... 122
Frailty And Ethnicity ................................................................................... 127
Theories Of Ethnicity And Aging Revisited ................................................ 130

CHAPTER SEVEN .......................................................................................... 133
Conclusion ................................................................................................... 133
Implications For Clinical Practice ............................................................... 134
Implications For Health Care Policy ........................................................... 137
Limitations Of Study ................................................................................... 138
INTRODUCTION AND OVERVIEW

The purpose of this study is to understand how ethnic background frames the experience of frailty from the perspective of elderly women living alone in the community. There are a multitude of factors which could conceivably shape the experience of frailty such as class, gender, socio-economic status, living arrangements, and social support networks. Using the metaphor of a camera, these factors serve as lenses which provide alternative ways of framing the "big" picture; in this study, the experience of frailty. I have chosen ethnicity as the lens with which to frame the experience of frailty. It is my belief that looking at frailty through the lens of ethnicity will promote a broader understanding of this construct beyond traditional, biomedical dimensions.

There are two themes that have informed this direction of inquiry. The first is the well publicized "greying" of the population. Canada qualified as an aged nation by United Nations standards in 1986 as 10.7% of its population was 65 years of age and over. By the year 2031, this figure is projected to be 24% of the total population (Novak, 1993). In addition, the "older" population itself is also increasing in size. In 1986, those who were aged 80 years and over represented almost 20% of Canadians over the age of 65. By the year 2001, they are projected to comprise almost one quarter of this age group (Ujimoto, 1983).
The second theme concerns the pluralistic nature of Canadian society. Canada is home to individuals from a wide variety of diverse backgrounds which is reflected in the ethnic composition of our aged population. The proportion of those aged 65 years of age and over as a percentage of the total population for ethnic groups is relatively high among Jewish (16.5%), Polish (14.5%) and Ukrainian (13.7%) ethnic groups (Statistics Canada, 1984). The percentage age distribution statistics for Chinese and Italian immigrants indicate that there will be a significant increase in elderly persons from these ethnic groups in the near future related to a significantly large cohort in the 45 to 64 year-old age range (Ujimoto, 1987). In 1980, over 60% of the immigrants to Canada came from Asia, Africa, South America and the Caribbean further reflecting the changing demographic nature of Canadian society (Ujimoto, 1987).

These shifts in the structure and composition of the population have important implications for the provision of health care and the development of health care policy. In fact, the 1996 census contains a question requesting respondents to identify their racial origin. This question is intended to "provide information which is needed to deal with many important social and economic policy issues of concern to Canadians - issues ranging from national policies on immigration to ... the delivery of health care and other services." (Fellegi, 1996, p.A19). Of particular significance to this inquiry is the recognition that the aging population is not homogenous and the "limitations in the traditional ways of conceptualizing age-related issues must be recognized and basic assumptions that underlie existing theories must be modified or discarded entirely" (Ujimoto, 1987, p. 113).
Thus it follows that in order to respond to the health problems encountered by our aging and increasingly diverse population, we must be prepared to acknowledge the multiplicity of perspectives that shape how people understand and interpret their state of health. In other words, what we "see" may not be a mirror image of "how things are". "How things are" is embedded within a contextual framework which shapes the lived experiences of the individual. This perspective challenges the traditional world view regarding the nature of reality, a view which has been instrumental in informing the biomedical model. The belief that reality is "out there" and consists of observable and measurable phenomena (Dawe, 1970) is contrasted with an interpretive perspective which views reality as constructed, negotiated and rooted in social interaction.

The meaning of health-related concepts such as frailty are being reconstructed through a growing body of literature which challenges the dominant ontology and epistemology of science. This paradigm shift calls for innovative and enlightened approaches addressing the application of research concerned with promoting and maintaining health. We cannot be satisfied that we are getting a complete picture of "how things are" by employing a research strategy that decontextualizes and reduces meaningful experience to a set of variables such as the items listed on an ADL assessment. I believe that one of the keys to unlocking a critical new approach to understanding "how things are" with regards to frailty is embedded in the lived experiences of our diverse elderly population, and which is revealed in the stories they tell.
My own background as an occupational therapist, with the privilege of working with the elderly in their homes and in the hospital, first presented me with an opportunity to hear their stories. The stories came from a diverse group of people and gave me an appreciation for what Gubrium (1991) has described as being "more than just tales. They are about experiences, about ties, and troubles" (p. 144). I became afflicted with the so-called 'clinical itch' to do research as I felt that these stories gave personal meaning to an experience that is frequently referred to in the clinical setting as "decreased independence in activities of daily living (ADL)." I asked myself "what does this really mean to these elderly people?" The stories that unfolded appeared to have common themes; in particular, I noticed one thread that appeared to link experiences, and that was ethnic background.

I wanted to understand this observation at a more conceptual and systematic, empirical level. Consequently, I chose to undertake a study of the aforementioned research topic and to pursue it from a phenomenological perspective. A phenomenological approach is "fundamentally concerned with understanding the lived meaning of the life world—an interpretation of human experience" (Bergum, 1989, p. 9). My rationale for this decision lies in the belief that to understand "how things are" we should not only take into account objective findings, we must also enter into the subjective realm and give voice to those experiencing the phenomenon themselves, in this study, elderly women.

It is my contention that objective descriptions of frailty, such as those found in functional assessments, act to frame and illuminate one aspect of frailty, thereby extending the "clinical gaze" (Foucault, 1973) into the realm of activities of daily living. Utilizing ethnicity as a
lens to frame the experience of frailty locates the power to know and understand the body within the individual, thus contributing to a sort of inversion of the clinical gaze. At a conceptual level, the underlying value of focusing the metaphorical lens on the multiple facets of frailty will enable us to create a more comprehensive picture of "how things are" with respect to the experience of frailty. At a clinical level, this enhanced understanding will enable health care providers to develop and implement creative, relevant, client-centred and effective interventions that minimize and alleviate the negative dimensions and consequences of frailty.
CHAPTER TWO

A REVIEW OF THE LITERATURE PERTAINING TO FRAILTY, AGING, AND ETHNICITY

WHAT IS FRAILTY?

The word frailty has the ability to conjure up many images. One may visualize a premature infant dependent on intubation for life sustaining oxygen. Or it may be an anorexic teenage girl receiving total parenteral nutrition in the hospital to overcome malnutrition. More commonly, however, the word frailty is linked with an elderly adult, someone who may present with a myriad of physical and/or cognitive impairments and is dependent on other people or on aids to perform their day to day activities (Tennstedt & McKinlay, 1994). In fact, the terms frail and frailty are currently described as integral to the language of gerontology and geriatric medicine (Rockwood, Fox, Stolee, Robertson, & Beattie, 1994). Frailty is identified as a major threat to life expectancy and understanding the physiologic causes of frailty has been characterized as one of the most critical tasks in medical gerontology (Bortz, 1993; Fried & Mor, 1997; Buchner & Wagner, 1992). The plight of the frail elderly has been described as commanding global attention primarily due to the commonly held assumption that as their numbers are speculated to increase, there will be a concomitant increase in the public cost for their care (Tennstedt & McKinlay, 1994).
While widespread recognition of this construct is apparent, there is limited consensus on a concise definition of frailty and even less agreement on how it should be conceptualized (Brown, Renwick, & Raphael, 1995). The Merriam-Webster Dictionary (1974, p. 288) defines frail as “1: morally or physically weak 2: fragile, delicate.” Both definitions offer vague and indiscriminate descriptions of the concept but they also serve to elucidate how this term is operationalized in the academic literature. For example, some authors equate frailty with physiological dysfunction and locate intervention within the biomedical framework (Bortz, 1993; Buchner & Wagner, 1992; Elam, Graney, Beaver, El-Derwi, & Applegate, 1991). Other authors emphasize cognitive and mental impairments that characterize frailty such as dementia and depression (Collins & Abeles, 1996). Individuals who experience difficulties with mobility and ambulation, as well as persons at risk for falls and injury, are also included under the umbrella of frailty (Shomaker, 1990). Furthermore, elderly persons residing in supportive living environments (Kermis, Bellos & Schmidtke, 1986) or those who have reached a certain threshold of aging and are characterized as the “oldest-old” have also been described as frail. For example, Marshall (1987) refers to frailty as the “ordinary state of health for most people towards the very end of their lives” (p. 477-478). Such diversity in the way in which frailty can be understood lends credence to the observation that many factors can contribute to frailty; however, as voiced by Brown et al. (1995), these factors have not been linked to a shared meaning of frailty.

One common theme that emerges from the literature is the belief that decreased independence in the ability to perform activities of daily living is a precursor to frailty. In their research on frailty and the perception of choice among elderly people living alone, Rubinstein, Kilbride,
and Nagy (1992) define a frail person as “having one or more health or functioning decrements that seriously affect the person’s ability to carry out the expected and usual activities of daily living” (p.4). Rockwood et al (1994) propose a dynamic model of frailty whereby frail elderly are “those for whom the assets maintaining health and the deficits threatening it are in precarious balance” which “in practical terms … takes in those who depend on others for the activities of daily living or who are at high risk of becoming dependent” (p. 492). In this functional context, frailty can be conceptualized in opposition to independence and is subsequently utilized to indicate service needs and direct public policy. It should also be noted that there are normative dimensions to these definitions regarding what constitutes normal and expected behaviour with relation to the performance of ADL. While such an approach can be useful to health care providers and policy analysts, it restricts the discourse surrounding frailty to instrumental dimensions while undermining the socio-cultural dimensions inherent in the way frailty is socially produced and enacted (Kaufman, 1994).

Furthermore, utilizing instrumental definitions locates frailty as a condition residing within the individual, a point which is brought to the forefront when Bortz (1993) poses the question, “is frailty a disease? … or is frailty a part of aging?” (p. 1004). This perspective medicalizes and individualizes frailty despite the observation that “so often medical problems can be minor compared to the social and functional problems a patient faces” (Hatlelid, 1994, p. 668). Such a process serves to decontextualize frailty and to place the responsibility for overcoming or coping with impairment in the hands of the individual while de-emphasizing
social factors such as gender, class and ethnicity and their role in the production and experience of frailty.

The Independent Living Movement, spearheaded by younger people with disabilities, has challenged the cultural production of devalued identities by reframing the related construct “disability.” Through political activism and participation in the consumer movement in health care, proponents of this movement have challenged assumptions about their presumed passivity, powerlessness and dependency. They assert that the meaning of disability has little to do with actual losses or limitations but rather is supported by perceptions that are contingent on “time, place, and audience, and on who is seen to have a legitimate claim on deciding the definitional process” (Susman, 1994, p. 16). This reconceptualization of disability is supported by recent legislation which has set out to remove physical, economic and social barriers in order to facilitate the disabled population’s full participation in mainstream North American life.

At the individual level, the meaning of disability can also be challenged by actively negotiating preexisting frameworks of values, beliefs and assumptions during interactions with others (Riessman, 1990). In industrialized societies such as North America, values such as independence, self reliance, beauty, and health affect how disability is conceptualized (Susman, 1994). These values will in turn inform the manner in which the disabled individual construes her own identity. Awareness of the transformative nature of the meaning of disability and the social forces that are involved in shaping this experience
underlie a social constructivist understanding of disability. This perspective can also inform an understanding of the construct of frailty.

**THE SOCIAL CONSTRUCTION OF FRAILTY**

Recently (Becker, 1994; Kaufman, 1994; Raphael, Cava, Brown, Renwick, Heathcote, Weir, Wright, & Kirwan, 1995), increased attention has been focused on conceptualizing frailty as a social construction, thus taking into account contextual factors which impact on the shared meaning of what frailty is. Such an approach seeks to unpack the biomedical assumptions that underlie definitions of frailty and to understand the social, political and economic factors which contribute to the experience of frailty. This perspective does not disregard the reality of illness and loss of function, but rather it acknowledges that individuals experience these changes beginning with their historically situated and contextually informed bodies (Turner, 1987).

Raphael et al (1995) have defined frailty as a “condition of lived experience reflecting intersection of unique factors and proximal and distal environmental factors” (p. 225). Frailty is described as occurring ‘when there is diminished ability to carry out the important practical and social activities of daily living” (Raphael et al, 1995, p. 225). Personal factors that have been identified as contributing to the experience of frailty include cognitive, physical, psychological and spiritual factors. Environmental factors which influence the ability to carry out meaningful practical and social activities include financial, interpersonal, living situation, legal, and institutional factors (Brown et al, 1995). A multidimensional
assessment would take into account an individual’s strengths as well as limitations to diminish the negative associations concerning frailty (Brown et al, 1995). This definition, while retaining some normative language, does extend the conceptualization of frailty beyond biomedical and instrumental dimensions by recognizing the contextualized nature and the complexity of factors which are involved in the production and experience of frailty.

My own assumptions regarding the boundaries around frailty can be described as rooted in the social constructivist definition proposed by Raphael et al (1995). It is this definition of frailty which will inform the conceptualization of frailty for this thesis. I believe frailty is not “out there” waiting to be discovered; rather, it is negotiated and constructed in social interaction and is contingent on personal as well as social, political and economic factors. It is also my belief that in order to fully comprehend the nature of frailty, we must engage in the “analysis of factors in the social, political, and economic context - individual and collective - within which people live their everyday lives and experience their illnesses” (Robertson, 1990, p. 432). It is beyond the scope of this thesis to unpack all of the factors involved in the construction of frailty. Rather, it is my intention to focus on ethnicity as one social factor involved in the construction of the meaning of frailty. I also believe that in order to understand this meaning, we must take the perspective of those who are subjectively experiencing frailty; in this study, elderly persons themselves. Thus it follows that a phenomenological approach to research should be utilized and this approach with regards to frailty will subsequently be discussed.
A REVIEW OF PHENOMENOLOGICAL RESEARCH EXPLORING FRAILTY

Research which takes a phenomenological approach, that is, research which attends to the actors’ points of view and the meaning they attribute to their behaviour (Hyman, 1985) has been under-represented in the field of social gerontology (Aronson, 1994). There is growing consensus, however, that the experience of aging is a social, physical, and psychological process which can only be examined and understood vis-à-vis other individuals (Bonar, 1994). This endorsement of a phenomenological approach to research is reflected in the growing body of literature which utilizes this perspective and the studies described below are notable for their concerted efforts to link meaning, context, and voice.

In 1986, Kaufman wrote eloquently of the meaning of aging to elderly people themselves based on their personal reflections on growing old. Gubrium, in his community study, also utilized a phenomenological approach to “reveal and enhance an appreciation of the many voices that constitute and reconstruct the lives of frail elderly and their families” (1991, p. 151). Rubinstein, Kilbride and Nagy (1992) explored concepts such as independence and choice and how they are symbolically located in the home through extensive interviews with frail elderly men and women. In 1993, Gubrium explored the quality of long term care and quality of life from the perspectives of nursing home residents using in-depth interviews. Becker (1994) also utilized in-depth interviews to capture the meanings older persons attach to autonomy and diminishing functional abilities. Kaufman (1994) investigated the ways in which frailty is defined, framed and understood by older persons, their family members, and
their health care providers through observations and interviews within the context of a multidisciplinary geriatric assessment service.

Collectively, the aforementioned studies have insightfully articulated a foundation on which further phenomenological research pertaining to frailty can emerge. This study will contribute to the expanding body of knowledge by using the construct of ethnicity as a lens to frame the experience of frailty; a relationship which has been alluded to in the literature (Becker, 1994; Rubinstein et al, 1992), but which has not been explicitly addressed.

Prior to explicating how the relationship between ethnicity and frailty will be studied, it would be advantageous to conceptualize ethnicity and to locate the research within a theoretical context in order to expand our knowledge concerning the interplay between ethnicity and frailty.

THE INTERPLAY BETWEEN AGING AND ETHNICITY

The impact of ethnicity on the aging process has been acknowledged as an important area of study within the field of social gerontology (Ujimoto, 1983, 1987; Rosenthal, 1983). This area of research, however, has not been adequately developed and a paucity of literature exists. There is evidence that this situation is changing as more researchers are involved in disseminating knowledge pertaining to ethnicity and aging. The purpose of this section of the literature review is to highlight some of this research through the discussion of three theoretical perspectives on the interrelationship between the two constructs. Factors
influencing current levels of interest in this area of study and a conceptualization of ethnicity will also be described.

The shift in the structure and composition of Canada’s aging population has been addressed in the introduction to this thesis. In order to further explore the implications that these shifts have for contextually informed meanings ascribed to aging and more specifically, frailty, a comprehensive review of the related research is indicated. First of all, there is consensus among researchers that the social processes of aging vary from culture to culture (Palmore, 1983); however, social gerontologists have not sufficiently explored the importance of cultural factors as these differentially affect the aging individual or social group (Holzberg, 1983). Relevant literature has generally been descriptive in nature with minimal attention to theorizing. There has also been a tendency to subsume culture under social class with a concomitant failure to distinguish “ethnic” factors from situational factors such as poverty and racial discrimination (Holzberg, 1983). This lack of differentiation is characterized by Ujimoto (1987) as leading to inaccurate assumptions and questionable conceptualizations regarding the aging process. A propensity to treat various ethnic populations as culturally homogenous has also emerged as a problematic theme in the literature pertaining to ethnicity and aging (Rosenthal, 1986). Varying definitions of ethnicity itself have tended to obscure accurate relationships between ethnicity and aging (Ujimoto, 1983). Consequently, a definition of ethnicity which will take into account the socially constructed nature of this concept will be addressed.
THE CONCEPTUALIZATION OF ETHNICITY

Ethnicity is commonly characterized as “social differentiation derived from cultural criteria such as a shared history, a common place of origin, language, dress, food preferences, and values that engender a sense of exclusiveness and self-awareness of being a member of a distinct social group” (Sokolovsky, 1983, p. 154). Individuals who share ethnic ties may live in spatially contiguous areas, hold similar occupations and reveal ethno-specific social institutions (Holzberg, 1981). Isajiw (1974) listed the attributes of “ancestral origin, same culture or customs, cultural beliefs, common values, sense of ethnic group identity, race or physical characteristics and language “ (p. 124) as those most frequently included in various descriptions of ethnicity. Comparable definitions of ethnicity which are comprised of a similar list of ascribed attributes may not be instrumental with regards to conceptualizing ethnicity; however, they do provide an example of what factors may be taken into account when formulating ethnic content.

Rosenthal (1983) asserts that there have been at least two different focuses with respect to defining ethnicity. Some scholars have viewed ethnicity as primarily immigrant culture, equated with the “traditional” way of life. Other scholars have perceived ethnicity as a determinant of social inequality whereby “differential access to societal rewards can be related to a model of ethnic change and persistence in families as explained by the relationship of ethnicity to social class and social conflict” (Rosenthal, 1986). Holzberg (1981) criticizes the latter approach to ethnicity for including situational factors, which are determined by wider society, as part of the minority culture. She emphasizes that
unemployment, low levels of education and poor health are the result of situational socio-economic exigencies and are not minority cultural traits. She also argues that attempts to view the cultural aspects of a group as responses to discrimination or reactions to victimization can lead to a propensity to ignore the internal cultural dynamics of that group. Alternatively, Markides (1982) states that class, culture, and minority status are not totally independent of one another and the influences of subordination and discrimination and the coping structures emerging from such experiences are incorporated into the culture of the ethnic group. He suggests that ethnic-minority status is a major determinant of low socio-economic status and he describes Holzberg’s view of ethnicity as being overly static in that it ignores the influence of situational factors.

It is evident that ethnicity constitutes an enormously complex variable which is involved in the mediation of thoughts and feelings, values and behaviour, and which in turn is mediated by various structural influences. In this context, it is useful to conceptualize ethnicity as a dynamic factor affecting and responding to the lifestyles, customs, culture, primary interaction networks, perceptions and world views of the members of a bounded social group (Giordano, 1992). Implicit in this view is the recognition of the compositional heterogeneity of any ethnic group, a factor not adequately addressed in the literature (Holzberg, 1981; Markides, 1982; Rosenthal, 1983). Research should be sensitive to cultural differences between and within ethnic groups; however, for heuristic purposes it is often desirable to ignore a certain degree of heterogeneity between individuals and groups. Dowd and Bengston (1978) clustered European-origin ethnic groups together as “Anglos” in their study on aging because what was important to the hypothesis under investigation was the majority
status of Anglos vis-à-vis African and Mexican Americans. This study will recognize and attend to intra-ethnic diversity through eliciting individual and subjective accounts concerning the meaning of frailty. However, for heuristic purposes, I will also categorize individuals as Anglo-Saxon Protestant, African-Caribbean or Polish-Catholic in order to differentiate inter-ethnic accounts of the experience of frailty.

Viewing the patterns of aging in Canada within the context of ethnicity appears mandated by the continuing cultural plurality of this country. In the emerging Canadian literature on this subject, the majority of the research has explored three theories which attempt to address the interrelationships between ethnicity and aging (Novak, 1993). Implicit in these theories are two themes: one emphasizes the extent to which structured inequality influences the difficulties associated with aging within ethnic groups; the second stresses the benefits conferred to those elderly who maintain an ethnic identity and subculture (Sokolovsky, 1983). The multiple jeopardy theory and levelling theory can be subsumed under the first theme while the buffer theory is illustrative of the second theme. Subsequently, each theory will be more comprehensively examined and critically analyzed.
A DISCUSSION OF THE PREVALENT THEORIES OF AGING AND ETHNICITY

MULTIPLE JEOPARDY THEORY

The combined effects of age, sex and ethnic group status have been described as contributing to a situation of “multiple jeopardy” (Havens & Chappell, 1983; Penning, 1983; Dowd & Bengston, 1978). The term “double jeopardy” refers to the situation of ethnic elderly persons whereby being old and a member of an ethnic group brings about distinct disadvantages. Individuals thus experience the additive effects of these constructs and are expected to endure a lower quality of life than younger persons belonging to the majority group (Bengston & Morgan, 1983). Gender may also exacerbate the negative implications of the aging process by contributing to the aforementioned situation of “multiple jeopardy.” Havens and Chappell (1983) characterize this condition by stating “to be a member of an ethnic group is to bring to the aging situation both the past history of disadvantage and discrimination based on gender” (p. 123).

There has been a body of research generated which supports the multiple jeopardy theory. Jackson (1980, p. 167) reports that income levels for elderly blacks have increased over the past thirty years; however the rate of poverty for elderly blacks is still over three times that of elderly whites (36.3% as opposed to 11.6%). Research conducted by Dowd and Bengston (1978) suggests that in terms of relative income and self-rated health, the label “double jeopardy” may indeed be descriptive of the minority elderly studied in their sample of 1, 269
individuals in Los Angeles. The mean incomes reported by older Mexican American and African American respondents were significantly lower than any other age-ethnic subgroup in the sample even when variables of socio-economic status (education, occupation), sex and health were held constant. In addition, the self-assessed health of whites was better than that of minority respondents at each age stratum studied (45-54, 55-64, 65-74) with the greatest disparity occurring among those aged 65 years and older. The other two dimensions explored in the above analysis, subjective dimensions of life satisfaction and indicators of social interaction, yielded complex results which did not substantiate the theory of double jeopardy. Holzberg (1981) criticizes this study for not differentiating between the “Anglo” or white respondents, thereby oversimplifying the data. Markides (1982) argues that the intent of the researchers was to test the hypothesis that aging has greater negative consequences for members of disadvantaged ethnic minority groups than for members of the ethnic majority, thus the key issue was whether or not an individual belonged to a minority (African American and Mexican American) or majority (Anglo or non-Hispanic white) group.

Further empirical assessment of the multiple jeopardy hypothesis is provided by Penning (1983) and Havens and Chappell (1983) who utilize a number of subjective and objective quality of life indicators to study the effects of age, sex and ethnicity. Both drew similar conclusions in that support was provided for this hypothesis with respect to objective indicators; however, subjective indicators did not substantiate a situation of multiple jeopardy for their respondents. For example, Havens and Chappell (1983) reported that on an objective measure of mental function “old-elderly women of Polish, Russian, and Ukrainian descent are significantly more disadvantaged … than any of the other groups” (p. 129).
Alternatively, subjective responses pertaining to whether or not minority ethnic elders felt “worse off” than majority ethnic cohorts did not yield support for this theory. Wong and Reker’s (1985) study comparing Chinese and Anglo Canadians was also purported to lend support to the multiple jeopardy theory. They stated that Chinese-Canadians reported coping less well, experiencing more serious problems, and having a lower sense of well-being than the Anglo-Canadians in the sample. The authors concluded that stress due to living in a foreign cultural environment along with minority status compounded the problems of physical aging encountered by the Chinese-Canadians in their study.

There appears to be selective support for the double jeopardy hypothesis, particularly with regard to subjective measures of well-being and life satisfaction. The theory has been criticized for oversimplifying the effects of aging and ethnicity and underestimating the variation among ethnic and subcultural minorities in North American society (Gibson, 1988; Bengston & Morgan, 1983). The research generated in support of this theory has also tended to ignore the personal meaning of aging, the social context, and the availability of personal supports (Novak, 1993). Furthermore, it focuses on the negative implications of ethnic membership. The levelling theory, which will subsequently be discussed, offers an alternative approach to conceptualizing the aging process within an ethnic context.
LEVELLING THEORY

The age-as-leveller hypothesis purports that “growing old is a sufficiently potent process to cut across ethnic lines and mediate or level differences in the patterns of aging reflective of membership in distinct ethnic groups” (Sokolovsky, 1983, p.155). Consequently, differences between ethnic or subcultural groups are reduced as members undergo common experiences associated with advancing age. Widowhood or declining health, for example, will have similar implications for the elderly regardless of their ethnic status. This theory explicitly refutes the tenets of the of the double jeopardy perspective. Although both hypotheses on the dynamics of ethnicity and aging foresee a decline in the quality of life associated with aging, there is lack of consensus concerning the extent of the impact of structured inequality based on class and racial differences.

Support for the levelling theory is derived from research including that conducted by Dowd and Bengston (1978) involving data analysis of three ethnic groups in Los Angeles. On two subjective life satisfaction constructs termed “tranquility” and “optimism”, differences between African American and Anglo respondents became smaller with increasing age when the variables of income, socio-economic status, health, and sex were controlled. However, the data analyzed for Mexican Americans on the same dimension provided no support for this hypothesis. Another dimension which was examined in this study was social interaction. Frequency of contact with kin, excluding children and grandchildren, among the minority groups decreased as age increased and corresponded to that of the Anglo respondents in the
oldest age category (65-74). This selective support for this hypothesis further illustrates the complexity inherent in evaluating ethnic differentiation with regard to aging.

Research conducted by Rosenthal (1983) also lends support to the levelling theory. Comparisons between elderly Anglo Canadians (British background) and non-Anglo Canadians revealed similarities with respect to family structures, views of family life, and family relations (cited in Novak, 1993). A larger proportion of non-Anglo Canadians lived with their middle-aged children but this difference diminished in older age groups prompting the author to concluded that "there is a strong suggestion that age levels these differences (between groups)" (Rosenthal, 1983).

Rosenthal's findings challenge the tenets of the traditional/modern dichotomy which is frequently equated with the minority ethnic/majority ethnic conceptualization of aging. The modernization theory explicates five characteristic of modernization which are believed to contribute to a decline in the status of the aged: modern economic technology, rapid social change, urbanization, higher educational attainment, and advances in health technology (Palmore, 1983). Implications of this theory for family life are purported to include the following: a move from the extended to the nuclear family; geographical mobility increasing the distances between parents and children; higher education and higher social status for children; and a subsequent lack of integration into a kin group. Rosenthal (1983, p. 3) states that "the result of these factors, according to this theory, is that older people are geographically, socially and emotionally isolated from their children. This isolation is buttressed by an ideology which places individual achievement and preference above filial
obligations and familistic values.” She argues that this theory idealizes the minority ethnic family and fails to take into account the complexity of factors which differentiate ethnic groups from one another. Furthermore, she claims that there is little support to substantiate the assumptions concerning the lack of support to older people within the context of the so-called modern family.

Rosenthal presents a cogent argument for the disentanglement of interrelationships between aging and ethnicity from the underlying tenets of modernization theory. In doing so, she provides theoretical justification for an age-as-leveler hypothesis. Empirical evidence, however, is selective in its endorsement of this perspective. The assumption that the problems older people encounter and the supports they utilize are substantially similar regardless of ethnic background has been criticized as over generalizing and simplifying the interplay between aging and ethnicity (Bengston & Morgan, 1983). The argument has also been presented that this theory only holds true for individuals in late old age (Novak, 1993). Research is just beginning in earnest to substantiate the viability of this model of ethnic aging. Regardless of empirical outcomes, it does serve to illuminate the presumption that ethnic differences alone are not sufficient to comprehend the personal and social situations of the aged (Jackson, 1980). The final theory of aging and ethnicity to be addressed focuses on the positive influence ethnic identification can have on the process of aging and it is referred to as the buffer theory.
BUFFER THEORY
The buffer theory which represents a divergence from the aforementioned theories in that
ethnicity is viewed as an asset rather than a negative, or at least a negligible, influence on the
aging process (Novak, 1993). Holzberg (1981) states that in an environment where old age is
lamented and “where there are a multitude of cultural discontinuities in the transition from
adult status to old age and where the dominant values of self-reliance and independence make
it difficult for the elderly to age successfully, ‘ethnicity’ stands out as a potential corrective
alternative enabling individuals to better cope with the physical and psychical constraints of
decreased biological vitality” (p. 115). Giordano (1992) elaborates on this theme
emphasizing that ethnicity may be more critical to a person’s sense of security and identity in
the later stages of life, providing the individual with tried and tested methods for adaptation.

A number of studies have presented empirical evidence in support of this theory. Strain and
Chappell (1982) conducted research comparing the social supports of older natives with older
non-natives in Winnipeg. Data analysis indicated that social support networks were more
extensive and frequency of interaction was greater among the native respondents. Osako
(1979) determined from his study of Japanese American elderly that these aged did not
experience a sudden decrease in status or loss of self esteem. He concluded that these
findings were related to the continuity that existed between traditional rural Japanese and
contemporary American filial norms. In her ethnographic study of elderly American natives,
Schweitzer (1983) reported that ethnicity made a positive difference in linking elders to tribal
functions and extended family systems thus mitigating some negative influences related
situational factors such as poverty and poor health.
Ethnographic research conducted by Holzberg (1981) also validates the buffer hypothesis. This author implemented an ethnic history program whereby a collective effort was made to record the memoirs of the participants which in turn contributed to a sense of rejuvenation and the development of self-worth among the group members. Holzberg concluded that “it was the value of ethnic history to the group rather than the value of life history to the individual as a reaffirmation of the self that was the rallying point of collective effort” (1982, p. 253). Nevertheless, Holzberg cautions against idealizing the role and status of the elderly within the ethnic scheme of things. In situations where the expressed values of the group do not coincide with the actual behaviour of members, discontinuities and contradictions can exist. For example, Maldonado (1982) reported that the large, multigenerational family did predominate among Mexican Americans within rural communities when such a family structure was valuable in terms of economic productivity. However, the existence of such a family structure is largely a myth in today’s society where increasing urbanization and the predominance of the nuclear family has purportedly undermined the kin support network of the aged Mexican Americans.

The aforementioned studies, while not explicitly stated, can be viewed as being located within the theoretical framework of the modernization thesis. Modern North American society is reported to “dehumanize, humiliate, and create an underclass of those arbitrarily defined as old” (Holzberg, 1981, p.111). Primarily due to the institution of retirement and concomitant loss of income, the elderly are placed in a position of dependency in a society where productivity, self-reliance, personal autonomy and independence are dominant norms.
The elderly are commonly believed to be separated geographically from their kin in an environment where the two generation nuclear family is venerated thus cutting the elderly off from familial support systems. In this context, ethnicity is construed not simply as a resource but as a buffer to the negative attributes of "modern" society. Rosenthal (1983) cautions against equating minority ethnic membership with a "traditional" way of life whereby Anglo families in contemporary North America are subsumed under a "modern" typology. She states that "inherent in this view is the danger that researchers will idealize ethnic groups and will fail to differentiate them from one another" (1983, p. 6). However, Rosenthal does not dismiss the relationship ethnicity may have on family relations. Based on data generated from research examining contrasts in intergenerational solidarity in later life between Jewish and Anglo Canadian families, she concluded that the study demonstrated that ethnicity is related to somewhat greater intergenerational solidarity among Jews than among Anglos in Canada (1986). She qualifies this finding by suggesting that "while there may well be ethnic differences in family life, the traditional/modern typology may be misleading, clouding as many differences as it illuminates" (Rosenthal, 1986, p. 19).

It thus becomes increasingly apparent, when critically evaluating theories of aging and ethnicity, that no single theory adequately captures the intricacies and complexities inherent in understanding the interrelationships between the two constructs. Selective support exists for each theory promoting the recognition that a single hypothesis is not sufficient to explain all dimensions pertaining to aging and ethnicity. Bengtson and Morgan (1983) reiterate this perspective by stating "each ethnic group brings unique characteristics and resources to the
situation faced with aging; therefore, so that attempting to find one explanation acceptable to all ethnic groups is subject to failure” (p. 165).

The relevance of the preceding discussion of theories pertaining to ethnicity and aging to this thesis can be addressed by the following questions: To what extent can these theories also be used to provide an explanatory framework for the relationship between frailty and ethnicity? In addition, what are the implications of this relationship for the subjective experience of frailty as voiced by participants in this study? Of particular interest is the extent to which values associated with a “modern” typology such as productivity, self reliance, personal autonomy and independence are articulated by participants from varying ethnic backgrounds. These questions will be kept in mind when analyzing the data from this study to ascertain if this study supports any of these theories of aging and ethnicity.

SUMMARY

The purpose of this chapter has been to review the literature that has informed this study. The socially constructed nature of frailty has been discussed and a definition of frailty for the purposes of this study has been proposed. Research pertaining to frailty which is located within a phenomenological theoretical context has also been addressed. Finally, this chapter has presented some of the difficulties inherent in conducting research regarding the impact of ethnicity on the aging process. One of the difficulties concerns the conceptual confusion surrounding the term ethnicity. A definition of ethnicity which takes into account the socially constructed aspects of this construct has been discussed and three prevalent theories
of the interplay between aging and ethnicity have been reviewed. The next chapter will ground the subject matter of this thesis, frailty and ethnicity, in a theoretical framework informed by symbolic interactionism.
CHAPTER THREE

THEORETICAL FRAMEWORK: A DISCUSSION OF
SYMBOLIC INTERACTIONISM AND ITS CONTRIBUTION
TO AN UNDERSTANDING OF FRAILTY

INTRODUCTION

An attempt to understand how ethnicity frames the experience of frailty for elderly women living in the community must be informed by a theoretical perspective which is sensitive to this relationship. The theoretical framework guiding this study is embedded in the symbolic interactionist school of thought. A theoretical framework can be described metaphorically as a perceptual tool; the "compass" whereby one can discover and come to understand the complexities of social life. There are a wide variety of compasses available and each presents a different orientation to social life.

Where a researcher locates herself theoretically is generally indicative of how that individual views the world. The compass she selects to guide her inquiry will be calibrated to a specific set of assumptions. These assumptions are guided by what she conceives to be the nature of reality (ontological assumption), her perception of the relationship of the researcher to the subject (epistemological assumption), her acknowledgment of the presence of values and
biases (axiological assumption), and the research process that is utilized (methodological assumption) (Creswell, 1998).

Sociology is generally accepted as having basic divisions concerning how the researcher should go about things. Dawe (1970) contends that there are two sociologies: “a sociology of social system and a sociology of social action. They are grounded in the diametrically opposed concerns with two central problems, those of order and control” (p. 550). This opposition has facilitated the development of alternatives to traditional sociological approaches which view society as existing independently of its individual members. These alternative approaches have advocated a more expansive treatment of how individuals are linked to, shaped by, and in turn, create social structure (Hyman, 1985). There is an underlying presumption that the empirical world is dependent upon human group experiences and interpretations. Thus it follows that there can be in existence many worlds rather than one single, fixed objective world. The belief that communicating and engaging in the rituals of interaction and imbuing objects we encounter in our everyday lives with symbolic meaning will, in fact, create what we recognize as social reality is fundamental to these perspectives. Each assumption incorporates a distinctive approach to an ontology and epistemology of social life.

The "normative" and "interpretive" paradigms within sociology describe two contrasting world views which characterize the more influential research traditions in the social psychology of aging. The normative perspective implies that "established rules (norms) and status hierarchies are present in society in order to provide social control and social order"
Roles are learned by internalizing shared norms and values through the process of socialization. Social interaction is rule-governed and priority is given to the social system as opposed to the individual (Marshall, 1987). This approach is exemplified in structural-functionalism, age stratification, and life-span developmental theories (Marshall, 1987; McPherson, 1990).

The interpretive paradigm can be contrasted to the normative in that individuals are viewed as “social actors who, through the processes of negotiation, define, interpret, and control their institutionalized roles” (McPherson, 1990, p. 124). Thus the individual is conceived as having agency; she is not acted upon by external constraints, rather she is an active player in the creation of her social world. Reality is socially constructed through an “interpretive process in which meaning evolves and changes over the course of the interaction” (Wilson, 1970, p. 67). Fundamental concern is focused on the linkage between the individual and social structure and how this link is created through the language of symbols and shared meaning. People are viewed as “strategic” in their actions and social life is characterized by conflict (Marshall, 1987). Social interactionism, phenomenology, ethnomethodology, critical theory, neo-marxism, and social exchange theory exemplify this approach to sociological explanation (McPherson, 1990).

The development of various sociologies reflects the complexity of social life and the belief that coming to know this entity can be accomplished through the application of various theoretical assumptions. The approach utilized in this thesis, symbolic interactionism, is grounded in a world view which postulates that society is “the creation of its members; the
product of their construction of meaning, and of the action and relationships through which they attempt to impose that meaning on their historical situations (Berger & Luckmann, 1966, p. 551). The deterministic approach of other theoretical perspectives is eschewed in favour of a stance which views social organization arising from interaction which occurs between members of society.

The organization of social life is not conceived as solely dependent on the influence of external factors such as geography and biology. Frailty, as it is conceptualized in this thesis, encompasses both a social and a symbolic component. The meaning of frailty is not inherent, that is it is not some physical entity that exists separately and independently from social, political, cultural and economic contexts. Coming from this perspective, an attempt to more fully understand the process whereby frailty is framed and acted upon must embrace a theoretical stance which invokes the socially constructed nature of reality. Hence, a compass, calibrated to the assumptions underlying symbolic interactionism, will be used to chart the course of discovery in this thesis.

AN OVERVIEW OF SYMBOLIC INTERACTIONISM

Symbolic interactionism can be defined as a framework which "suggests the terms of and the ways in which explanations of social-psychological events and processes can be formulated" (Stryker, 1981, p. 4). Integral to this perspective is the belief that an individual cannot exist apart from society and there can be no perception of "self" apart from relations with "others". The "self" is thus viewed as a social entity which emerges from social interaction and is
critical to the understanding of human behaviour. Interaction is an emergent, negotiated phenomenon involving the creation, utilization and manipulation of words, meaning, and symbols to produce a language in which social knowledge can be articulated (Hewitt, 1991). Reality is conceptualized as a social product which emerges through the ongoing social interaction which relates mind, self, and society. This socially constructed reality thus becomes the subject matter of social psychology from a symbolic interactionist approach (Stryker, 1981).

THE TOOLS OF SYMBOLIC INTERACTIONISM

The Symbol

The most basic concept which forms the foundation of the symbolic interactionist perspective is the symbol. The symbol is generally defined as abstract meaning which is attached to objects, people and/or behaviour (Howard & Hollander, 1997). The symbolic interactionist makes the assumption that these entities which we encounter in our environment do not have intrinsic meaning. Social objects are described as “constructs and not self existing entities with intrinsic natures” (Blumer, 1969, p. 539). We do not act towards objects, people and behaviours simply on the basis of our perception of essential, concrete properties; rather we organize action based on meaning. The allocation of meaning is not performed independently by each individual in isolation; rather it develops through social interaction. Language, which is itself a symbolic system, is instrumental to the meaning-making process (Howard & Hollander, 1997).
To illustrate this observation, we can use the example of a cane. Physically, a cane can be described as a piece of wood or metal with a curved handle at one end and a blunt surface, possibly covered in rubber, at the other end. This description in and out itself does not impart information concerning what a cane represents. When asked to define what a cane is, we don’t state that it is a piece of wood or metal; rather, we make a response based on the meaning that object has for us. Based on our past experience, cultural background, age, gender and other social characteristics we may describe a cane as an object to make walking easier. Our relationship to the object will also contribute to our construction of meaning. For example, if a woman becomes frail, a cane may represent safety; it will enable her to get around her apartment on her own with a decreased fear of falling. However, a cane may represent something entirely different for a young man with a degenerative muscle disease. He may view the cane with contempt for his loss of strength and inability to walk unassisted is reinforced by his dependence on the cane. In each scenario, the individual has drawn on a shared system of cultural meaning to bring to their own situation. Subsequently, they have adapted that meaning to accommodate their symbolic relationship with the object in question, the cane.

In summary, symbolic interactionism contends that individuals attach symbolic meanings to objects, behaviour and other people; consequently they develop and impart these meanings through interaction. A person’s self and identity act as a resource, or tool, for interaction. We draw upon our sense of self when we engage in interactions in order to present an image
which will facilitate the attainment of the outcome we desire. The following section will elaborate on this concept of self.

The Self

Mead, one of the founding fathers of symbolic interactionism, envisions dual aspects of self (Stryker, 1981). One aspect, the "me", incorporates the organized attitudes of others. It refers to the person's perception of herself as an object where she can be "the self as known" (Howard & Hollander, 1997). The "I" refers to the experiencing, acting, being self, the 'self as knower' which integrates the responses of the individual to the collective attitudes of others (Howard & Hollander, 1997). A cyclical discourse is generated whereby the "I" influences the "me" and vice versa. The reflexivity of self inherent in the "I-me" dialectic serves to shape society as does society act to shape the self (Stryker, 1981). The self emerges as "not a state but a process linking the organism and the social environment" (Marshall, 1993, p.130). Individuals are able to choreograph their own actions as well as the actions of others. Hence, social interaction is constructed through this reciprocal process.

The writings of Herbert Blumer have also been very influential in the development of symbolic interactionism. He conceived society "as consisting of people's actions taking place in and with regard to a situation and constructed by interpreting the situation, identifying and assessing things that must be taken into account, and acting on the basis of the assessment" (Stryker, 1981, p. 9). In his view, society was not determined by the social
organization; rather, social organization was pertinent to the extent that it provided a framework to define and interpret a social situation.

His premises of symbolic interactionism include the following:

(1) “… that human beings act towards things on the basis of the meaning that the things have for them.”

(2) “that the meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows.”

(3) “that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with things he encounters.” (Blumer, 1969, p. 797-798).

This vision of social life, created and sustained through a continuously constructed and reconstructed interpretive discourse, runs as a basic theme underlying the tenets of symbolic interactionism.

If we accept a view which elucidates the reciprocity between the self and society, then the perception that societies are highly complex and differentiated entities should then have implications for the construction of the self. Differentiation entails that “only certain persons interact with one another in certain ways with certain resources in certain settings” (Stryker, 1981, p. 23). It follows that interactions do not occur randomly; hence, there are only certain others available to the individual who will act to shape the self. Access to these others will be influenced by social structure. The particularities of an individual’s social structure will then have direct material implications for the scope of actions that a person can envision, yet
Ethnicity is one aspect of an individual's social structure which will have consequences for action. The enactment of frailty, for example, will encompass the selection of certain behaviours. The behaviours and meaning ascribed to such behaviours will be drawn from a pool of previous interactions. These interactions will, most likely, be informed by social arrangements based on ethnicity, gender and other various structural relationships.

This interplay between self, interaction, and society was succinctly characterized by William James when he claimed that "people have as many selves as there are others who react to them" (Stryker, 1981, p. 23). The images people have of themselves and the images they have of others shape how they present themselves. Inversely, how people present themselves enables others to infer what self image that person has as well as the image he or she has ascribed to others. Self is "all the consequences of this self-and-other-awareness, our convictions, values, motives, and experiential history, carried in the spatial and temporal boundaries of our physical bodies" (Howard & Hollander, 1997, p. 94). Denzin (1992) has suggested that the basic object for all interaction is the self, and through the process of self-lodging we attempt to imprint crucial features of our selves into the subjective experience of others. Furthermore, Denzin argues that satisfactory interactions are characterized in terms of successful self-lodging and "if valued portions of the self are not lodged, recognized and reciprocated, a dissatisfaction concerning the encounter is likely to be sensed" (Denzin, 1992, p. 262).

The self concept arises out of seeing one's self as others do. Over time, an individual develops a sense of the 'generalized other', that is "he reacts to his sense of the general,
typical and predominant views of himself shown by others” (Hyman, 1985, p. 119). Kuhn refers to this stability in meaning which is attached to the self as object as the ‘core self’ (Stryker, 1981). He argued that it is the core self which imparts structure and relative uniformity to personality and provides continuity and predictability to behaviour. The behavioural repertoire, in turn, is mediated by situational context. Our spatial and temporal location in the social hierarchy will influence what we can do and who we can do it with. This situation will have implications for how we organize and direct action based on the joint construction of meaning that occurs between our ‘selves’ and others. In symbolic interactionism, this conceptualization of the self as a social structure emerging from social interaction is critical to the understanding of human behaviour.

While conceptualization of the self is characterized as fairly stable and predictable across successive interactions, the more public aspect of self, our ‘identity’ will be shaped and modified in accordance with situational context (Howard & Hollander, 1997). Identity construction is conceived as an intentional, strategic process which is located within the personal experience of the individual; however, the scope of identity presentation is mitigated by social structure (Denzin, 1992). In this thesis, I take the position that the personal experience of frailty along with ethnic, racial, class and gender affiliations will influence identity formation. The role of identity in symbolic interactionism will be addressed in more depth in the following section.
Self And Identity

Identities are construed as "parts" of the self and it is the actions, attributes and appraisals of this self which contribute to the concept of identity (Charmaz, 1987). They locate a person in social space by virtue of the relationships and memberships with which an individual is linked. Hence, identities are contingent on memberships in social groups (voluntary and ascribed) and on the subjective definitions which others ascribe to us. Inherent in the individual's sense of self are social identities which incorporate socially defined images of the individual in others' minds (Goffman, 1963). The reciprocity between self and society characteristic of the symbolic interactionist perspective is instrumental to the identity process which accounts for the ongoing emergence and shaping of the self concept.

The social settings where an individual engages in interaction enable her to anticipate the categories of persons she is likely to encounter there. Implicit in her expectation is the understanding that individuals she will meet will conform to certain pre-conceived categories and attributes. The categories and attributes on which such expectations are hinged comprise the individual's social identity. Goffman differentiates between a "virtual social identity" and an "actual social identity" (1963). The former refers to assumptions made concerning the category and attributes we expect an individual to possess; the latter refers to characteristics the individual could actually be proven to possess. A discrepancy between the two is referred to as a "stigma" (Goffman, 1963).
SELF, IDENTITY, AND STIGMA

A stigma is defined as an attribute which renders an individual “different from others in the category of persons available for him to be, and of a less desirable kind” (Goffman, 1963). The stigmatized individual possesses the same beliefs about identity as the larger society to which she belongs; she is therefore acutely sensitive to this inability to live up to what she believes she really ought to be.

Supernormal Identity

The stigmatized person may also try to indirectly change her condition by devoting an excess of time and energy to the mastery of activities defined as unattainable to someone with her stigma. Pursuing this course of action can be characteristic of an individual aspiring to a “supernormal identity”. Those who identify with this goal seek to construct a “personally valued and socially credited identity in conventional worlds” (Charmaz, 1987, p. 296). Emphasis is placed on rejecting stigmatizing images through demonstrating to others that “they” are no worse off than normals. Normals in this context refer to persons who conform to societal expectations regarding who they ought to be (Goffman, 1963).

Preferred Identity

The knowledge that an individual can be discredited and possibly rejected by normals due to a stigma can motivate that person to attain a preferred identity. A preferred identity represents assumptions, hopes, plans and desires for the future and is a reflection of who an individual wishes to become and how they wish others to know them (Charmaz, 1987).
Acquiring a preferred identity can help to avoid or minimize stigma. For example, a woman who is becoming more frail, perhaps because she is having problems walking and climbing up and down stairs, may immerse herself in volunteer activities which involve phoning people, such as checking up on other housebound seniors. Engaging in this type of activity decreases the probability that she will have to leave her home and enter situations where she could potentially be discredited. Instead, she has invoked a preferred identity, that of an useful and active volunteer, which helps to render her own physical limitations as less stigmatizing.

**Identity Salience**

The construct “identity salience” is a theoretical term used to describe the manner in which identities making up the self can be organized. Identities are arranged in a hierarchy of salience based on the probability of a particular identity being invoked in a specific situation or over many situations (Stryker, 1981). The more committed one is to a particular identity, the greater salience that identity will have for the individual; consequently, behavioural choices will be influenced by that particular identity. Over time, identity salience will elicit behavioural continuities and personal resistance to change which will in turn shape one’s sense of self (Howard & Hollander, 1997).

The invocation of a preferred identity by an individual to reduce stigma can be conceptualized using a hierarchy of identity salience. For example, a woman who encounters difficulty with sewing, an activity she always enjoyed, due to sore and stiff hands, may
experience a decline in her commitment to her identity as seamstress. Rather than struggle clumsily with a poorly executed sewing project which may be a stigmatizing experience, the woman may instead present a preferred identity. This identity, perhaps as a singer, will transcend her potentially stigmatizing identity. She can still incorporate her sense of herself as a creative individual; yet, by committing to an identity which draws attention away from what she perceives as a shortcoming, she can present a preferred identity. An identity hierarchy which focuses on the types of preferred identities available to persons experiencing chronic illness has been described by Charmaz (1987). In addition, Yoshida (1993) constructed a model which incorporates five predominant identity views of individuals with traumatic spinal cord injuries.

The possession of a particular stigma can contribute to the experience of a similar "moral career" among individuals. This career is shaped by learning experiences with regards to an individual's discredited status and alterations to the conception of self (Goffman, 1963). The integration of this concept within the theoretical framework underlying symbolic interactionism is exemplified by the observation that the "shaping of the self, and self concept change, is the heart of the problem of socialization from a symbolic interactionist standpoint" (Stryker, 1981). Self presentations are inspired not only by our conceptions of selves but also by our conceptions of others. We confirm our beliefs about others through our own behaviour.

Behavioural confirmation thus acts as the basis for generalized beliefs and stereotypes regarding the expectations we have of others (Howard & Hollander, 1997). We have learned
to expect a certain type of interaction to occur so we behave as if that behaviour has occurred; thus, preconceived identities are mutually reinforced through this reciprocal process. The moral career involves the application of the process of behavioural confirmation to stigmatized individuals.

Inherent in the socialization process characteristic of the moral career are two initial phases. During one phase the individual learns and incorporates the identity beliefs of the normal, gaining awareness of what it would be like to possess a certain stigma (Goffman, 1963). In this context, the individual learns to take on the role of the other, enabling her to anticipate the responses of herself and others, and to react to those responses on the basis of anticipation (Stryker, 1981). The next phase is characterized by the realization that a person has a stigma and the consequences of this situation. The process of embarking on a moral career illustrates that it is not the attribute itself which discredits the individual but rather the social process of conferring a stigmatizing meaning on the attribute (Freidson, 1972).

**SELF, IDENTITY, STIGMA, AND OLD AGE**

Old age can also be conceptualized as an attribute which has been stigmatized. However, there is much ambiguity surrounding the age category ‘old’ such as an explicitly recognized rite of passage and a lack of agreement concerning norms and expectations which constitute ‘old behaviour.’ Thus, old age can be described as evoking a weak stigma (Matthews, 1979). Older persons are “unsure of how to view themselves in relation to their chronological age. And those with whom they interact suffer from the same uncertainty, for it is not always clear
whether age is a major attribute to which to attend or if some other status attribute should take priority” (Matthews, 1979).

The possession of a weak stigma combined with a lack of power which stems from limited economic viability combines to make self-identity and self-presentation problematic for older persons. The theoretical perspective of symbolic interaction can be used to understand how the invocation of a stigmatized status has implications for the conceptualization of self and identity in older persons who have internalized the social meaning ascribed to ‘oldness.’ The following section of this thesis will discuss the research of Matthews (1979) and Kaufman (1986) who both used a symbolic interaction perspective to explore issues of identity and sources of meaning in later life among women.

Matthews (1979) used symbolic interactionism to address issues pertaining to the management of identity in later life. Her findings are based upon a qualitative study using participant observation and intensive interviewing to acquire “intimate familiarity” (Lofland, 1976) with the social worlds of old widows. Matthews asserts “old women are not atypical because of their age, but are similar to other members of society in their ability to develop strategies to cope with personally threatening situations” (pg. 22, 1979). She contends that being old is not a pivotal aspect of informants’ self-identities. Conversely, she asserts that being old is a pivotal social identity, a status which others may attribute to the elderly woman.
Social stereotypes have shaped the view that “there is something about old people by virtue of their age that makes them members of a legitimate social category ... a social category with negative connotations” (Matthews, 1979). These connotations are linked with the presumed mental and physical incapacitation which occurs when one enters the ‘golden years.’ Therefore, even though an aging woman may not view herself personally as old, she must deal with others in a variety of situations who do view her as old and she may start to recognize evidence in her own behaviour that she is conforming to social expectations associated with being old.

Thus, maintenance of self-identity becomes problematic for older adults as they must develop strategies to protect the image they have of themselves. These strategies may not be consciously planned and performed; however, they do affect social interaction such that preservation of identity is the outcome (Matthews, 1979). She described how her informants used four strategies to manage encounters with others. The first strategy involved suppressing evidence of one’s age such as avoiding telling people your true chronological age. The next strategy concerned using different definitions of old, for example, informants would apply one set of criteria for other old people and use another set for themselves. The third strategy was to bring in outside sources to verify perceived “unoldness.” In other words, the women would use what others had said about them to confirm their own view that could not be old. The final strategy involved organizing daily activities so that the women were infrequently exposed to threatening situations where they could be discredited. For example, riding on a bus at the same time school gets out. In this situation, younger kids
might comment on the woman’s slowness getting on and off the bus or they might resent that she takes up a seat which could evoke negative age-related comments.

The other situations an old woman must deal with involve encounters with the self whereby “signs, both physical and social, ... indicate that she is a ‘typical’ old woman after all” (Matthews, 1979, p. 80). These strategies are directed at coping with self-doubt as opposed to the doubts of others. The first strategy used by the informants Matthews (1979) referred to as ‘what seems like oldness really isn’t.’ In other words, women looked for alternate explanations for behaviour which might otherwise be associated with “oldness.” Another strategy involved attaching new meaning to old activities. Matthews (1979) commented that “crocheting, cleaning house, watching television become ways of ‘keeping busy,’ which is now the justification for living” (pg. 82). In this respect, the women viewed their daily routines as busy and worthwhile; thus a self-identity of not old was maintained. If the informant was indeed old, she would be whiling away her days in a rocking chair instead of bustling about accomplishing various tasks throughout the day.

Another strategy proposed by Matthews (1979) concerned the accounts given by the informants for less than satisfactory relationships with their families. A common justification for this situation was reported as a lack of time on the part of relatives who had busy schedules. Conversely, if the relatives had more time they would surely be spending it with their mother, grandmother, etc. The fourth strategy presented in the study involved the informant’s sense of reciprocity. Matthews (1979) asserted that “by making herself useful and seeing herself as needed, she is able to maintain this semblance of reciprocity and avoid
feeling dependent and, therefore, old” (pg. 89). For example, an informant may explain that she relies on her daughter to do her grocery shopping yet she may also pay for her daughter’s groceries as well as her own which alleviates her own sense of dependency and guilt.

In summary, Matthew’s work elucidates how old widows maintain images of themselves which counteract the stigma associated with oldness. Oldness was described as a weak stigma which informed their social identity but was not experienced as a pivotal self-identity. Her research emphasizes the overriding importance of the social meaning, rather than the biological meaning, of chronological age which shaped the social worlds of old widows thus eliciting the socially constructed nature of oldness. The work of Kaufman (1986) and her contribution to the discourse on self and identity in old age will now be addressed.

Kaufman (1986) looked at the meaning of aging to elderly people themselves, as it emerged in their personal reflections on growing old. She used symbolic interactionism as a framework of orientation in her qualitative study of 15 elderly people. Her findings elucidated the observation that people who are elderly do not speak of being old as a definitive characteristic of the self. Rather, they express a sense of self that is ageless - “an identity that maintains continuity despite the physical and social changes that come with old age” (Kaufman, 1986, pg. 7). She contended that people create themes which are informed by shared as well as individual experiences. These themes enable them to construct identities which serve as frameworks to describe who they are to others and to explain how they come to know themselves.
The construction and interpretation of experience as one ages were speculated to be critical elements which gave form and meaning to one’s actions. Kaufman (1986) asserted that the self utilizes the past as a resource for creating meaning in present encounters and she conceived of identity formulation as a lifelong process. Themes are created to shape a coherent sense of self. Normative ideas about the form and meaning of the individual life course provide the context for identity formulation and are rendered more explicit by factors such as one’s gender, cultural heritage and ethnicity. Kaufman expressed that “the focus on themes in the lives of the elderly allows us to conceive of aging as continual creation of the self through the ongoing interpretation of past experience, structural factors, values, and current context” (p. 151). Identity was structured around themes as the informants described themselves in terms of themes which they continually reformulated and applied to new contexts so that an integrated sense of self emerged.

The process of continually shaping the self enabled the informants to cope with socio-cultural demands for change which helped to achieve and maintain a sense of well-being. While Kaufman did not explicitly refer to the stigma associated with old age, she did confirm that her informants were aware of negative attributes associated with getting older; however, their concerns were framed in the thematic material they presented. Kaufman (1986) stated she “found that in the expression of the ageless self, individuals not only symbolically preserve and integrate meaningful components of their pasts, but they also use these symbols as frameworks for understanding and being in the present” (pp. 19-20). In this context, the socially constructed nature of self and identity in old age is elicited through the creative, symbolic process of self-formulation in late life.
SUMMARY

In summary, this section has attempted to illuminate some of the defining characteristics of symbolic interactionism utilizing the concepts of self, identity and stigma. Within this framework, the individual and society are not conceived as operating in some deterministic fashion. The individual is not a puppet whose strings are manipulated by social forces; rather the individual is conceptualized as a “self-conscious creature who employs his intelligence in the organization of his actions” (Hyman, 1985). Social knowledge is conveyed through interaction and the individual learns from society while at the same time collectively creating the very social order in which he or she is immersed. The world is, in most respects, intersubjective and socially experienced and becomes known through language which enables people to share meaning and make sense of their worlds. Given this emphasis on meanings, interpretations and lived experience, the symbolic interactionist perspective provided me with an appropriate compass to guide this study which sought to understand how ethnicity frames the way elderly women talk about frailty, and by inference, what frailty means to them. In particular, this perspective alerted me to look for certain things, such as the interplay of self, identity and stigma on the experience of frailty, when collecting and analyzing the data for this study.

The fourth chapter of this thesis will discuss the research methodology used in the study. The methodology is informed by the theoretical framework of symbolic interactionism
addressed in this chapter. The assumptions guiding the inquiry, methodological orientation, methods used and the analytical approach applied will subsequently be addressed.
CHAPTER FOUR

METHODOLOGY

RESEARCH OBJECTIVES

The underlying assumption guiding this study is the belief that ethnic differences will contribute to diverse meanings concerning the experience of frailty. The defining questions that were used to guide this inquiry are:

- **What are the stories of elderly women regarding their experience of frailty?**

- **How are these experiences of frailty mediated by ethnicity?**

My expectation was that these stories would reveal the embodiment of ethno-cultural beliefs and ideals regarding the construction of self in relation to health and well-being. I did not determine how these beliefs and ideals have been described in the literature prior to undertaking my study. I believed that entering this study with such knowledge would bias my interpretation of the data. It was my intention to allow ethno-cultural beliefs and ideals to emerge from the data during the course of data collection and analysis and to use this information to facilitate a conceptualization of the relationship between frailty and ethnicity.
It also follows that, in the tradition of qualitative research, I expected to be surprised by other issues that could emerge from my descriptive data.

For example, I anticipated that ethnic background would shape the experience of frailty for elderly women. Consequently, I believed that this experience would vary for women of different ethnic backgrounds. On the other hand, I could have anticipated that all of the women, regardless of ethnicity, might not view themselves as "slowing down." In fact, they might describe themselves as energetic and alert and perhaps bored by not having enough activities to fill their day. Or, some women, irrelevant of ethnicity, might perceive the experience of frailty as positive. They might eagerly anticipate receiving assistance with ADL because it is a reward they have justifiably earned for spending most of their lives looking after others. These findings could provide as much insight into the topic under study as those outcomes which are explicitly stated.

**METHODOLOGICAL ORIENTATION**

Research methodology establishes how one will go about studying a phenomenon; it is the approach that is utilized to guide the entire research process (Silverman, 1993). The previous chapter addressed the ontological, epistemological, and axiological assumptions which establish a conceptual framework with which to guide scientific inquiry. These assumptions shape our view of reality and from these distinctions about reality a germane methodology will emerge.
Consistent with the symbolic interactionist approach outlined in the previous chapter, the methodology of this study is informed by the interpretive framework which endeavors to describe and illuminate the meaningful social world. In accordance with its underlying ontological assumptions, the methodology will be grounded in a particular view of the world. That is, I am entering this study with the belief that the world is not some entity that exists "out there" waiting to be discovered but rather it is a world that emerges in our thoughts and interactions (Berger & Luckmann, 1966). Everyday life presents itself as a subjectively meaningful reality which is interpreted by individuals as a coherent world. Schutz and Luckmann (1989) refer to the life-world as the "quintessence of a reality that is lived, experienced, and endured. It is, however, also a reality that is mastered by action and the reality on which and in which our action fails. Especially for the everyday life-world, it holds good that we engage in it by acting and change it by our actions" (p. 1).

This everyday life world is the reality in which we subjectively experience our existence. We do not experience our world in isolation; rather, the reality of everyday life presents itself as an intersubjective world, a world which we share with others. Thus the world that each of us perceives is shaped by common experiences which we all share. However, our views are unique to each of us because we are all differently situated with respect to the experiences that we encounter. The ontological implication is that the world is comprised of multiple realities. In this study, the realities will include those of myself, the researcher; those of the individuals being researched; those of the my thesis supervisor and other members of my committee; and also the realities of those who choose to read the thesis.
In order to make some sense out of our everyday reality, we utilize our own unique "stock of knowledge." Such knowledge is biographically articulated and can be described as "the accumulated and sedimented experiences that enable the individual to orient himself interpretatively in his life situation and to plan and act within them" (Wagner, 1983, p. 96).

Interaction with others in everyday life is constantly mediated by our common participation in the available stock of knowledge. This participation serves to locate individuals in society and shapes our interaction with each other.

This social stock of knowledge possesses certain characteristics. It includes a knowledge of one's situation and its limits (Berger & Luckmann, 1966). For example, as one gets older, it may become apparent that projects and actions which one previously did not have to pay much attention to now require careful thought. Schutz and Luckmann (1989) refer to this awareness of limitations as a "capability" shift. For example, an elderly woman may encounter a situation where doing up the buttons on her blouse becomes a cumbersome and difficult task due to her experience of stiff and sore fingers. This routine task was previously performed without any conscious concerted thought or effort. The project of action must now be reconstructed and the options that are selected will be informed by her stock of knowledge and potentially the stock of knowledge of others with whom she interacts. For instance, she may opt to wear only buttonless tops, she may procure the assistance of a friend or relative to help with the buttons, or she may purchase an assistive device to enable her to do up the buttons.
Knowledge of everyday life is also structured in terms of relevances. These relevance structures intersect with the relevance structures of other individuals which can be influenced by immediate pragmatic interests as well as by social structural factors (Berger & Luckmann, 1966). In the above example, the woman knows “better than” to tell a bank teller about her inability to do up buttons. She may speak with a nurse or an occupational therapist who could suggest a button hook to enable her to do the buttons up herself. On the other hand, this solution may be at odds with the relevance structure of the woman’s daughter who finds that it takes an excess of time for her mother to use the button hook and to expedite the process she would just as soon do up the buttons for her mother. Alternately, the whole issue of doing up buttons may no longer hold relevance for the elderly woman and she may decide to forgo buttons altogether in favour of pullovers.

In addition, knowledge in everyday life is also socially distributed and is possessed differently by various individuals and types of individuals. The knowledge we possess is not shared equally with all people and there may be information that is not shared with anybody. There exists variation in the boundary lines concerning what is taken for granted and what presents as problematic among members of the same group (Wagner, 1983). This situation can be illustrated using the theoretical construct of stigma. An individual may be aware that she no longer conforms to societal expectations concerning the type of person she ought to be. For example, a woman in her mid seventies may find that she has an incontinence problem of which she is acutely aware. This is a woman who has been very active and enjoys engaging in various activities with her friends such as tennis, golf and swimming. Rather than place herself in a situation where her potentially stigmatizing condition may be
discovered, she deliberately avoids these activities by telling her friends that she no longer has time to participate. In this context, a taken-for-granted function such as the ability to control her bladder has become problematic for this woman. However, her own knowledge of how the socially available stock of knowledge is distributed allows her to seek out the expertise of a urologist who can help her to address the problem.

Alfred Schutz, one of the most important phenomenological theorists, developed a sociology of common-sense knowledge that involved a reconstruction of the sociological framework from philosophical assumptions to sociological research. According to Schutz, our knowledge of other persons, in the form of typifications, derives its utmost validity from direct experience in the face-to-face situation. In other words, "the ideal types that we use as interpretive schemes for knowing others gain the greatest meaning from the immediate experiences between consociates" (Heeren, 1971, p. 51). The reality of everyday life contains typificatory schemes in terms of which individuals are approached and 'dealt with' in face-to-face relations. For example, I may locate an individual as a "an elderly, frail woman", "black", "a church goer", and so forth. These typifications will pattern my face-to-face interaction with her as long as they do not become problematic for either one of us. For instance, I may interpret a physical sign such as avoidance of eye contact for lack of interest which may prompt me to end our interaction. The woman, on the other hand, may be enjoying our conversation but she may view indirect eye contact as a sign of respect, a cultural value affiliated with her ethnic identity.
These typificatory schemes are also reciprocal (Berger & Luckmann, 1966). The individual with whom I am interacting also “measures me up” in a typified way. I may be apprehended as a “younger, white, woman”, “inexperienced”, “student” and so on. These typifications are as susceptible to my interference as mine are to the intervention of others. For example, many of the woman were surprised when they found out that, at the time of the interview, I was the mother of two children. This new information required a reformulation of my typification as the ongoing negotiation of our identities occurred during the course of the interviews.

Berger and Luckmann (1966), who were profoundly influenced by Schutz, further expanded on his ideas, particularly regarding the role of knowledge in society. Specifically, they were concerned with the manner in which reality is socially constructed and a sociology of knowledge which takes account of the process whereby this occurs. They proposed that the “reality of everyday life is organized around the “here” of my body and the “now” of my present … Closest to me is the zone of everyday life that is directly accessible to my bodily manipulation. This zone contains the world within my reach, the world in which I act so as to modify its reality … my attention to this world is mainly determined by what I am doing, have done or plan to do in it” (Berger & Luckmann, 1966, p. 22). The subjective experience of everyday life thus becomes the subject matter for sociological analysis within an interpretive conceptual framework and the experience of frailty is one of these subjective experiences.
Methodologically, it follows that if we are to understand the socially constructed nature of the reality of everyday life from an empirical perspective, then we must attend to interpretations of this reality by individuals who experience their life-world as subjectively meaningful. This approach is termed phenomenology and this is what it means to take a phenomenological approach.

This approach seeks to understand the lived experiences of individuals and their intentions within the life-world whereby the researcher seeks to “understand, make sense, and elicit the meaning of a phenomenon” (Morse & Field, 1995, 208). It was my intention to enter in some manner the everyday world of elderly women who are living alone with some measure of frailty. I hoped to understand in some way what this experience meant to them, that is, how they talked about it, how they viewed their world and what were the implications for courses of action. Utilizing a phenomenological approach also entails locating myself as the researcher with respect to my understanding and experience of frailty and ethnicity. These personal assumptions will be addressed in the next section of this chapter.

**RESEARCHER’S ASSUMPTIONS GUIDING THE EXAMINATION OF THE SOCIAL CONSTRUCTION OF FRAILTY**

My own impressions of frailty are not informed by my own personal experience with the phenomenon but rather by my involvement with women and men who are themselves experiencing some degree of frailty. As revealed in the introduction to this thesis, my
professional background as an occupational therapist brought me into contact with frail, elderly individuals both in their homes and in a hospital setting. In this context, my primary role was to increase the independence of referred clients, specifically in terms of activities of daily living. Consequently, I performed various assessments of functional abilities such as bathing, dressing, meal preparation, eating, walking, transferring from various surfaces and so forth. Thus, my impressions of frailty at this point were primarily skill-focused. What a person could and couldn’t do in terms of looking after themselves on a daily basis formed the framework for my clinical intervention. My own understanding of aging and frailty is also shaped by my relationships with family members, in particular my grandparents, who are experiencing some decline in their own abilities.

Thus, I acknowledge that I am not a blank page waiting to be inscribed through the research process. I entered this process informed by my own professional and personal experiences with frail individuals. Furthermore, my page is shaded by perceptions that reflect my age, class, gender, educational background and my ethnic affiliation. At the time I started the study, I was a thirty-two year old female graduate student from a white, middle-class background with an Irish-Catholic and French ethnic affiliation. These characteristics informed my own view of frailty and how I am situated with reference to it. Phenomenological research does not view acknowledgment of personal assumptions as a negative feature which would jeopardize effectiveness as a researcher. Rather, explicit awareness of the researcher’s expectations regarding the experience of frailty and ethnicity is viewed as enabling her to focus more clearly on the lived experiences of the participants in this study and to interpret their stories in a meaningful context. Thus, I entered the study
with the belief that to understand "how things are" with regards to frailty, I must enter the subjective realm and give a voice to those who are experiencing frailty themselves, in this study, women who are elderly, while also acknowledging my own assumptions.

The introductory paragraphs in this thesis also discussed my background working with the elderly from various ethnic backgrounds and alerted the reader to my "hunch" that the experience of frailty could be framed by an individual's ethnicity. More specifically, I believed that ethnic differences could contribute to diverse meanings concerning frailty. I anticipated that these meanings would reflect the embodiment of ethno-cultural beliefs and ideals regarding the construction of self in relation to health and well-being. To give a more concrete example, I will subsequently present a scenario which illustrates my expectations regarding the relationship between frailty and ethnicity through the embodiment of ethno-cultural beliefs and ideals.

One aspect of daily living which may pose difficulties for elderly women is bathing. They may not be able to get in and out of the bathtub easily, sit comfortably, get up from a sitting position, or reach certain areas of their body to wash and dry. Diminished ability to perform this activity according to one's earlier set of standards may contribute to an experience of frailty. One solution to address this problem would be to equip a woman with assistive devices such as a bath bench, grab bars placed on the walls of the tub enclosure, a hand held shower head, and an extended reacher with a sponge on the end. These devices could enable her to bathe independently, and, for an individual who had embodied such values as self-reliance, privacy and autonomy, this would be a desirable outcome. An experience of frailty,
that is the inability to bathe on one's own, would then be reframed by using assistive devices to maximize independence.

Another situation may arise for a woman who had embodied a different set of ethno-cultural beliefs such as interdependence and mutual assistance. In this case, the woman may enlist members from an extended family to help with bathing which would, for her, be preferable to using assistive devices. She may enjoy this opportunity to socialize with her family members and/or she may expect this assistance from them in return for care she has given them in the past or present. Again, an experience of frailty would be reframed, this time by using family support to accomplish the task. Alternatively, regular bathing in a tub may not even be valued by some individuals. They may prefer to take a sponge bath at the sink; consequently, difficulty taking a tub bath would not be meaningful and thus would not contribute to an experience of frailty.

The aforementioned scenario helps to illustrate my contention that individuals' perceptions and interpretations of "how things are" with relation to the experience of frailty is framed by ethnicity through the embodiment of ethno-cultural ideals. I did not seek to determine in a comprehensive fashion how the ethno-cultural beliefs and ideals of African-Caribbeans, Anglo-Saxons, and Polish-Catholics had been described in the literature prior to undertaking this study. I believed this prior knowledge could influence my interviewing of participants and bias my interpretation of the data. Instead, I hoped that effects would emerge from the data during the course of data collection and analysis. These results would be conveyed in the form of quotes which would provide a framework from which to make a conceptual link
between meaning, context, and voice. Finally, since the stories related by the respondents by their nature reflected complexity, inconclusiveness, and diversity (Gubrium, 1991), I approached this study with respect for unpredictability and inconclusiveness and I expected to be surprised by unanticipated outcomes.

The methods used to implement this study will subsequently be described. These will include the sample selection, site selection, data collection, ethical considerations pertinent to study and data analysis.

METHODS

Sample Selection

The purposive, convenience sample for this study included twelve elderly women, seventy-five years of age and over, who lived alone in the community and received assistance with ADL (activities of daily living) for three to twelve hours a week. Furthermore, each woman expressed affiliation with one of three ethnic groups: Polish-Catholic, Anglo-Saxon or African-Caribbean. The sample was stratified to include four members of each group. The participants also possessed conversational English to the extent that they were able to comprehend and respond to the interview questions. This ability was determined by the activities co-ordinator from the entry site. I recognized that nuances of meaning and expression could not always be fully acknowledged during the course of the interviews;
however, all attempts were made to be sensitive to these nuances through active listening and reflecting with participants during each interview.

It was decided that twelve respondents would be adequate to access the most relevant information based on Lincoln & Guba (1985) - "it is usual to find that a dozen or so interviews, if properly selected, will exhaust most available information" (p. 235). Bergum (1988), and Morse and Field (1995) also support this sample size for the purpose of obtaining descriptive data. The specified criterion of receiving three to twelve hours weekly of assistance with ADL excluded participants who had severe cognitive and/or physical impairments and would not be able to adequately attend to the interview questions. Consequently, the boundaries around frailty for the purposes of this study were shaped by this criterion. That is, frail women who were living alone at home with moderate to severe cognitive and/or physical impairments who required in excess of twelve hours of care each week were not included in the study. It was my assumption that women who received three to twelve hours of care had, in effect, been categorized as frail due to their diminished capacity to perform ADL; however, I believed that they had the ability to meaningfully participate in the interview (i.e., possessed a willingness and desire to commit time to be interviewed, were able to express themselves, and were agreeable to share their experiences with researcher).

Women have been selected for the sample because research data suggests that more women than men are living alone with some degree of frailty in this age range. Demographic information indicates that half of elderly women, while only a fifth of elderly men, live alone
(Arber & Ginn, 1991). This situation exists because women, on the average, outlive men by 7.5 years in Canada) and as a result, they experience a higher incidence of widowhood (58% of women compared to 18% of men at ages 75-79). Women also report higher levels of disability at all ages in the life course (Martin Matthews, 1987; Chappell, 1990; Clarke, 1990; Wilkins & Cott, 1994).

The sample also included four members each of three distinct ethnic groups. Four of these women identified themselves as Polish-Catholic with respect to ethnicity, four identified themselves as African-Caribbean, and four identified themselves as Anglo-Saxon. The citizenship status and country of birth of the respondents were not used as determinants of ethnic background; rather, what was important to this study was personal perceptions of self identification and affiliation with an ethnic group rather than how long a respondent lived in Canada.

The rationale for the selection of participants from Polish-Catholic, African-Caribbean and Anglo-Saxon backgrounds was premised on several assumptions guiding this research. The first assumption was that the experience of frailty will be informed by distinct ethno-cultural beliefs and ideals for women from different ethnic backgrounds. Traditionally, aged Polish-Catholic women have been described as holding in high esteem qualities such as interdependence and familial responsibility. Alternatively, Anglo-Saxon women have been characterized in the gerontological literature as favouring such qualities as independence, autonomy, and self-reliance (Sokolovsky, 1983). Elderly African-Caribbean women have
been portrayed as valuing qualities that are a combination of those associated with the Polish-Catholic and Anglo-Saxon groups (White-Means & Thornton, 1990).

Another assumption that has guided the selection of the three ethnic groups was premised on the probability of recruiting participants who meet the aforementioned criteria from the Greater Metropolitan Toronto area. Currently, the proportion of those aged 65 and over is particularly high among Polish and Ukrainian ethnic groups in Canada (Ujimoto, 1987). The proportion of people of African-Caribbean origin in the over 65 age category is relatively small with regards to the Canadian data, but there is higher representation in the Toronto area. There are also significant numbers of Anglo-Saxons who meet these criteria in the relevant geographic area according to the demographic data (Statistics Canada, 1984).

Markides (1982) alerts the researcher to be sensitive to cultural differences between and within ethnic groups. In order to address the compositional heterogeneity within each group, a phenomenological approach which explores personal meanings and interpretations of frailty was utilized. Differences between ethnic groups was captured using the stratified sample described in the preceding paragraphs.

**Site**

The criteria for site selection included the following: an organization or facility which (1) promotes independent living for clients living in the community who are members of the ethnic groups of interest; (2) serves clients in Greater Metropolitan Toronto; (3) is a non-
profit organization so that the range of participants available would not be limited to those of a higher socio-economic status.

In order to access respondents who met the criteria for participation in the study, I phoned various agencies and presented my intentions regarding my research project. If an agency expressed interest, I arranged a meeting with a representative from the organization to further discuss my research proposal and mutual expectations regarding participation in the study. Once an agency agreed to participate, I then initiated the process of recruiting participants. I found that the activity co-ordinators and home care workers directly involved with potential respondents were able to assist in the identification of suitable participants who met the criteria for participation in this study.

It was my original intention that the majority of the interviews would take place in the homes of the participants. Each potential participant was asked during the initial introduction where and when they would like to be interviewed. The preference for the nine of the respondents recruited from one site was at the actual site where a day program was attended by all participants recruited from this site. The site's tuck shop, which was not open at the time, was used to conduct the interviews. Another two interviews were conducted in the communal dining area of a senior’s apartment complex which was the second site utilized for this study. One interview took place in the apartment of one of the respondents. Such activities as confirming arrangements for the interview, arriving promptly, keeping the interview on schedule, not stepping outside the boundaries of the interview unless invited and
providing the respondents with a list of interview questions were done to convey respect and professionalism.

Data Collection

The data collected for this study was derived from semi-structured interviews that were conducted with the participants. This method of data collection enabled the researcher to meet the stated purpose of the study, that is, to understand how ethnicity frames the experience of frailty for elderly women living alone in the community. Since the study was concerned with how elderly women themselves talk about frailty and the relationship between ethnicity and the experience of frailty, a research method which explicitly addressed these issues was required. The strength in interviewing lies in "the opportunity to learn about what you cannot see and to explore alternative explanations of what you do see" (Glesne & Peshkin, 1992, p. 65).

Semi-structured interviews comprised of mostly open-ended questions were utilized. This method limited the scope of the interview to relevant areas of interest while permitting the flexibility to capitalize on the special knowledge, experience, and insights of the respondents (Singleton, Straits, & Straits, 1993). Furthermore, such a technique takes into account how the respondents' views and understandings of themselves and the world can be shaped by the form and context of research interviews, thus allowing for explicit recognition of the joint construction of meaning in an interview between interviewer and respondent (Mishler, 1986).
The interview was characterized by mutual reformulation and specification of questions which took on context-bound meanings and enabled the interviewees to have some control over the ways of "naming their world."

The interview guide has been included in the appendix of this thesis (Appendix A). The effectiveness and appropriateness of the interview guide in terms of eliciting valid responses was assessed during the first interview with a subject from each respective ethnic group. No substantive revisions of the interview guide were required; however, I found that some questions needed to be repeated or reworded in order to elicit the most informative responses. This process was expected and informed by the methodology of the study as "adjusting the design as you go along is a normal, expected part of the qualitative research process" (Rubin & Rubin, 1995, p. 44). Through learning how the respondents understand and interpret their world, I sometimes modified my line of questioning in order to pursue unexpected developments in the interview. The interview, like a conversation, was re-invented each time it occurred; therefore, questions and probes were designed to flow from answers to earlier questions.

With the consent of the interviewee, each interview was recorded using a Pearlrcorder S924 Microcassette Recorder. Each interview was completely transcribed and the transcription was re-checked against the original tapes to ensure accuracy. Following each interview, I recorded reflective notes which summarized my impressions of the interview to be used for data analysis and interpretation.
Ethical Considerations

Paramount to any study involving human subjects is the protection of the rights of the participants. Ethical considerations pertaining to issues such as maintaining the confidentiality of data, preserving the anonymity of informants, and using the research for intended purposes only (Creswell, 1994) were addressed in this study in the following manner. First of all, only I had access to the raw data. The anonymity of the raw data including tapes, transcripts and notes was maintained using pseudonyms. The pseudonyms were selected by most of the participants themselves and the code sheet that matched this name with the actual name was in my sole possession. All direct quotes used in this thesis will use pseudonyms.

All of the data relevant to this study will be kept in a secure, locked location in my study and will be archived according to University of Toronto regulations.

Each respondent was given a consent form which outlined any risks or benefits involved in the study. The consent form also informed her that she could withdraw from the study at any time and that any direct quotes, which could be recognizable to her, would be attributed to a pseudonym. The participant and myself read the consent form prior to starting the interview and this process gave me further opportunity to answer any questions and to obtain informed consent from each respondent.
Finally, it is acknowledged that the subject matter of the research, talking about frailty, may have the potential to have left some participants with decreased feelings of self-worth. The study endeavoured to focus on the strengths and abilities of each individual and their assistance with the research was duly acknowledged. Each woman will be given the opportunity to receive copies of all reports and papers that are written as a result of this study. In addition, the study was reviewed and approved by the Review Committee on the Use of Human Subjects at the University of Toronto to ensure adherence to ethical protocol.

The following section of this thesis will discuss the approach that was used to analyze the data collected from the interviews. In accordance with research objectives, the methodological orientation, my own assumptions regarding the social construction of frailty and the methods used in this study, a phenomenological approach to data analysis and interpretation was utilized in this study. The manner in which data analysis was implemented will be addressed in the subsequent section.

DATA ANALYSIS

The data gathered for this study was subjected to an interpretive analysis. The first step involved immersion in the data as a whole (Omery, 1983). I tried to attain this objective by listening to the transcribed interview tapes and reading and re-reading the transcribed interviews. Once I had completed these tasks, I then reflected on the data in its entirety. At this stage of analysis, I tried to identify persistent words, statements and phrases as stated by the participants during the course of the interviews that were somehow linked to the
experience of frailty. While I was sorting out these initial impressions of the collective interviews, I also made a concerted effort to set aside my own experiences and assumptions regarding frailty to better understand the experiences of the participants in the study. This process is called "bracketing" and it is a critical first step in taking into account my own positionality as a researcher in the context of this study. Explication of my own understandings of frailty, as discussed earlier in this chapter, facilitated the recognition that such positionality will in itself create meaning and can contribute to the shared yet different realities which are expressed during the interview process (Gubrium & Sankar, 1995).

Phenomenological analysis, which treats the participant’s answers to questions as narratives or stories, keeps intact the contextual nature of each response (Mischler, 1986). Stories are described as "a means of hearing, as it were, the different ways meaning can be attached to events, problems of living in particular" (Gubrium, 191, p. 154). They emerge as recurrent and prominent features of the dialogue in all types of interviews, but are especially prevalent in unstructured and partially structured interviews and reveal a tendency for people to construct their understandings of experiences in narrative terms (Mishler, 1986).

The analysis addresses the question, "what is this story about?" There are different models of analysis which seek to address this question. The model used for this study is based on thematic analysis which "involves the search for and identification of common threads that extend throughout an entire interview or set of interviews" (Morse & Field, 1995, p. 139). More often than not, these themes were concepts suggested by the data rather than concrete entities exactly described by the respondents.
Prior to establishing themes or patterns, significant statements that relate to the investigated phenomenon were extracted from each narrative. This process is defined as "horizontalization" and it involves eliminating redundant statements while also giving equal weight to all statements that are viewed as relevant to the subject under study (Moustakas, 1994).

The third step in thematic analysis involved clustering significant statements into themes or meaning units which relate to the study questions (Moustakas, 1994). The clusters of themes are then referred back to the original descriptions in order to determine their validity. Comparing and contrasting between the various groupings is also performed to enhance understanding of the themes that have surfaced (Creswell, 1998). Further reduction of the data leads to a textural description regarding what was experienced, a description of the meaning individuals have experienced (Moustakas, 1994). A structural description is then proposed which elicits how the phenomenon was experienced. This step involves seeking all possible meanings, seeking divergent perspectives, and varying the frames of reference about the phenomenon or using imaginative variation" (Creswell, 1998, p. 235). Further reduction results in the emergence of a typology which acts as a powerful and suggestive analytic tool which facilitates the formulation of conceptual/theoretical coherence, usually through "comparison with the referent constructs in the literature" (Huberman & Miles, 1993, p. 432).
Analysis can also be extended to questions of cultural values and personal identity. Agar & Hobbs (1982) focus their analysis on the problem of coherence such that the parts of a story can be linked together to create a unified, meaningful whole. There are three levels of coherence: *local*, where each successive utterance is connected to earlier ones through syntactic, temporal, or causal relations; *global*, where utterances advance the overall intent of the story; and *themal*, where utterances exemplify general cultural values and beliefs (Mishler, 1986). This study is primarily concerned with a themal level of coherence because it is my intention to describe the ethno-cultural beliefs and ideals regarding the experience of frailty among elderly women from different ethnic backgrounds. There are two critical assumptions which underlie this analysis. The first being that “whatever else the story is about it is also a form of self-presentation, that is, a particular personal-social identity is being claimed; second, everything said functions to express, confirm, and validate this claimed identity” (Mishler, 1986b, p. 243).

I believe that the implications of these assumptions for this study are grounded in the recognition that each participant presented a “side” of herself. This presentation may not be congruent with how others may describe the individual, but that is not what was relevant to me. What matters is each participant’s account of “what is going on,” their version of reality; and how they present themselves, vis-à-vis their identity, is what gives shape and meaning to these accounts. Thus, what is pertinent for analysis is what identity they have claimed for themselves and how they have claimed it.
Furthermore, it is recognized that the interview act itself gives shape and texture to what is reported, further emphasizing the contextual nature of the interaction (Gubrium, 1991).

The phenomenological approach to analysis described in the preceding pages seeks to address the problems of meaning and context, problems which are instrumental to understanding how individuals construct their social worlds and perceive their personal identities. It was my belief that such an analysis would complement the objectives of this study through attempting to avoid the decontextualizing tendencies inherent in other forms of analysis; approaches which Gubrium (1992) describes as "shortchanging meaning". The experience of frailty is conceptualized as meaningful, contextual, and perspectival and as such it demands a method of analysis which will enable us to hear the voice of frailty in its diverse meanings and contextual contours. It is also informed by the theoretical framework of symbolic interactionism which places emphasis on the participants' perspectives, interpretation, and meanings as they relate to her environment (Bryman, 1988).

This chapter has reviewed the methodology used to conduct this study which seeks to understand how ethnic background frames the experience of frailty for elderly women living alone in the community. The research objectives have been stated, the methodological orientation has been explicated, my personal assumptions concerning the social construction of frailty have been discussed and the methods used to implement this study have been described. The following chapter will focus on the presentation of the data collected during the interviews conducted with the elderly women and the analysis and interpretation of the results.
CHAPTER FIVE

RESULTS AND ANALYSIS

PART 1 - DESCRIPTIVE DATA

The purpose of this chapter is to present the results of the data collection phase of the interview process. The results will be presented in the form of various responses which I received to the questions that were asked during the course of each interview. Examining descriptive information concerning the responses indicates what the respondents said directly about the questions that they were asked. Specifically, the questions addressed how the respondents spent a usual day, what was important to them, how getting older had changed what they did and how they did it, who they liked to spend time with, where they went and what they felt was the most important thing they wanted the interviewer to know about them.

The five series of questions were designed to elicit responses concerning the experience and implications of increasing frailty as expressed through the activities, locales and interactions that constitute the daily life of the women in the sample. The questions were also intended to provide shape and contour for the expression of ethnicity pertaining to the experience of frailty without explicitly directing the respondents to focus on ethnicity as a factor influencing this experience. I hoped that the individual impact of ethnicity on the experience of frailty would emerge during the course of each interview and by inference, could be
described in the context of the questions asked during this process. No attempt will be made here to use ethnicity as an organizing construct to present the data. In this chapter I will categorically present the descriptive data obtained from the interviews and in Chapter Six I will address the construct ethnicity within the context of the analytic framework for this study.

**HOW RESPONDENTS SPEND A USUAL DAY**

The first question that was asked of the respondents in the study was the following:

*Please describe for me how you spend a usual day?*

The purpose of this question was to get a sense of how the women in the sample used their time. The question was also a good ice-breaker in that it was straightforward for the respondents to answer, was focused in the present and it provided an open door through which the impact of increasing frailty on the daily life experiences of the respondents could be further pursued.

In response to this question, the women in the sample progressively described the types of activities that they engaged in each day, starting with the morning and ending in the evening. For example, Francine (age 84 years) answers:

"I get up in the morning, I come here (to the Senior's Centre), spend the time here. I come home, I read, watch t.v. Go for a walk and go to bed. There is somebody who picks me up in the morning to bring me here and they take me
home, but we pay for it of course, you know. I sit on the verandah a little bit. I have a friend who lives on the same street, so if it is nice, we go for a walk. That’s all.”(pp. 1-2).

Another typical response is given by Jane (age 75 years) who describes her day as follows:

“I get up in the morning and have my breakfast and then I get washed. I spend a lot of time with the seniors in my apartment. I go downstairs and have a coffee with my friend and a cigarette ....I come down [to the centre] Tuesday, Wednesday and Thursday. [A driver] takes me here and takes me home .... [After the centre] I just go home and do my thing. And that is how I spend my day” (pp. 1,4,6).

Louise (age 76 years) also describes how she spends a usual day:

“Get up in the morning, wash. My left arm is weak after two strokes but I try to do my best. I dress. My son helps me. I can manage sometimes with making breakfast. When my son is not here I try and cook something light. I sometimes like an egg in hot water. I put the kettle on and make a little tea ... I come to the centre everyday and they come to get me (in the van) and I sit in the back. And they bring me back. My son makes me dinner. I used to read but my eyes bother me now” (p.1).

The preceding quotes provide some typical responses to the first question. In addition, respondents also described weekend activities. These usually involved church related activities and visiting family. For example, Kathleen (age 78 years) states that:

“I worship on the Sabbath day God’s commandments” (p. 4).

“And on Sunday night we have Sunday night gospel service” (p. 7).

Joan (age 75 years) also responds:

“I go to church every Sunday. And I go every Wednesday to communion and church ... and we have lunch, the four of us, every Wednesday.” (Pt. 2, p.6).
Ella (age 83 years) describes how she spends her time on the weekends:

"... And the weekends, I am at my children's. They pick me up on Thursday. I am there until Sunday. You see I lost my husband, I still live alone. At home" (p. 3).

In summary, the majority of the responses to this question indicate that the women in this study engage in a variety of activities each day. These activities tended to revolve around self-care (washing, eating, dressing, and so forth), leisure (watching television, visiting with friends and family), and religion oriented activities. The women readily discussed how they spent a usual day and, typically, they did not express much variation from one day to the next.

**IMPORTANT ACTIVITIES AND INTERESTS**

The second question that was posed to the interviewees concerned the value of various interests and activities in the women's lives and was phrased:

**What sorts of things are important for you to do?**

The intention of this question was to elicit responses which indicated what types of activities and interests were important and meaningful to the woman in the sample. These responses were quite varied in their content and thus a typical answer cannot be readily described. The following quotes give some indication of the range of answers that were provided for this question. For example, Francine, describes the most important thing for her to do as the following:
"To be able to get up. That is the most important thing. To get dressed and wash myself. I cannot take a bath myself now. I have somebody helping me. Somebody from the city that they send ... [I fear] I will not be able to do it [get up in the morning]" (p. 5-6).

Others like Martha (age 73 years) talk about the importance of performing an activity on her own:

"Walk, yeah, with the walker, at this point I can’t even imagine walking without the walker, I don’t want to precede myself" (p. 3).

Joan refers to the importance of being able to do things without assistance as well:

"I am quite happy getting along the way I am getting along. For a long time I had a cleaning lady brought in. I didn’t like her ... it would take me fifteen minutes to do all my floors, I do not have lots, and she would take about two hours. That is about the time it takes her for doing it. And I would not have her. And I am independent and I do it myself." (Pt.1, pp. 12-13).

For others, like Jane, the emphasis is on her enjoyment of social and leisure activities:

"Talking with friends now is important and I still like my knitting. I like listening to my radio. I watch t.v. once in awhile" (p. 13).

Minnie (age 88 years) talks about her love of gardening and being outdoors:

"My interests are being outside as much as I can. Tidying up the garden. Watching things grow. I like to do outside work more than inside work" (p. 2).

Ella discusses the importance she places on being knowledgeable about current events:

"I like to read a lot. I know what is going on. You know and I keep up" (p. 10).

Some of the interviewees emphasized the importance of being able to perform activities pertaining to their religious beliefs. A pertinent example would be the statements made by Kathleen who explains:
"The most important thing in my life now is to go to church, serve the Lord, talk about the Lord. That is the most important part of my life now. God help me" (p. 7).

These are some examples of the types of responses that were given for question two. These responses, which have been presented without any attempt at interpretation, indicate how the questions were answered using the respondent's own words. In summary, the women expressed interest and placed value on doing a variety of different activities. For some women, being able to get up and get going in the morning was critical while for others being informed about current events was identified as an important thing to be able to do. Although the scope of answers was varied for this question, each woman in the sample was able to identify important and meaningful activities without hesitation or prompting.

EXPERIENCING CHANGES IN THE ABILITY TO DO THINGS AS ONE AGES

The next question was directed at getting the interviewees to discuss if they had experienced any differences in their ability to do things as they had gotten older. If they had, then they were prompted to describe the experience and to comment on how important this was to them. I hoped that this question would evoke some description of the experience of frailty by the women in the sample. Specifically, the question was phrased:

Some people find that as they get older they cannot do the same things they used to do - has this happened to you? Can you tell me about it? Is it important to you?
All of the women identified activities that they were no longer able to do. For some of the respondents, this list was quite lengthy while for others it was short and succinct. A sample of some of the responses includes the following. For example, Joan explains that:

“It is the walking that is harder on me. And usually, sometimes if I sit I can go without the oxygen, but I manage and I just keep thinking .. sometimes I think when I, I don’t call myself old, when I get old ....” (Pt. 1, p. 10).

Beth (age 85 years) talks about not being able to do some of the activities she previously enjoyed, yet she also acknowledges that despite limitations, she is in better condition than other elderly people she has encountered.

“I used to do the crochet and sewing but I can’t. I used to do so many things. Did you notice? Did you see the eye? ... I cannot concentrate as I used to, but I still remember ... ‘Auntie, you still remember?’ You know if you say something today I will not remember, but suddenly tomorrow I remember .... [There are] many, many worse off than us because we can still move around. I cannot walk as far as I used to which I like” (pp. 2, 3-4).

References were also made by respondents to work related tasks that could no longer be performed. For example, Kay states:

“The only thing is I used to work. Last year I stopped working. It was through my arthritis. I have arthritis in my knees. I had to stop working. The doctor said I push myself too much. So, I have to take eight tablets in the morning, then I have to take five in the evening. I used to take care of the elderly. But nowadays I can’t, I am not as strong as before” (pp. 11-12).

Kathleen also reflects on not being able to engage in previous professional and occupational pursuits:

“Like I am accustomed to do nursing, delivering babies ... A maternity nurse, so I am a maternity nurse. Well you see now I am not doing those things because I am unable” (p. 10).
"I was a bride's dressmaker. Here, now I cannot hold the scissors to cut nothing. So that is sort of it ... of course, I am not young. My right hand is not much, thank God I am not crippled altogether" (pp. 4-5).

And Jane makes the following statement:

"Right now I wish I was still working ....I miss my, you know, you make so many friends. That is what you miss the most" (p. 9).

In contrast, some of the respondents were reluctant to view themselves as getting older as illustrated by Martha in the following example:

"Oh, I’m not old! No, this is what I chastise myself about often, 'Come on, Martha, why can’t you? You’re only 73.' Well, I'm not 73 in my head. Some people can accept their oncoming years. I don’t care, I’m not one of those people because of my interests.

I see seniors who say things like, ‘I don’t like that kind of music anymore.’ Well, how do you know unless you listen to it? You can’t all of a sudden stream yourself, you can’t let your life go. If you allow yourself to age, this is what happens to you, you get into a wedge” (p. 4).

These are the types of responses that were elicited for the third question. In summary, all of the women in the sample were able to identify and discuss a difference in their ability to perform an activity or activities as they had gotten older. Some women emphasized their difficulty with functional activities such as walking while others stressed their inability to engage in work related activities. For some of the women, changes in their abilities were viewed as a result of getting older while others challenged this assumption, claiming that personal perceptions of abilities were more relevant to carrying out various tasks than the actual process of getting older. Finally, some of the woman acknowledged difficulties performing certain activities while emphasizing their capacity to successfully perform other relevant activities in their daily lives.
WHO RESPONDENTS SPEND TIME WITH, WHERE DO THEY GO, AND WHAT DO THEY DO

The fourth interview probe pertained to preferences regarding lifestyle and social activities. I wanted to get a sense of whom they spent time with, what they did and where they did it. For instance, did they like to spend with family and/or friends? And to what extent were social activities shaped by ethnic preferences and perceptions of frailty. These were some of the issues I hoped to address through including the following series of questions in the interview guide:

Who do you like to spend time with? How do you get together? Where do you go?

What do you do?

Typically, the respondents enjoyed spending time with family, friends, other seniors and people from church. Kay, for example, describes the sustained support and frequent interaction she engages in with her children in the following quote:

"I have very loving children. To me that is very important. We talk, we laugh. We don’t have no squabbles because they are family. We get along very good, everybody gives what money. They learn to share and they grow up with love. My kids are very supportive. It is very important to be with family" (pp. 21-22).
Minnie comments on the enjoyment she derives from spending time with friends:

"Friends are wonderful and I have lots of them. Four of us girls went to a birthday party for ___ last week. I made the cake and it was the first cake I have made in a long time. We had a wonderful time" (p. 4).

Although many of the women reported visiting regularly with family they also expressed enjoying the privacy of their own homes when the visitors departed. For example, Francine states:

"No one [with the exception of relatives], comes over and visits in my home. My younger niece comes to visit once a week, she has three children. She wanted me to stay [at her home]. I cannot, I like to come home. When I lay down, I lay down. If I want to watch t.v..... with three kids you cannot do this. I want the room all to myself" (pp. 16-17).

"It is important for me to live in my own home. Nobody tells me to put the lights out or if it is too cold not to put the heat on, you know ... it is your own" (pp. 17-18).

This view is also reiterated by Joan:

"I like to go out. Now, I like living alone and I do not socialize a lot. Or have people in. I do not want them coming to my place. I like my time, my own time when I sit" (Pt. 2, p. 5).

"I like to come out. And I do have friends. But they stay at the place where I am when I go to church" (Pt. 2, p. 6).

Ella discusses how her son and daughter-in-law would like her to move in with them, but, in addition to enjoying her privacy she foresees a potential for conflict as she states:

"... sometimes things that they do bother me because I am from the old school. They have a lot of waste and I hate to see that .... I know they earn good money both of them. But they spend it as fast as they earn it" (p. 6).
Some of the interviewees talked about experiencing a decrease in contact with family and friends. Jane, for example, provides the following quote:

"I have got two girls. And I have got two grandsons. My daughter out in Scarborough, she is married. They could not have children so they adopted. Two little boys, oh, are they ever dolls .... When they get the chance, they come in. But ... they work. I used to [get out there] but it is a long way .... I do not spend a lot of time with my daughter [who lives in the same apartment building]. She has got her own life to live" (pp. 6, 22-23).

In summary, relatives, friends, other seniors and church acquaintances were mentioned as people with whom the women in the sample liked to spend time with. Many of the women also reported that they enjoyed spending time alone, usually in their own home. Social activities were described as taking place in various venues such as a relative’s home, a senior’s centre, or a church and typically the location determined what the respondents did (organized activities such as a craft class at the senior’s centre). In general, the respondents expressed an interest in talking and visiting with the people in their social network.

**RESPONDENTS' PERCEPTION OF THEIR MOST IMPORTANT ATTRIBUTES**

The final question that was asked in the interview was an open-ended question which provided an opportunity for respondents to address what they viewed as their most important attributes. It was my intention that this question would provide an opportunity for the women to discuss any issues pertaining to their self perception which may not have been addressed in the other preceding questions. For example, although I did not make any explicit reference to ethnic identity in the previous questions, I hoped that this question
would provide an opening for the respondent to engage in a discussion of this aspect of their identity if she so chooses. Specifically, the question was worded:

**What is the most important thing you would like me to know about you?**

There was not what I would describe as a typical reply to this question for each woman interviewed had a unique perspective of her own individuality. For example, Martha, when posed this question, replied:

"I have a zest for life. I really enjoy it. I really enjoy the interests that I pursue. I thoroughly enjoy learning. I've always been like that. I was always in trouble as a kid for asking 'whys'. That's lifelong. I think when you quit learning, you quit thinking" (p. 8).

Joan answered the question by stating:

"I used to, I remember when I was young and J was young, I used to thank God for giving me a good job and making so much money that it was like a man's wage. And I would go up the street sometimes from work and say to myself, 'job well done,' and be real pleased. That is the type of person I am .... I am a good citizen" (Pt. 2, pp. 19, 20).

On a more forlorn note, Sally provides the following quote:

"Sometimes I am so lonely, I want to sit down and cry. I do not know what is coming of me" (p. 30).

Ella provides a more positive perspective regarding her feelings about herself:

"I am a happy person. I am very content. I am not envious, that you know. I thank God that I have reached this age because my mother did not, my father did not. So, I think life is precious. And I like to enjoy it while I can. I do not feel sorry for myself. Some people tell you 'This hurts me, that hurts me.' I mean there is nobody that is 100%. I mean just tell them you are happy, you know, and this is the type of person I am" (pp. 17-18).
Ann (age 94 years) explains herself in the following manner:

“I’m okay, I manage fine, everything works out day to day” (p. 4).

She reflects on her own life experiences and summarizes her story by stating:

“It’s funny how you meet people and things work out. It’s funny how things work out” (p. 4).

In summary, the respondent’s replies to this question reflected their own personal perceptions of themselves, what personal traits they perceived as indicating what kind of person they were. For example, some women reported an upbeat and positive image of themselves while others emphasized a more negative image characterized by loneliness and lack of hope for the future. Finally, some answers were fairly concrete and descriptive while others alluded to deeper introspection on the part of the respondents regarding their sense of place and purpose in society.

The preceding discussion has provided an illustration of the responses given to the questions that were posed to the women in this study during the interview process. The quotes from the respondents were the building blocks which I subsequently used to develop an interpretive framework for understanding the experience of frailty and ethnicity from a more conceptual perspective. The themes that I have identified as emerging from the descriptive data reflect my own personal orientation as well as the theoretical and methodological orientation of this thesis.
The following section of this chapter will present the analytic themes that were developed from the descriptive data. Each theme described is founded on significant statements articulated during the process of interviewing the respondents. Illustrative quotes derived from the various interviews will be utilized to substantiate the inclusion of each theme. Finally, the conceptual relevance of each theme to an interpretive framework exploring the experience of frailty and its relation to ethnicity will be discussed.
PART II - THEORETICAL ANALYSIS OF DATA

The women who participated in this study came from varying ethnic backgrounds and thus articulated the experience of frailty in multiple ways. There were, however, conceptually similar statements which provided the basis for pulling out interconnecting themes which tell the story of frailty for these women. These themes include the following: adhering to a predictable daily routine, including the related sub-themes experiencing boredom and experiencing loneliness; altering expectations; reframing abilities; restructuring roles; and negotiating shifting relationships. Each theme will be described and illustrated with relevant quotations from the interviews conducted in this section of the thesis. The first of the themes to be addressed concerns the implications which the onset of frailty clearly had for the rhythm of daily life for the respondents in the sample.

ADHERING TO A PREDICTABLE DAILY ROUTINE

Rubinstein, Kilbride, and Nagy (1992) characterize certainty as a behavioural or ideological task to which the elderly will aspire. They define certainty as pertaining to "predictability, to maintaining life on a regular basis and with a regular rhythm, to routine, and to the reduction or rationalization of risk" (p. xi). While it is difficult to argue that individuals do not aspire to a degree of certainty in the sense that their personal safety is ensured through the adherence to certain routines, or to the extent that it ensures the performance of minimum standards for selfhood, there can also be resentment for this focus can unduly compromise spontaneity.
For example, a frail elderly women living alone may establish a pattern which she follows pretty much everyday. A composite that emerged from the data collected for this study resembles the following scenario. "Ruth" gets up at seven every morning and she makes some tea and toast for breakfast. She then telephones a friend or two to chat for awhile. Subsequently, she walks down to the neighborhood green grocer's to pick up some food for lunch and supper. She then drops in at the local library to look at the day's newspaper. Next, she returns home for lunch followed by television and then perhaps some knitting. Twice a week she attends a church group or a craft class. In the evenings, she prepares her supper and then perhaps phones a friend and watches some more television or reads a book before retiring to bed at 9:30. Adherence to this schedule may instill a sense of certainty: "Ruth" knows what to expect each day and those individuals with whom she is in contact are also made aware of her predictable routine. Safety and the reduction of risk is enhanced since any deviance in the prescribed routine would likely be noted by others who would be alerted to a potential accident.

One can understand why a frail and elderly woman who lives alone, such as our composite "Ruth", would be concerned with following a certain and prescribed routine each day. One respondent, Ann sums up this state of affairs by stating:

"When you live alone and you’ve got nobody near you, you get very regimented. I get up early, up by 7:00. Between that and 8:00, I put on my clothes, half of them anyway, and I go and make my breakfast. I have a slice of toast, half a banana, and a bit of cheese and a cup of tea. Every morning. And after that I go and make my bed and then I go and give myself a good wash and look around and see what else needs doing" (p. 3).
Martha also refers to the predictability of her day:

"as for my daily thing, it's just a regular routine. I get up and do as much as I can for myself" (p. 1).

Joan concurs as well by remarking:

"Mostly I am out, they call for me about 10:00 and on Tuesdays I go for bingo and lunch and on Thursdays for lunch and exercises and whatever they have [at the centre]. I am pretty well the same every day." (Pt. 1, pp. 1-2).

Related to this theme of a predictable daily routine were two emergent sub-themes, the first of which concerned the monotony of following the same routine day in and day out. This theme which is referred to as experiencing boredom will be explored further in the next section.

**EXPERIENCING BOREDOM**

There appears to be an underlying assumption in the literature that adhering to a predictable routine everyday is a desirable goal to which to aspire (Rubinstein et al., 1992). However, over the course of interviews conducted for this study, the sense that one's daily life was patterned and predictable elicited comments that reflected on the boredom of this routine.

This perception is elicited by Francine who states:

"I just live from day to day ... It is a boring life." (pp. 19-20).

One respondent, Jane, contrasted the predictability and routine characteristic of her life now with the period during which she worked.

"It gets boring after awhile [at home]. Especially when you worked six days a week .... I earned good money. What can you do" (p. 12).
Martha also comments on her own negative perception of the adjustment required to her daily life when she could no longer participate in the work environment:

"I had to retire because of the osteoarthritis, going up and down stairs, you know how, how much activity it requires to be a case worker. Well, you never know what situation you're in or anything like that so I unfortunately had to retire and, like I said to the rheumatologist when he said I had to retire, and I said 'and do what?'" (p. 2).

We are inclined to associate the work milieu with opportunities for economic productivity, socialization and creative and intellectual outlets. However, we cannot underestimate the variety and diversity it adds to daily life. It appears to take on even more significance when this period in one's life is associated with good health and vigour. For Jane and Martha, work provided a valued opportunity to get out of their respective apartments and participate meaningfully in skilled positions and, because they never knew exactly what to expect each day; this opportunity also provided a sense of unpredictability and, hence, adventure to each day.

In terms of ethnic variation, it is interesting to note that only one of the women in the African-Caribbean sample made references to boredom. This respondent was the frailest of the women that I interviewed. Sally is a seventy-six year old who has recently experienced a dramatic decline in her physical condition including the ability to walk on her own. She has recently had to rely on a wheelchair for seating and mobility and she finds her current wheelchair very uncomfortable. Sally has no family in Toronto and lives on her own in an
apartment. She worked at a local university prior to retirement. She describes her daily routine in the following manner:

“I wake up in the morning and I have somebody come in and give me a wash. And I come to the centre. On weekends if I do no get to go to church, I stay home and relax. I have a hard time to get things done. I have somebody to come in only to do housekeeping and laundry as they feel. When I go home from the centre, the girl comes and she takes me up-stairs (to my apartment). She comes and puts something on me. When she goes I stay all by myself .... I have a T.V. but I do not watch it. I have this darn eye trouble, it gets very boring” (pp. 5-6, 8).

This passage helps to illustrate the monotony which characterizes Sally’s days. The lack of variety appears to be precipitated by her deteriorating condition and her increasing reliance on home care workers who take care of her physical needs but do not necessarily attend to Sally’s psychosocial needs.

On the other hand, not everybody expressed concerns pertaining to the experience of boredom. For example, we can contrast Sally’s experience with Kay’s experience. Kay is the only woman in the sample who really emphasized how busy she was. Kay is a seventy-two year old African-Caribbean woman who, similar to Jane, enjoyed a stimulating career as a nurse’s aide. Although her activities have become restricted due to pain and weakness associated with arthritis, she describes her day as active and makes no references to boredom. Kay’s day is no longer as physically active nor does she spend more time out of the house than other participants; alternatively she spends time devoted to religious activities such as studying the Bible and she is also very involved in the lives of her children and grandchildren. Thus, although the rhythm of her daily life has been disrupted, she continues to experience her day as varied and interesting.
"I get up in the morning, I say my prayers and I have a shower. Then I go upstairs and make breakfast; no, I do my blood sugar. And then I see what level it is and then I go upstairs. We sit down and eat our breakfast. And during the day, sometimes on Wednesday I do laundry. Sometimes I go to the doctor, I go to the doctor with somebody - and I cook ... On Friday I come to the centre. On Saturday I go to church. I am a Seventh Day Adventist. And my daughter dresses me and somebody else brings us back and we have lunch again together. Sometimes we go back [to the Church] ... We pray every morning and then we read in the morning before sermon. I am busy" (pp. 1, 4-5).

The second sub-theme which was prevalent in discussions regarding the adherence to a predictable daily routine concerned subjective feelings of detachment and isolation encountered by the women in the context of their daily lives. This theme was somewhat entangled with the experience of boredom expressed by the respondents in the study, but will be treated as a separate sub-theme pertaining to the experience of loneliness and is discussed in further detail in the next section.

EXPERIENCING LONELINESS

Typically, we tend to associate loneliness with factors such as size of social network and physical proximity to friends and relatives (Rubinstein et al, 1992). However, it is interesting to note that in this study, references to boredom also elicited parallel comments relating to loneliness. That is not to imply that there is some causal relationship between the two, rather there appears to exist a thematic link. This link is mediated by the respondent’s perception of how they utilize time and space during the course of their daily lives, particularly in the evening.
Many of the respondents commented that the evenings were the most difficult time for them in terms of loneliness. The activities available to them were, for the most part, occurring during the day. Although the repetition, lack of spontaneity and variety of day to day living tended to be construed as boring, further restrictions were in place in the evening. Kathleen comments on this shift when she remarks:

"I like to come out in the days, like come in here (the centre), you know. Takes away the loneliness. Loneliness is the hard part. In the night. Now in the days I am not lonely. I go downstairs and we are with another. You know talk and talk and then in the night. And most of the time I go up in the bedroom and sit by the window" (pp. 17-18).

Sally also reiterates these impressions:

"It is very important [to come to the centre]. Yes, I enjoy it. When I come here I don't seem lonely and I get home and I am always sad" (p. 10).

"There are seniors [at apartment building], but when I go to my apartment I am by myself. There is nobody who comes in" (p. 11).

Ann also comments on her experience of loneliness in the evenings:

"When it begins to get dark, I feel lonely. They're [my family] not in the city, they're all out. Nobody in the city at all .... It used to be when I had neighbours with kids around [sic] ... but now there's no one to talk to" (p. 3).

Ann's comments hint at an underlying assumption that if neighbours, friends and family were available for interaction in the evenings, she would be less inclined to experience loneliness. However, since Ann is legally blind and unsteady on her feet, socializing and traveling about in the evenings, especially in the winter, could provide a challenge. She chooses not to explicitly acknowledge these potential physical limitations thus framing her experience of
loneliness in terms of her lack of opportunities for social interaction rather than in terms of her frailty.

Alternatively, Martha does frame her own feelings of loneliness in terms of frailty, specifically her inability to walk.

“At this time I’m not walking. The bottom line is... I’m bloody lonely, I don’t have to be lonely. If I could walk ... you talk to yourself all day” (p. 3).

In contrast to the respondents who have expressed their loneliness, Kay was the only participant who reported not feeling lonely at all. Kay was the same woman who characterized her patterned daily life as busy and varied and it is noteworthy that she has only recently experienced a decline in her abilities to perform various activities of daily living. At this time, the onset of frailty does not appear to inform a subjective sense of boredom nor feelings of isolation and loneliness. The following statement provides an example of her ongoing interactions with others:

“... we talk, we discuss the scripture. We call the kids and my kids come home and they sing. And then, my other children will also call me .... I talk to friends, talk to people from my church. I call them and they call me. So, I am never lonely” (pp. 9-10).

The preceding discussion has explored how the experience of frailty has been contoured by alterations in the daily rhythm for the participants in this study. These alterations were frequently experienced in terms of boredom and loneliness as captured by the quotes in the preceding paragraphs. The next theme to be presented will be concerned with alterations in expectations as expressed by the respondents which are also informed by ethnicity and the experience of frailty.
ALTERING EXPECTATIONS

An important focus of gerontological research has been the relationship of personality to successful adaptation (Kaufman, 1986). One favoured line of inquiry has focused on the role played by both change and continuity in adaptation. Continuity can be defined as ‘the maintenance of a stable or coherent sense of self despite decline, deleterious change, illness or threat to self’ (Rubinstein et al, 1992, p. xi). Several researchers (Neugarten, 1982; Maddox, 1963) have proposed that continuity is the key to psychological well-being in later life. Their work and related work by others analyzes continuity only with respect to social activity (Kaufman, 1986). The role of cultural values, norms and expectations in the maintenance of continuity has not been fully articulated. It is acknowledged, however, that the manner in which the individual responds to the impact of change will influence her interpretation of the aging process (Ryff, 1984).

The following quotes will illustrate how participants in the study drew from general cultural expectations and assumptions about ‘becoming’ and ‘being’ older and frailer. Many of the respondents equated frailty and the subsequent restriction on activity levels with increasing age. For example, Francine, an eighty four year old woman from a Polish background describes her experience of frailty in the following passage:

“I used to go skating. I used to go swimming. I cannot do it now. I accept it. I know that it comes with age. You are not as active as when you are younger when you get older … so you expect it. You have to know that sooner or later it will be worse you know. Whatever I can do, I do, that is all.” (pp. 9-10).
Kathleen, a seventy eight year old woman from an African-Caribbean background, also reflects on the implications of getting older:

“I watch television. Until I really want to go to sleep. Of course I do not drop to sleep early. I suppose that now of course I am old and I cannot do it anymore. What I would like to do now I cannot do it again” (pp. 18-19).

Minnie, an eighty-eight year old woman with an Anglo-Saxon background, shares her fears about losing her memory as she ages:

“I’m beginning to lose my memory. This is really worrying me. I’ve been reading a lot about it [Alzheimer’s Disease] ... that worries me. I’m getting very forgetful, because maybe my age is against me” (p. 6).

Ella, age eighty three and with a Polish ethnic affiliation, comments on her own frailty by sharing the following information.

“You know I have trouble with my hips and that, but I try, try to manage it. I keep thinking thank God for that. I am here [at the centre] most of the time .... So like I say, I manage right now. What tomorrow is I do not know. That is about it ... we manage you know” (pp. 11-16).

These passages reflect to a large degree the feelings that most of the participants expressed toward the altered expectations that accompany the experience of frailty. For many of the participants, there appear to be shared assumptions concerning the staging and timing of certain biological and social events, specifically related to aging. Many statements which refer to activities that participants can no longer perform are followed by the reflection that “I am no longer young.” No specific age is specified which foretells of impending frailty; however, there appears to be some consensus that as one gets older, one will have to alter personal expectations in accordance with expectations concerning what one is able to
accomplish. This view was apparent in interviews conducted with members of each of the three ethnic groups.

Francine used skating and swimming as examples of activities she can no longer perform. It is interesting that to note that these are not activities that one would normally associate with an eighty-four year old woman. Another respondent, Kathleen makes reference to no longer being able to deliver babies or to work as a maternity nurse, another example of activities that are not typically expected of a seventy-eight ear old woman. Respondents also talked of not being able to take long journeys. For example, Kathleen described how she used to travel around the United States:

“When it is time I go to my bed, lay down and get up in the night. Get ready, take a taxi and gone to the station and it would mean nothing to me. I cannot do that no more. To take off to the States meant nothing. Lay down, rest, get up and get ready. Five o’clock be at the bus station and gone to the States. I’ve gone to Salt Lake City, Fort Wayne, Indiana, Kentucky. Gone to Memphis, Tennessee. Everywhere in the States. But now I am not able ... I cannot cope with that much again” (pp. 13-14).

Once again, Kathleen has described some wonderful journeys that she has taken. However, we would not typically expect a woman who is well into her seventies to be travelling alone by bus all over the over the country. In fact, a frail woman who engaged in such activities would be conferred with a “supernormal identity” (Goffman, 1963). Thus shared assumptions and ideas concerning the shape of the individual life course act to construct expectations regarding normative behaviours of the elderly.
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Ann is another respondent who is no longer able to pursue a pleasurable activity due to her deteriorating eyesight. However, she also describes how she has altered her own personal expectations in order to cope with this limitation.

“You see with my eyesight now, I’ve lost it. But I used to knit, knit, knit for everybody, I was always knitting. Mittens and toques and socks, sweaters, ever since I was a girl .... You have to take the good with the bad, you know .... You get used to different things, you get used to doing things a different way and then it works so easy, you know” (pp. 1-2).

Baltes & Baltes (1990), who developed a model of successful aging which provides a useful framework for understanding the aging process from a psychological perspective, use the terms selective optimization with compensation to describe their model. The process of selection refers to “an increasing restriction of one’s life world to fewer domains of functioning because of an aging loss in the range of adaptive potential” (p. 21) and implies that “an individual’s expectations are adjusted to permit the subjective experience of satisfaction as well as control” (p. 22). The concept of selection as defined by Baltes & Baltes (1990) is congruent with the process of altering expectations which occurred when the women in this study were confronted with the onset of frailty.

**REFRAMING ABILITIES**

A third theme that informed the stories presented during interviews with the respondents concerned the tendency of the women interviewed to reframe, in other words to look at from a new perspective, the abilities that they still have and to contrast these with what they perceive as other more potentially debilitating effects of frailty. For example, a respondent
would make a comment about a change in their capacity to do something such as increased difficulty with walking or a problem with their vision so that they could no longer read. This statement would be followed up by a pronouncement such as “thank God I am not crippled altogether” or “there are plenty worse off.”

Implicit in the above statements is the recognition that some parameter of function has been compromised but this loss is viewed in relation to other potentially more pronounced impairments. The respondent acknowledges that she may not have the same abilities as before but she does not dwell on the loss. Rather she expresses the view that she could still be much worse off and she uses this perspective to help mediate the more negative characteristics associated with the experience of frailty.

Baltes & Baltes (1990), in their well-developed theory of aging, also refer to the tendency of older people to “orient their comparison standards toward other old people in similar situations. The result is an adjusted assessment that allows one’s own life situation and one’s self to appear in a new frame of reference” (p. 19). This description is comparable to the process of reframing abilities which was an emergent theme in this study.

For example, Louise makes the following statement about her vision:

“I used to read but my eyes bother me now. It hurts, like something in here, like grabbing .... I can’t do much but I still have my speech. I have got my speech” (pp. 5-6).
Shirley (age 79) also comments that even though she had a stroke ten years ago she feels lucky that she is not in a wheelchair and she can still walk and use her hands.

Kathleen provides the following quote when discussing activities that she is currently having difficulty performing:

"My right hand is not much. Thank God I am not crippled altogether. [I am] having trouble with my mind, my brain, trouble with my memory a little...In my life, [at this time] I have no strength, but tell God my mouth can preach" (pp. 5-6, 10).

In this quote, Kathleen has reframed her abilities in relation to service to God. The ability to continue to preach the gospel allows Kathleen to engage in a meaningful and fulfilling social role which, for her, carries more significance than being able to look after her self care needs or being able to remember as much as she would like.

Louise also explains how she has experienced a shift in the types of activities that she now pursues and the effort she exerts to maintain her involvement. Gardening is described as a favoured activity and during the course of the interview she expressed pride in her knowledge of and her ability to nurture the large number of plants that are placed throughout the main dining area of the seniors centre.

"I can’t do things now with everybody. I just try now. Sometimes I like doing planting. Talk about plants. I water them. I trim them. Give them sun .... It is not something I used to do a lot of [gardening]. I am sick now and ... I try to do some things. I try, I try" (pp. 8, 10).

In another interview, Beth contrasts her own experience involving a loss of concentration and visual difficulties with other elderly people who are no longer able to walk. She views her
own ability to walk as overriding these other concerns and even though her mobility has been compromised to some extent, she still asserts that her own situation could be more precarious if she was no longer able to ‘move around.’

“I used to do the crochet and sewing but I can’t. I used to do so many things. Did you notice, do you see the eye? I cannot concentrate as I used to, but we still remember. ‘Auntie, you still remember?’ You know if I say something I will not remember, but suddenly tomorrow I will remember. [There are] many, many worse off than us because we can still move around. I cannot walk as far as I used to, which I like. So we come back and go out again” (pp. 3-4).

These quotes illustrate how women in the sample compared and contrasted their own experience of frailty with hypothetically worse scenarios as well as with other people who were viewed as worse off. Like Kathleen, some of the women interviewed looked at what they were still able to do from a religious perspective. Other women reframed their abilities from a more functional perspective such as Beth and Shirley who place importance on still being able to walk or Louise who is grateful that she can still talk. Regardless of the ability that is discussed in the context of the interview, the inclination to acknowledge and accentuate some kind of nascent ability is a feature that is characteristic of many of the women interviewed in this study.

**RESTRUCTURING ROLES**

The fourth theme that linked together the stories of the participants in this study concerned the concomitant need to restructure roles with the onset of frailty. It is generally accepted within the field of social gerontology that with the coming of old age, the relationship
between the individual and society is influenced by a cumulative variety of circumstances and events which can profoundly alter social roles and activities (Chatters & Taylor, 1990). While the “middle years” may be associated with an increased engagement in societal roles, the “late years” have been portrayed as time for relinquishing these roles and obligations. In particular, the loss of the active parental role, retirement, and widowhood often occur in fairly rapid succession for the older female. Some researchers have postulated that diminishing opportunities to obtain satisfaction from such roles can precipitate a state of rolelessness in the elderly. This state may be accompanied by lowered morale and a decreased sense of personal self worth (Chatters & Taylor, 1990). Kaufman (1986) also notes that “much of adult-development theory conceives of the life course as a trajectory: a person “rises” and develops by gaining knowledge, skills, roles, power, and self-esteem, and then “declines” by losing some or all of these attributes (p. 5).

Alternatively, some writers have concluded that the negative impact that occurs with the loss of traditional roles such as a spouse and a worker can be mediated by identifying and investing in alternative roles. The access and opportunity for engagement in such roles through continued social activity and interaction in a variety of contexts thus promotes personal well-being and adjustment.

All of the women in the study described situations where they have had to relinquish former roles and adopt new ones due to the onset of frailty. For example, Kathleen discusses how a stroke has changed her participation in various roles related to self care and meal preparation.
“I have to [spend my day] in a different way because of the stroke. Somebody has to do things for me…. I kind of help myself every morning but then Thursdays I allow my homemaker to scrub my back for me” (pp. 1-2).

“I have a cook. She comes in and cooks the food on Sundays and puts it in the fridge so I can take it out a little then to warm in the microwave when I need to eat” (p. 3).

Sally also describes how other individuals such as home care workers have assumed responsibility for roles she previously performed:

“[Homemakers] help out with vacuuming. They take a sponge mop and wash the floors. Nice and spoiled. That spoils me because I like sitting down on my knees” (p. 7).

Francine comments on how her own declining health had implications for engagement in previous occupational and leisure roles:

“I used to make ladies’ hats … I used to like to paint. I just lost interest. You see I would shake, [then], I was in the hospital” (pp. 19-20).

In a bit of an ironic twist, Kay’s experience with the onset of frailty has compelled her to restructure a previous role, that is, her prior job which involved providing care to the frail elderly.

“I used to take care of the elderly … but nowadays I can’t. I am not as strong as before” (p. 34).
Minnie discusses how her sister and daughter have assumed responsibility for cooking and baking, roles which she used to strongly identify with but which no longer interest her.

"I hardly do any more baking ... my sister does all of it. Now I don't have the interest in it. My daughter does all my cooking. I wouldn't enjoy getting a big meal ready. If I overdo it, I have aching legs" (p. 3).

Finally, Joan discusses how her son has adopted an administrative role with regards to her personal business matters.

"My son he does my paper work, a lot of paper work. Because he is the one I go to for asking questions when I want to know something. And he is always willing to listen and to help me" (Pt. 1, p. 5).

In summary, these quotes have illustrated how various roles had been relinquished or altered by the women in this study as they experienced the onset of frailty. The women did not focus on the significance of the loss of these roles; rather, they discussed how various roles had been restructured to accommodate changes in their functional ability. There was a shift from active engagement in roles such as homemaker to overseeing the performance of these roles by other individuals such as home support workers and/or family members.

**NEGOTIATING SHIFTING RELATIONSHIPS**

A fifth theme that emerged from the descriptive data concerned the perception that interpersonal relationships, particularly with family, took on a different dynamic. That is, the respondents reported that there was a shift in the nature of the interactions, especially around receiving assistance, that took place notably within the context of family relationships. This observation was reflected in the responses to interview questions one through four. For
example, Kay, an African-Caribbean woman describes in the following passage how her
children and husband have assumed some of the household responsibilities for which she was
previously accountable.

"I make myself and my husband breakfast, then we sit down and eat our
breakfast. And during the day, sometimes on Wednesday, I do laundry.
Sometimes, I have to go to the doctor, I go to the doctor with somebody ....
And I cook. At lunch time I do the preparing .... My children buy all the
food and do the shopping .... My husband does the vacuuming and making
up the bed ... he loves doing that” (pp. 1-2, 3).

Jane, who comes from a Polish background, also comments on the help she receives from her
daughter to assist with homemaking activities.

“My daughter does most of the grocery shopping. I have got a daughter living
in the [same] apartment building. She does the laundry” (pp. 5-6).

Ann, an Anglo-Saxon woman who is legally blind, describes the integral role her daughter
has assumed in managing her personal care and homemaking activities in the following
quotes.

“My daughter helps with bathing. If I stand up, there could be a stupid slip in
that tub. My son bought me a couple of years ago, a mitt, one of those bath
mitts and I can wash up and when I stand up I can do my back. When she
comes she gets me in the bath and gives me a couple of good scrubs you know
and washes my back” (p. 3).

“I don’t do the cooking at all. I’m scared, it’s a gas stove and when she comes
on Wednesdays she always has her bag with her and she’s cartons of this,
cartons with stew in and potatoes, homemade soup, and all kinds of cooked
stuff’(p. 4).

“And she washes my clothes, makes sure they’re clean and they fit and if a
button is off she’ll sew it. She organizes my clothes into colours. She has the
two cupboards you know, one in each bedroom for separate things .... These
slacks, I can’t distinguish blue from black, navy blue and black. So she puts navy blue in one cupboard and black in another” (p. 2).

The above quotes describe some of the ways Ann’s daughter assists her with activities such as bathing, food preparation and laundry. At one time, Ann carried out these activities for her daughter and perhaps she even taught her daughter how to perform these various homemaking and personal care tasks. Her daughter has also developed an organizational system, in this case for sorting out colours of clothing, so that Ann can co-ordinate her outfits each day without having to rely on others.

While Ann expresses gratitude regarding the assistance she receives from her daughter, she also describes the difficulty inherent on depending on someone else to get these tasks done when you are accustomed to doing them on your own.

“I think it’s worse on you when you have your sight all your life and when you come to be old, you lose it. You get exasperated with these things. You know when you want to do things. I’ve always been able to do things, to sew a button on, to fix things. Now some things I get so annoyed at, leaving so much for [daughter] to do” (p. 2).

Francine, whose ethnic background is Polish, also expresses concern that she may be asking too much of her niece, who resides rent free with her aunt in return for helping her out with various tasks. She states:

“My fear is that I do not want to be a burden to my niece. She looks after all the financial, pays all the bills you know” (p. 10).

The respondent’s immediate family are not the only people who assist them with various activities. Grandchildren were also described as quite helpful to some of the women by
performing such activities as shopping and cooking. For example, Ann makes the following statements about her granddaughter:

"She goes to the M & M’s and gets Scotch meat pies and they go right in the freezer. My freezer is full. If they ever came in and opened my freezer door, they wouldn’t know what’s coming out! They’d think I had a store or something! And she bakes, she’s always baking things .... I’m well fed” (p. 4).

Shirley, an African-Caribbean woman, describes how she is “good friends” with her nine-year old grandson who always gives her a kiss in the morning before going off to school and who comes to see her upon returning home in the afternoon to tell her about his day.

Some respondents who did not have children of their own discussed the importance of extended family members. When referring to her nephews, Beth, whose ethnic affiliation is African-Caribbean states:

"We are close. I was like a mother. The boys they are good to me. They are all nice boys. This was family. They are family” (p. 13).

The following quotes illustrate how family members are perceived by many of the respondents to be integral to the performance of various household and personal care tasks. Family members were also discussed as being important to the social milieu of the respondents, primarily in association with question four. These results were applicable to members of each ethnic group. Many of the interviewees talked about their desire and the subsequent enjoyment associated with spending time with relatives; however, there was also recognition that their families had busy schedules. A low frequency of visits by a family
member, even if a relative lived in close proximity, was rationalized by a stated recognition of the time constraints on the family member.

Joan, for example, an Anglo-Saxon woman who brought up her one son on her own, makes the following statements:

"I do not see my son so often now. He is in the computing business. So I cannot see him as much and I can understand this because he gets so tired. And they have lots and lots of studying to do" (Pt. 2, pp. 6-7).

"He phones me. But I can understand that I will not be seeing him as much because of the studying. And the working, he works full time, too" (Pt 2, p. 9).

"We go to the bank together but the bank moved from where we are. We do not do a lot but we talk. And he takes me, every time he takes me out [to the bank]. He takes me out to dinner. And this is quite often. At least it was, now it is not going to be so often because he is going to be tired ... I would not really mind going to the show sometimes. But he always seems that he has got things to do. And he is busy. But he looks after me" (Pt 2, pp. 7-8).

Kay, an African-Caribbean woman, also makes reference to her experience of her children taking care of her; yet, she also makes the distinction that she continues to look after them. She may not attend to their physical or financial concerns as she did when they were younger; however, she recognizes that the emotional and spiritual guidance she offers to her children can be equally supportive and nurturing.

"My children they care and they are concerned about their parents. We help to look after them and they help to look after me [italics added]" (p. 16).

In summary, the above quotations illustrate how the women in this study perceive the experience of frailty as altering relationships with family members. In the majority of cases, this relationship was characterized by a reported increase in reliance on family members,
particularly children, to help with activities and to provide socialization for the women interviewed. Some of the respondents expressed gratitude for this assistance; however, they also indicated that it was at times frustrating to rely on others to perform tasks that they could accomplish independently prior to becoming frail. Ann, Jane, and Francine all make references to this experience in their interviews.

Alternatively, other respondents reported that they relied more on family members but they regard this relationship as more reciprocal in nature. In other words, they are explicitly aware of the balance between giving and receiving conferred in these relationships. For example, Kay and Joan describe their experiences of providing emotional and financial support while accepting other forms of social and caregiving support from their respective family members. It is also relevant to note that when describing their experiences of increased reliance on others, it was primarily family to whom the respondents referred. What is noteworthy is that reliance on home care personnel, friends and acquaintances is mentioned infrequently despite the observation that all of the respondents receive at least minimal home care services and for the majority, their days are spent in a program socializing and participating in activities with other seniors. This tendency to focus on family members when discussing shifting relationships was apparent for each ethnic group represented in this study. In addition, there was no discernible pattern concerning which ethnic group members consistently valued independence as opposed to a more interdependent relationship with family members. However, there was a tendency for African-Caribbean respondents to make comments which illustrated the importance of reciprocity within an extended family while the Anglo-Saxon
and Polish-Catholic women were more inclined to discuss reciprocity with respect to the immediate family.

**SUMMARY**

This chapter has addressed the results and the subsequent analysis of the data generated during the interviews conducted for this study. In the first section, analysis was informed by how the women in this study answered the questions that were presented to them during the interview. As such, the presentation of this data was descriptive in content and provided context for how the themes that emerged in the subsequent analysis were developed. From the descriptive data, some patterns started to emerge and these patterns shaped the analytical framework for the next level of analysis. This next level took on a more conceptual nature as the data gathered from the interviews was examined for themes that pertained to the underlying questions guiding this study: “What are the stories of elderly women regarding their experience of frailty?” and “How are these experiences of frailty mediated by ethnicity?”

The themes that emerged were embedded in the stories that were told to me as the respondents answered questions which elicited how the experience of frailty affected how they lived their lives. The influence of ethnicity on these experiences was not explicitly discussed as the women did not directly identify how ethnicity shaped their experience with the onset of frailty. Furthermore, the women did not describe exactly the same experiences; however, there were similarities in their stories that I have identified and conceptually linked
to provide an analytical framework for this study. These conceptually similar statements which have informed the analysis have been described as the following themes: adhering to a predictable daily routine, including the sub-themes, experiencing boredom and experiencing loneliness; altering expectations; reframing abilities; restructuring roles; and negotiating shifting relationships. The following chapter of this thesis will address how these themes have informed the constructs of frailty and ethnicity. Pertinent quotations from the interviews will be used to further our understanding of these theoretical constructs. Finally, the relevance of this study to the health care discourse will be discussed as implications for policy, practice, and further research are suggested and the limitations of the study are identified.
CHAPTER SIX

DISCUSSION

MAINTAINING IDENTITY

The purpose of this chapter is to integrate the conceptual themes that were presented in Chapter Five to further our understanding of the theoretical constructs of frailty and ethnicity. The major finding of this study was that frailty was not a pivotal aspect of self identity for the women interviewed in this study. Rather, the onset of frailty was experienced as an affront to established identity, and in order to maintain a sense of continuity with respect to this established identity, the women engaged in two major strategies. These two strategies involved affirming a sense of personal competence and incorporating new aspects of the self which, along with various sub-strategies, enabled the women to attain their objective. The balancing act implicit in maintaining a personally valued, continuous, and cohesive identity while affirming competence and incorporating new aspects of the self forms the crux on which the experience of frailty and its impact on identity can be understood.

The answer to the question “where is ethnicity?” is more subtlety interwoven in the responses made by the participants. In this study, it did not emerge that ethnicity was a pivotal aspect of the experience of frailty for the women interviewed. However, it is my contention that
while ethnicity was not explicitly referred to, it was embedded in the strategies used by the elderly women in this study to maintain a sense of identity when experiencing the onset of frailty. I will discuss relevant examples in the second section of this chapter. Finally, to further address the construct of ethnicity, the three theories of ethnicity and aging presented in Chapter Two will be revisited.

The respondents were able to maintain continuity with relation to their established identity by affirming their own sense of competence and by incorporating new aspects of the self. The women’s propensity to assert their sense of personal competence by focusing our discussion on favoured attributes, the things they could successfully perform which were not impeded by frailty, was informed by some of the conceptual themes described in Chapter Five. Specifically, it was informed by the elderly women’s expressed tendency to seek out predictability and routine in their daily lives. It was also informed by their tendency to reframe rather than disaffirm abilities when they encountered health problems which limited what they were previously able to do. The methods whereby the women in this study affirmed their own personal sense of competence will subsequently be described.

**AFFIRMING A PERSONAL SENSE OF COMPETENCE**

The women interviewed expressed acceptance with respect to how they were managing their daily activities and collectively conveyed the sense that they were “doing their best” under the circumstances. In other words, the women’s stories reflected that they were affirming their own sense of personal competence. Verbalizations that reflected this perception were
common in the majority of the interviews. Most of the women interviewed acknowledged that there were activities that they could no longer perform because they were becoming more frail. For example, Ann referred to not being able to knit and Kathleen had curtailed travelling on long journeys. Many of the respondents, such as Francine, equated frailty and the subsequent restrictions on activity levels with increasing age. Other respondents identified activities that they could no longer perform; however, they also compared themselves to others whom they viewed as less fortunate than themselves with respect to their abilities. For example, Beth is thankful that she can still “move around” and Kathleen appreciates that she is not “crippled altogether.”

For the majority of the women interviewed, there was explicit acknowledgment that they were no longer able to do many of the things that they used to enjoy doing. While some viewed this turn of events as an expected consequence of aging or presented it as a comparative experience with relation to more frail individuals as indicated above, a significant number of respondents made mention of how they continued to try to do things and thus manage within the context of their daily lives. For example, Joan states that she is “pretty well the same every day.” This comment, regarding how she feels about herself, is fairly typical of the women in the study. Although most women acknowledged that they were no longer able to perform many of the activities that they were formerly able to do, they retained the view that they really hadn’t changed all that much. Affirming competence can be compared with the concept of optimization proposed by Baltes & Baltes (1990) in their model of successful aging which refers to the finding that “people engage in behaviors to
enrich and augment their general reserves and to maximize their chosen life courses (and associated forms of behavior) with regard to quantity and quality” (p. 22).

Keeping to a predictable schedule helped to reinforce this perception as the respondents described patterns which characterized their daily routines. These routines revolved around many of the same types of activities which were performed prior to the onset of frailty; however, they now took more time and effort or the women required assistance with the activity. For example, Kay is a Seventh Day Adventist who would always attend church on Saturday. She continues to attend the service on Saturday with the help of her daughter who dresses her and another relative who drives her there and back. Maintaining this valued activity reinforces her view of herself as a devout Seventh Day Adventist, an integral part of her identity.

Other respondents also described the importance of religion in their lives. Their active participation in the church not only influenced how they spent their time, it also focused attention on their competencies and reinforced the valued attributes of their self image. For example, Kathleen made the following statements. In the first quote, it becomes evident how her time is structured by her participation in various religious activities.

“I am a commandment keeper, I go to church. Always Sabbath. And Sunday night. We have Sunday night gospel service. And Wednesday night we have prayer service. That is my life” (pp. 7-8).
The next quotes illustrate how her religious beliefs enabled her to focus on what she could do and although she is limited in what she can physically achieve, she can still offer salvation and this forms a critical aspect of her identity.

"Church is my life from the root. It is great in my life. I wake up, God is strength. That’s what keeps me going. Really strengthened. I am strengthened by the Lord" (pp. 8-9).

"I love to do dressmaking. And I love church. And I love to go on outings. I love to be kind to people. I love to go and pray with the sick and all the rest of it. So, the most important thing in my life is salvation .... I have something I need to offer people and that’s salvation" (pp. 15-20).

Jane also places importance on participating regularly in religious activities as she states:

"We have the rosary every night. It is nice, to pray for everybody. And I look forward to it. We have had it going now over three years. And I think I have missed it once” (pp. 20-21).

Some of the respondents also described living in their own homes as critical to maintaining their sense of identity. These comments tended to more prevalent among the Anglo-Saxon participants; however, a few of the Polish-Catholic women made similar references concerning their living arrangements. Alternatively, the African-Caribbean women in the study did not place emphasis on the importance of living alone in their own homes during the course of the interviews.

Living in their own homes enabled the respondents to have control over how they structured their daily routines; therefore, they could continue to participate in valued activities without interference from others. While discussing the possibility of spending time at a niece’s home with her three children, Francine expressed her preference to stay in her own home where she
is free to do what she likes. She recognized that being on her own means she will not receive assistance with activities such as dressing and food preparation; however, her own need for privacy and control over her environment outweighs the benefits of living with her niece’s family. These are integral aspects of her identity that existed prior to the onset of frailty and they continue to influence the choices that she makes.

“I like to come home. When I lay down, I lay down. If I want to watch t.v., with three kids you cannot do this. I want the room all to myself” (pp. 16-17).

Joan makes the following comments which are fairly typical of the respondents with respect to explaining why it is important for them to stay in their own homes. She describes her own need for stability and, having recognized this quality in herself, she uses it to justify her desire to stay in her current apartment even though the upkeep is becoming more difficult for her and the area in which it is located no longer feels safe and secure.

“It has changed a lot. Well, I am used to it. And as I have said, it is over twelve years since I have lived here. I do not want to [move], I was never one for change, or moving. Not even when I was young. And I would not want to pull all my roots out” (Pt. 1, p. 14).

Joan, like many of the respondents, also places emphasis on the importance of scheduling her own time as she states:

“I like living alone and I do not socialize a lot. Or have people [in]. I do not want them coming to my place. I like my time, my own time when I sit” (Pt. 2, p. 5).

Control over her schedule is viewed by Joan as one of the advantages of living alone and it also reinforces the perception that she can continue to take care of herself, a quality which
affirms her own sense of competence. The value she places on her personal competence is also evident in the following statement:

"I managed myself and I did not have a great education. But I just simply know how to budget .... But I did make very good money .... I seem to have managed well" (Pt. 2, pp. 14, 19).

In the following quote, Martha reframes her own abilities and personal sense of competence by emphasizing the value she places on learning.

"I have a zest for life. I really enjoy it. I really enjoy the interests that I pursue. I thoroughly enjoy learning.... I've always been like that. I was always in trouble as a kid for asking "why," that's lifelong. I think when you quit learning you quit thinking" (p. 8).

Martha's mobility is limited as she must use a scooter to get around the senior's facility where she lives and to get out shopping. In the preceding section of this paper, which discussed reframing abilities, Martha's immersion in social and political activities at her complex were discussed. Her participation and eagerness to learn from these experiences are natural extensions of her lifelong curiosity. Personal competence is also reinforced as she derives satisfaction and self fulfillment from helping others.

Ella also talks about her appreciation of life and how she has dealt with the onset of frailty by continuing to project that aspect of her personality that is upbeat and positive in the face of adversity.

"I am a happy person. I am very content. I am not envious, that you know ... I thank God that I have reached this age because my mother did not, my father did not. And I am the only one left from grandparents .... So, I think life is precious. And I like to enjoy it while I can. I do not feel sorry for myself. Some people tell you this hurts me, that hurts me. I mean there is nobody that
is 100%. I mean just tell them you are happy, you know, and that is the type of person I am” (pp. 17-18).

These findings complement previous symbolic interactionist research concerning the active redefinition and renegotiation of meanings of independence as people experience increasing levels of disability (Charmaz, 1995; Cott & Gignac, 1999). For example, the identity of people who are older and experiencing osteoarthritis and/or osteoporosis as being independent was described as relating both to their level of disability and to their ability to accept that disability. Thus the meaning of independence was extended beyond instrumental definitions (Cott & Gignac, 1999). Differences in subjective definitions of independence reflect how individuals incorporate various levels of disability and diverse roles into their interpretation of the situation. Variations in the definitions and meaning of independence and dependence reflect the discrepancy between struggling with and struggling against a chronic physical condition (Charmaz, 1995). In this study, struggling with frailty can be framed in terms of affirming a personal sense of competence and incorporating new aspects of the self to maintain a sense of continuity with respect to established identity.

The subsequent section of this chapter will address the sub-strategies that were implemented by the women in the study to incorporate new aspects of the self into their own formulated sense of identity, a second higher order conceptual theme. These new attributes are related to the onset of frailty and they may involve the utilization of equipment designed to compensate for functional losses.
INCORPORATING NEW ASPECTS OF THE SELF

Incorporating new aspects of the self involves the integration of the following sub-strategies which were presented in the thematic analysis section of Chapter Five. It is informed by the theme of restructuring roles which emerged from stories which described how respondents had acquired new roles while also modifying previous roles. This strategy is also informed by dialogue pertaining to the shifting nature of relationships which elucidated the respondents’ awareness and adaptation to changes in social interactions, especially with family members. Finally, this strategy is informed by stories about altering expectations. The respondents acknowledged the implications frailty would have for their expected life pathway and they have explicitly modified their own perceptions about what course they will chart for themselves in the future.

Incorporating new aspects of the self can be compared with the concept of compensation proposed by Baltes and Baltes (1990). They use the example of a hearing aid to illustrate how restrictions in adaptive potential can be compensated for by the use of a technological device; however, they do not elucidate how such compensatory efforts would affect an elderly person’s sense of self.

Joan provides a descriptive account of her struggle coming to terms with the onset of frailty in her life and how she has adjusted to dependence on her oxygen tank.

"I have bad lungs and I have not got enough oxygen in my blood. But you naturally get older, you cannot do as much, or it takes longer … That is my bad part, the walking. But I am alright if I have this oxygen tank with nasal
prongs] .... When I first had this it bothered me and I was embarrassed about it which I never should have been. Now it is like an arm to me. It is like my own. I felt embarrassed at first. Why? I do not know because it is nothing to do with me now” (Pt. 1, pp. 15-16, Pt. 2, p. 1).

“I did not want people to see in the apartment, see me you know. I never let on if I am sick or not. I do not want people to know ... maybe I figure people do not like complaining. I just do not and maybe that is why I felt like that about this” (Pt. 2, p. 1).

Joan acknowledges that she is having difficulty with some activities because of her ‘bad lungs’ and her account describes her initial difficulty accepting the oxygen tank, primarily because she was concerned what other people would think about her. She was not comfortable adopting a ‘sick role’ and she would avoid having people in her apartment or engaging in physical activities in order to hide this aspect of herself from others. However, in the following quote, she relates how using the oxygen has enabled her to do many of the things which she values and the benefits it provides now outweigh the negative qualities she previously associated with the oxygen tank.

“You know you are able to do things that you would not, you know, be otherwise able to do .... So if I am doing something like washing, I will have a good mop and pail. And I can put it on if the breathing gets a little bit hard ... I can put it on and go anywhere in the apartment and do my business” (Pt. 2, pp. 2-3).

Martha discusses how her own feelings of embarrassment at having to ask for assistance have restricted her participation in volunteer work, a role with which she strongly values. Martha uses her scooter to get around her apartment building and the neighborhood but she acknowledges that she would be able to get more places if she “put my pride in my pocket, got out my roll-a-tor (walker with wheels) and asked for assistance” (p. 5). For Martha, using
her scooter independently was more important than the versatility and flexibility inherent in using the roll-a-tor, albeit with assistance. She states:

“I’m embarrassed. I’m embarrassed that there’s a lot of places I can’t go with the scooter, I’m embarrassed that it’s okay to use a scooter but to not be able to get up off the scooter and sit in a chair is very embarrassing for me. And it’s very embarrassing for me that I can’t walk down the hall. So as opposed to being totally independent, which I am on the scooter, I just ride in the door and back into a spot” (pp 5-6).

Sally is also experiencing some difficulty incorporating a new aspect of self, that is, dependence on a wheelchair for mobility. Similar to Martha, she has osteoarthritis which has limited her ability to get around on her own. Both Sally and Martha have restructured participation in valued roles, negotiated altered relationships with friends, family, and caregivers, and modified their expectations regarding their goals and aspirations; however, incorporating new aspects of self into their respective identity has involved using different strategies. For example, Sally discusses how her wheelchair:

“is very uncomfortable. But I want to get another chair that is comfortable, but I cannot. [This] chair is like being in chains .... that electric chair would help me very much. It is the money, the money. I need that [electric] chair to sleep comfortably” (pp. 8-9).

Sally appears to accept that she will be reliant on her wheelchair to get around and to rest in while she is at the senior’s centre. She also recognizes that she will require more assistance from others to perform her ADL and to participate in activities that she enjoys. Her overriding concern is informed by the situational context, her immediate experience of discomfort, and the resolution of this problem takes precedence over other concerns at this time. Martha, on the other hand, is concerned more with the social, rather than physical, implications of frailty. She emphasizes the importance of remaining independent in the face
of frailty and has compromised her lifestyle to avoid her embarrassment at having to ask for assistance from others.

Alternatively, Jane presents a different perspective on incorporating a new aspect of the self when she describes how using a walker provides her with the confidence she needs to go out of her apartment and participate in meaningful activities.

"When I am out I use my walker. Yes, it gives me more, I do not know, more support and I am scared to fall again. .... I fell in the lobby of the apartment, right by the elevator. I tripped on the rug I think ... fractured my hip. I got two hip operations. And that was not funny. I have got a scar from here right up" (pp. 16, 18).

In summary, the women in this study implemented strategies to present an image of themselves, this image was not exclusively defined by the experience of frailty, yet, frailty had implications for self presentation. The women did not personally describe themselves as frail nor did they express undergoing a radical shift in identity. Rather, they aspired to maintaining their identity while incorporating new aspects of the self and affirming competence when confronting the onset of frailty. Essentially, they perceived themselves in much the same way as they had prior to experiencing limitations in their ability to perform various activities of daily living. However, this decrease in functional ability potentially has implications for how others view the elderly women. Specifically, it has implications for how caregivers view these women.

The majority of women in this study lived alone but, due to the onset of frailty, they required assistance with various ADL and this support was usually provided by home care workers.
The provision of this service enabled the women to live in their own homes, an arrangement which was highly valued among the respondents. The procurement of home care services is a double-edged sword, however. The elderly women can continue to live “independently” in their own homes, yet they have been exposed as persons who are different from others in the category of persons available for them to be (Goffman, 1963). In this respect, the stigma of frailty has been conferred on the women who now require assistance performing activities of daily living. They have encountered a dilemma whereby they are no longer perceived as living up to what they really ought to be. This discrepancy invokes a stigma and, in congruence with “oldness,” frailty also confers a weak and ambiguous stigma.

The same criteria can be applied to the term “frail” as Matthews (1986) applied in her description of the factors contributing to the discrepancy surrounding the age category “old.” For example, a rite of passage does not exist, there is lack of consensus regarding a definition of frailty, and the norms and expectations which constitute a frail individual have not been explicated. However, despite this ambivalence, the construct of frailty has entered the lexicon of health care. Indeed, there is a whole service sector currently being developed which is based on serving the needs of the frail elderly. Funding for home care support is a hotly debated political issue and the City of Toronto recently restructured their home care program to better meet the needs of this population. The New York Times recently ran an article which described the recent proliferation of ‘assisted living’ centres in the United States. Residents, who live in private apartments, receive three meals a day, housekeeping services and assistance with bathing and dressing. The centres are described as filling the gap between “independence and helplessness” (Rimer, 1999). In other words, they aspire to
meet the needs of the frail elderly. Thus, we see further evidence of the emergence of a
social category, the “frail elderly,” a category that is increasingly given more credence as the
economic and political viability for doing so becomes more consequential. As the number of
people entering old age increases, along with the amount of money available to spend on
products and services, there will be ample incentive for organizations, institutions, and
companies to position themselves favourably with regard to addressing the concerns of the
“frail elderly.”

FRAILTY AND ETHNICITY

The results of this thesis have illustrated how identity can be maintained in the face of frailty.
I started this study using ethnicity as a lens to better understand the socially constructed
nature of frailty by expecting to elicit variations in the experience of frailty as informed by
distinct ethno-cultural beliefs and ideals. As I suggested at the beginning of this chapter,
ethnicity was not explicitly addressed by the women in this study. However, this does not
mean that ethno-cultural beliefs and ideals are not operating as they struggle to maintain a
sense of identity. My explanation for what might be regarded as a negative finding is
premised on the belief that ethnicity is integral to the core self as conceptualized by Kuhn (in
Stryker, 1981). An individual’s expression of their core self imparts consistency and
predictability across successive social interactions and ethnicity, as a crucial feature of the
core self, has been constructed and internalized by the women in this study for at least
seventy-five years. In this study, various strategies were utilized to maintain an established
identity with the onset of frailty and I believe these strategies were implicitly informed by ethnicity.

The selection and implementation of strategies to maintain identity occurred within the context of social arrangements based on structural relationships, including ethnicity. Such relationships conferred normative ideas and beliefs about the form and meaning of the life course (Kaufman, 1986). Consequently, these ideas and beliefs then patterned the behavioural repertoire for the elderly women. For example, Kay, Kathleen, Shirley, Beth, and Sally are all African-Caribbean women who regularly participated in religious activities and derived strength and self worth from their respective involvement. Engagement in religious activities to affirm one’s sense of competence is not strictly the domain of African-Caribbeans; however, in this study, we see a tendency among women from this ethnic background to focus much of their time and energy on activities organized around formal religion.

Taking another example, Joan, Martha and Ann, who are Anglo-Saxon, expressed the desire to be independent and they reported frustration and embarrassment at having to rely on others for assistance. A personal sense of competence was reinforced by completing tasks independently. This emphasis on self-reliance and independence is purported to be a dominant value among members of the white Anglo ethnic group (Holzberg, 1981). Thus culturally mediated beliefs and expectations about the relationship between aging and independence may have informed these respondents attitudes and behaviour towards
accepting assistance from others. However, given the nature of the data, it is not possible to make broad generalizations concerning this relationship.

Among the Polish women in the sample, there was a trend to live in close proximity to their family members. For example, Ella’s son lived a short drive away and she would spend each weekend with his family in their home. Abigail also reported spending time at her daughter’s home, especially since she had been widowed. Jane had a daughter who lived in the same apartment building and Francine shared her home with her niece. Furthermore, Ella and Abigail stated that their respective children would have liked them to move into their homes with them. However, their preference was to remain in their own homes as long as they were able. This finding supports the data collected by Gerber (1983) who reported that older Polish persons are fairly likely to live in their children’s homes and, conversely, very unlikely to reside in institutional settings.

The subsequent section of this chapter will review the three theories of ethnicity and aging introduced in Chapter Two and will discuss the support for these theories based on the data collected from this study. The first theory to be addressed is the multiple jeopardy theory, followed by a discussion of the levelling theory, and finally, the relevance of the buffer theory to frailty and ethnicity in elderly women will be revisited.
THEORIES OF ETHNICITY AND AGING REVISITED

This study did not elicit support for the multiple jeopardy theory of ethnicity and aging which contends that aging has more negative consequences for minority women than for members of other ethnic groups or for men. Black African-Caribbean women, as the only visible minority included in the sample, did not appear to experience more negative consequences due to aging than other participants in the study. However, I did not focus the interview on the implications ethnic membership may have had for the experience of frailty which could have provided more analytic data to address this theory. Related to where I was conducting my interviews, all of the respondents were from a more or less similar socio-economic background, which limited my ability to comment on the validity of this theory.

The levelling theory purports that differences between ethnic groups are diminished as individuals age due to the compatibility between the experiences they encounter such as widowhood and declining health. The experience of frailty, as conceptualized by the women in this study, does appear to lend support to this theory. While there were ethnic differences with respect to how the respondents were managing their lives when confronting the onset of frailty, there were more similarities. The strategies that comprised the analytic framework of Chapter Five were utilized to some extent by all the women interviewed. This study supports the argument that the subjective experience of frailty has similar implications for elderly women regardless of ethnic affiliation in that the women aspired to achieve the same outcome. Namely, the maintenance of identity through affirming personal competence and incorporating new aspects of the self.
Finally, the buffer theory contends that ethnic group affiliation can exert a positive influence on the aging process through providing the individual with successful adaptive strategies to alleviate the negative consequences of aging. Since the women in this study did not explicitly refer to ethnic group membership when providing answers to the interview questions, I could not discern whether or not there was support for this theory. In order to understand the relationship between aging, ethnicity, and frailty in a more systematic fashion, the interview questions would need to explicitly refer to ethnicity. I had hoped that the women themselves would refer to ethnicity when discussing their daily lives with me but this did not occur during the course of the interviews.

To summarize, this chapter has focused on the integration of the conceptual themes introduced in Chapter Five to inform a higher order analytical framework. Based on this framework, the socially constructed nature of frailty can be elicited through the emergence of strategies which concern the social meaning of frailty. The elderly women in this study experienced the onset of frailty as an affront to their identity and they implemented strategies to maintain continuity of an established identity through affirming a personal sense of competence and incorporating new aspects of the self. The sub-strategies utilized include the following: adhering to a predictable daily routine; altering expectations; reframing abilities; restructuring roles; and negotiating shifting relationships. Ethnicity, as a critical feature of the core self, implicitly informed the selection and implementation of specific strategies to maintain an established identity. Finally, three theories of aging and ethnicity were reviewed with support emerging for the levelling theory which contends that the differences between
ethnic groups are minimized as members undergo common experiences associated with advancing age.
In conclusion, this study endeavoured to address the questions “what are the stories of elderly women regarding their experience of frailty?” and “how are these experiences of frailty mediated by ethnicity?” Data gathered from interviews with elderly women, from three different ethnic backgrounds, who lived alone in the community was analyzed utilizing phenomenological analysis and the emergent themes provided a framework to understand how the onset of frailty was experienced by these women. The themes have been described as: adhering to a predictable daily routine, including the sub-themes experiencing boredom and experiencing loneliness; reframing abilities; altering expectations; restructuring roles; and negotiating shifting relationships. Chapter Six of this thesis discussed how these themes acted as sub-strategies which then informed higher order conceptual themes. A personal sense of competence was affirmed through adhering to a predictable daily routine and reframing abilities and new aspects of the self were incorporated through altering expectations, restructuring roles, and negotiating shifting relationships. Affirming personal competence and incorporating new aspects of the self enabled the elderly women in this study to maintain a valued identity. Frailty was experienced as an affront to identity; however, it was not a pivotal aspect of identity and the strategies in which the women engaged were directed at minimizing the negative impact of frailty on their personally valued
and socially constructed identities. On a more systemic level, the relevance of frailty to the health care discourse will subsequently be addressed.

This thesis examined the emergence of frailty as a social construct, a construct which may have more relevance for health care workers than for the elderly themselves. As such it has implications for how the women in this study viewed themselves and, in turn, were viewed by others in their environment. The onset of frailty brought them into contact with the home care system, a relationship which enabled them to live in their own homes and carry on with their lives; however, the relationship had implications for how they were perceived by others. The stigma of frailty had been conferred on them and even though this did not significantly alter their own sense of identity, they engaged in the implementation of strategies to ensure a sense of continuity with respect to this identity. Past and present views of the self were integrated with new aspects of the self in a strategic process which also acted to affirm the women’s sense of competence when confronting the onset of frailty. Embedded in identity is the core self, of which ethnicity is a contributing factor. Ethnicity informed the choices and actions available and as such shaped the behavioral repertoire available to the African-Caribbean, Polish-Catholic and Anglo-Saxon women interviewed for this study.

**IMPLICATIONS FOR CLINICAL PRACTICE**

There are several implications for clinical practice and health care policy which can be derived from this analysis. First, clinical assessment and intervention should take into account the impact of frailty on the individual’s sense of identity. When the onset of frailty
appears to threaten continuity of identity, the clinician can be instrumental in helping the client to identify and facilitate the implementation of strategies to help achieve that balance inherent in maintaining identity through incorporating new aspects of the self and affirming competence. The clinician could use the strategies discussed in this thesis as a guideline to determine how the client is managing within the context of her own personal life by focusing on what is salient to her in terms of maintaining her identity. For example, a client who has recently experienced stiffness and pain in her hip and shoulder joints may become overwhelmed by her inability to perform her usual daily activities. Perhaps this woman was very active in caring for her grandchildren and her days were structured around this activity. Each weekday she would take the bus to her grandchildren’s home early in the morning, walk them to school, prepare and feed them lunch, return them to school in the afternoon, and help with the laundry and housekeeping while they were at school. On their return she would assist with homework, then prepare, and feed the children supper. At the end of the day she would return to her apartment where her own household chores were completed before she retired to bed.

Caring for her grandchildren while her son and daughter-in-law worked in the family store is a very powerful determinant of this woman’s sense of identity. She reports that not only does it provide her with a sense of self worth, but it is also an expectation within the context of her ethnic background that she assume this role on becoming a grandparent. Clearly, the inability to carry out these activities will have a negative impact on her identity. I believe that the strategies outlined in this study could be used to help her maintain a valued sense of identity.
Intervention could initially focus on altering expectations: this woman may no longer be able to take full responsibility for her grandchildren's care, but she could still help out to the extent of her abilities. For example, she may not be able to personally walk the children back and forth to school every day; however, she could arrange to walk them part of the way. She could also assist in the lunchroom at school where she would not be expected to cook a full meal, yet, she could still participate in the mealtime routine. In this respect, she would also be restructuring roles as she would no longer be the primary cook and housekeeper for her children's family. Yet, she could continue to assume a nurturing role by overseeing the implementation of these activities.

There would also be a subsequent shift in the nature of the relationship with her family. She may no longer be able to fulfill the requirements of being a full-time caregiver to her grandchildren, yet by negotiating an arrangement where the children can take on more responsibility and/or outside assistance could be procured, the transition could be rendered more acceptable and affirmative of the woman's competencies. This case scenario illustrates how some of the strategies could be implemented within the context of a potential clinical situation to promote health and well-being in a client-centred manner.

Secondly, this research has focused attention on the role of therapeutic assessment and intervention by alerting us to the potential domain of the health care provider/practitioner. The practitioner should not just focus on alleviating the physical and cognitive aspects of frailty, but, should also consider the implications the interventions themselves have for
construction of identity. The importance of maintaining a sense of continuity with regard to identity has emerged as an important aspect of managing frailty and clinicians should be sensitive to how interventions affect their client’s sense of self. For example, we need to assess whether encouraging independence may overwhelm a client who would rather focus her limited energy on achieving alternate goals.

Thirdly, I believe that ethnicity, when conceptualized as being integral to the core self, can be used as resource to maintain continuity of identity. Ethnicity acts to shape a person’s behavioural repertoire thus influencing the choices and actions which can be taken when individuals are confronted with the onset of frailty. These choices and actions then inform how strategies are implemented in the situational context of frailty. Awareness and active utilization of ethnicity as a therapeutic tool can help to effect a valued identity through affirming a personal sense of competence and enabling the client to incorporate new aspects of the self.

**IMPLICATIONS FOR HEALTH CARE POLICY**

Finally, from a policy perspective, this research accentuates the active role that individuals assume in creating their identities. The elderly women who were interviewed continually integrated past and present views of themselves while they incorporated new aspects of the self to construct cohesive and valued identities during a tenuous time when they were not only losing control over their physical and cognitive selves, but also over how they claimed their social identities. It is imperative that in the interests of meeting the needs of the ‘frail
elderly, the individual behind the construct of frailty remains visible. While the framework utilized in this study emphasized the similarities between the women in this study, it is important to recognize that each woman was a unique individual who brought a lifetime of interactions to the experience of frailty. There exists the risk that categorizing individuals as frail can undermine their personal quest to achieve and maintain a valued identity which may not be directly informed by frailty.

LIMITATIONS OF STUDY

The limitations of this study pertain to methodological and theoretical concerns. First, the interview guide did not directly refer to ethnicity and how ethnic background affected how the women lived their daily lives while experiencing the onset of frailty. I hoped that the influence of ethnicity on daily life would emerge during the course of the interview and it did not. The women interviewed did not explicitly discuss their ethnic background and although my understanding of frailty was enhanced, I think a more comprehensive view of ethnicity would require a direct question concerning the impact of ethnicity on the experience of frailty.

Second, even though my sample was comprised of women from three different ethnic backgrounds, the woman shared many other characteristics in terms of their lifestyle, socio-economic status, degree of frailty and involvement with home support services. In other words, they were a fairly homogenous group which initially I had hoped would help me to view more clearly the experiences of frailty using the lens of ethnicity. My findings may not
be applicable to women who are more entrenched in their ethnic communities, for example, recent immigrants to Canada from Poland. I also focused my recruitment on women who met criteria pertaining to the physical parameters of frailty. Women who are experiencing more cognitive limitations such as memory losses and difficulty with concentration may offer different insights into this experience.

Finally, in accordance with a phenomenological research approach, using myself as a research tool also conferred limitations on study. That is, by directly inserting myself in the data collection, my own age and ethnic identity could influence the interview process. For example, the women interviewed may not have been comfortable discussing certain details of their lives which would have implications for the kind of data that was collected in this study.

**IMPLICATIONS FOR FURTHER RESEARCH**

The implications for further research as suggested by this study include expanding the scope and breadth of the parameters of this study. In terms of scope, different ethnic groups could be studied to ascertain if there was congruence with the findings reported for this study. In addition, since the construct of frailty has been postulated as having more relevance for health care workers than for persons who are elderly themselves, it would follow that a study seeking to elicit health care workers' understanding of the experience of frailty would be justified.
In terms of expanding on the breadth of this study, it would be informative to proceed with follow-up interviews with the participants to determine to what extent the strategies identified in this study enabled them to maintain continuity with an established identity, particularly if they became more frail. It would also be instructive to interview family members and caregivers to provide a more comprehensive view of the social world of the elderly women included in this study. In order to elicit more data on ethnicity, the interview guide should include a question that explicitly refers to how ethnicity affects the experience of frailty.

**SUMMARY**

In Chapter Three, I made reference to my theoretical framework as a "compass" I would use to navigate my course of discovery. My destination, revealing the meaning of frailty for elderly women and understanding how ethnicity frames this experience, could be reached using a wide array of different compasses. Using the compass of phenomenology, informed by the tenets of symbolic interactionism, I have had the opportunity to navigate an amazing journey linking meaning, context and voice for elderly women living alone in the community. A journey where each turn, twist and obstacle has furthered my own understandings not only of frailty and ethnicity, but also what it means to share with others this incredibly wonderful and complex thing called life.

In conclusion, this study has used a phenomenological approach to further our understanding of how ethnic background frames the experience of frailty for elderly woman living alone in the community. Data analysis revealed that for the women in this study, the onset of frailty
was experienced as an affront to established identity and various strategies were implemented to maintain a sense of continuity with respect to established identity. These strategies involved affirming personal competence through adhering to a predictable daily routine and reframing abilities and incorporating new aspects of the self through restructuring roles, negotiating shifting relationships, and altering expectations. These strategies enabled the elderly women in this study to maintain a personally valued identity when confronting the onset of frailty.

In light of these findings, it would appear that we need to rethink our perceptions concerning how people who are aging view themselves. We cannot assume there is a link between getting older and feeling more frail. The state of being old has already been stigmatized (Matthews, 1979); conferring the stigma of frailty on people who are elderly may only further undermine their quest to maintain a valued identity, an identity which is informed by a multitude of factors such as ethnicity, and whose expression renders each of our lives meaningful and unique.
REFERENCES


Culture, 1, 110-122.


Appendix A

INTERVIEW GUIDE

(1) Please describe for me how you spend a usual day?

(2) What sorts of things are important for you to do?

(3) Some people find that as they get older they can't do the same things they used to do - has this happened to you? Can you tell me about it? Is it important to you?

(4) Who do you like to spend time with? How do you get together? Where do you go? What do you do?

(5) What's the most important thing you would like me to know about you?

Probes will include such phrases as: please go on; tell me more; and, is there anything else that you'd like to add?

End interview by thanking participant for time and assistance.
Appendix B

DESCRIPTION OF THE WOMEN INTERVIEWED

Francine

Francine is an eighty-four year old woman who has identified a Polish ethnic affiliation. She has lived in Canada for sixty years but she still retains a slight accent. Francine looks younger than her stated age and she comes to the senior’s centre every week day. While at the centre she does not actively participate in the structured activities but she enjoys spending her time talking with others and reading. She lives in her own home and for the past five years she has shared her home with a niece who works full time out of the house. Francine can walk on her own with minimal difficulty but she has arthritis in her shoulder which limits her ability to look after some of her self care needs. She receives home care assistance with bathing. She does not drive and so she relies on others to take her grocery shopping and visiting.

Joan

Joan is a seventy-five year old woman who has described her ethnic background as English and Welsh. She lives in a bachelor apartment on her own and she has one son who lives in Toronto. Joan presented a very upbeat and positive attitude and she was eager to participate in the interview. She comes to the centre on Tuesdays and Thursdays and enjoys participating in activities such as Bingo and socializing with other seniors and staff. Joan
walks with the assistance of a walker and she also has an oxygen tank to assist her with breathing as she becomes short of breath with exertion.

**Kathleen**

Kathleen is a seventy-eight year old woman who describes her ethnic affiliation as Jamaican. She looks younger than her stated age and she dresses quite formally, wearing a dress, hat and pumps for the interview. Kathleen answered the interview questions with ease; however, at the end of the interview she had difficulty locating her keys and she became quite distraught. She disclosed that her memory was poor since she had experienced a stroke three years ago. Her right hand is also very weak. Kathleen lives on her own and receives assistance with personal care and homemaking. She has one nephew in Toronto and the rest of her extended family lives in Jamaica or the United States. She comes to the centre five days a week. Kathleen describes herself as very religious and she views preaching the Gospel as the most important thing in her life.

**Shirley**

Shirley is a seventy-nine year old woman who describes her ethnic background as Jamaican. She has two sons that live in Toronto and she splits her time living with each of them. She spends the weekdays with one son and his family so that she can attend the centre and she spends the weekend with her other son. She has fourteen grandchildren in total and she describes her relationship with the grandson with whom she lives as being particularly close. Shirley had a stroke ten years ago and she walks quite slowly but steadily. She has visible cataracts in her eyes and reports that her eyes are failing her. She also talks about arthritis in
her knees which makes it very difficult to bend them and she takes aspirin to help relieve the
pain. Unfortunately, the tape was not recording for this interview so I was not able to use
direct quotes; however, I used my own notes from the interview to include in the study.

Jane

Jane is a seventy-five year old woman who describes her ethnic background as Polish and
French Canadian. She lives in an apartment and her husband is currently hospitalized. She
also has a daughter who lives in the same apartment building and another daughter who lives
with her two children in Scarborough. Jane fractured her left hip a few years ago and she has
had two operations since then. She uses a walker to ambulate and her gait is slow with a
noticeable limp. She comes to the centre during the week and she spends her time sitting at
the same table and socializing with the group that shares the table.

Louise

Louise is a seventy-six year old woman whose ethnic background is African-Caribbean.
Louise also lived in England and she moved to Canada in the late eighties. She has
experienced two strokes and she also has glaucoma. Louise participates in the activities
offered at the centre and she also assumes additional responsibilities such as taking care of
the plants that are in the windowsills.

Beth

Beth is an eighty-five year old woman who is African-Caribbean. She lives alone in an
apartment and has never married. She has a very close relationship with her nieces and
nephews who live in Toronto and Brampton. Beth attends the programs at the Senior’s Centre on Mondays, Wednesdays and Fridays. She experiences dizzy spells and has difficulty with her balance and she is also a diabetic. Beth enjoys socializing with other seniors at the centre and she is actively involved with her church. Unfortunately, Beth’s interview was often difficult to transcribe because she has quite a strong Jamaican accent.

**Ella**

Ella is an eighty-three year old woman with a Polish ethnic background. She was widowed a number of years ago and she continues to live in her own home which is a duplex. Ella lives in the lower level and she rents the upper level to tenants. She attends the Senior’s Centre on Tuesday and Wednesday where she spends much of her time volunteering in the tuck shop. On the weekends she stays with her son and his family. Ella states that she has some problems with her hips and she is also a diabetic who has to watch her diet and her blood pressure.

**Kay**

Kay is a seventy-year old African-Caribbean woman who is originally from Trinidad. She is the youngest woman in the sample and she currently lives with members of her immediate family; however she was included in the sample because of the difficulty finding African-Caribbean woman who met all of the criteria for inclusion in the study. Kay has eight children, six of whom live in Toronto. She has recently stopped working as a aide in a nursing home due to painful arthritis in her knees which has limited her mobility. She is also
diabetic. Kay attends the centre one day a week and she is very involved with her church as a Seventh Day Adventist.

**Sally**

Sally is a seventy-six year old African-Caribbean woman who lives alone in a Senior’s apartment. She has no family in Toronto and has never been married. She has been in a wheelchair for the past two months as she has difficulty walking related to arthritis. Sally attends the programs at the Senior’s Centre every week day and she worked at a university prior to retiring.

**Ann**

Ann is a ninety-four year old Anglo-Saxon woman who came to Toronto from Scotland when she was twenty-three. She is widowed and lost her husband eleven years ago. She has a son and daughter who live north of Toronto but come to visit her regularly. Ann is legally blind and she lost her sight five years ago due to a fall. She use a cane to get around and states that she is not stiff or sore. Ann has been coming to the Senior’s Centre regularly for the past two years and she enjoys socializing with the people who sit at her table.

**Abigail**

Abigail is a seventy-five year old woman with a Polish background. She lives on her own in a two bedroom apartment and lost her husband the previous year. She has some hand deformities related to arthritis and she was also recently hospitalized for a respiratory infection. Unfortunately, the interview was recorded at high speed and I was not able to
transcribe the interview so the data obtained from this interview was minimal. I tried on several occasions to set up interviews with other Polish woman but unfortunately the women cancelled due to health reasons and I was not able to conduct another interview in the time frame I was adhering to.

**Martha**

Martha is a seventy three year old Anglo-Saxon woman who lives in her own apartment in a senior’s housing complex. Martha has osteoarthritis (OA) and she uses a scooter to get around. She also wears splints on her wrists and she has visible deformities on her hands which limit her ability to use her hands. She is actively involved in volunteer work and prior to being diagnosed with OA she was a caseworker. She has nine children from two marriages as well as fourteen grandchildren who live all over Canada.

**Minnie**

Minnie is an eight-eight year old Anglo-Saxon woman who lives in her own home. She was widowed eight years ago and she has two daughters, one of whom resides in the same city. Minnie enjoyed a career as a school teacher for twenty-eight years and she still confesses a strong affection for children. Currently, she finds it difficult to walk due to pain in her ankles, hips and back which is related to arthritis. She uses a cane when she needs to walk for longer distances and she also wears a corset to help support her back. She does not attend organized senior’s programs but she enjoys socializing with friends and relatives.
INFORMATION LETTER

Dear Potential Participant,

My name is Michelle Meneley and I am a graduate student at the University of Toronto. I would like to invite you to participate in a research project I am doing for my master's thesis. My research will involve asking women over the age of 74, from different ethnic backgrounds, about their daily activities.

I will ask these questions during an interview that will take about 60 minutes and it can take place in your home or some other place you would like. I will send a copy of the types of questions I will ask before the interview so you will know what to expect. Each interview will be taped with a tape recorder so I can focus on listening to what you have to say.
I would really appreciate your help with this research project. Nobody will know your name and all personal information will be kept strictly confidential. If you would like, I will give you my report at the end of the study. Whether you participate or not will in no way affect your care and is completely separate from the services you receive as confirmed by

.................................................................
(Signature of representative from home care agency)

Please let me know if you are interested in participating in this study. My phone number is (416) 789-2174 and I would be happy to answer any of your questions.

Thank you for your time.

Sincerely,

Michelle Meneley
Appendix D

CONSENT FORM

Daily Activities Study

I, ................................................................., consent to be interviewed and tape-recorded as part of a student research project about the daily activities of elderly women from different ethnic backgrounds for the master's thesis of Michelle Meneley of the University of Toronto, Department of Community Health. I understand that even though I have agreed to take part, I can withdraw at any time and I can refuse to answer any questions.

I also understand that my identity will not be known and my name will not be attached to any quotes that are used. I understand the study results will only be used for educational and academic publication purposes. I
may request at any time that my answers are not to be used in this study.

I understand that there are no direct risks to myself if I participate in the study. I also understand that there are no direct benefits. I can request copies of any reports or papers that are written as a result of this study.

..............................................................
Signature and Date
Appendix E

CONFIRMATION LETTER

Daily Activities Study

Dear .............................................,

Thank you so much for your call expressing interest in my study about how older women go about their daily activities. I am delighted that you agreed to participate and I would like to confirm that we are meeting on ................................ at ............... o'clock at ..........................................................

The interview will last about 60 minutes.

I have included a consent form with this letter for you to sign. This consent form will make sure your identity is protected at all times and lets you know you can withdraw from the study at any time. I have also
included a copy of the interview guide so you will have an idea of what I will be asking.

If you have any of your own questions, please call me at (416) 789-2174, before or after our interview session. You can also call my thesis supervisor at the University of Toronto, Professor Ann Robertson at (416) 978-6051 if you have concerns about myself or the interview.

Thank you again for your support of this study,

Sincerely,